



# **STRATEGY TO PREVENT AND MINIMISE GAMBLING HARM**

**2019/20 – 2021/22**

**Submissions Analysis for the Ministry of Health**

**Final Report: 2 November 2018**



**ALLEN+CLARKE**

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# CONTENTS

|  |           |
|--|-----------|
| <b>CONTENTS</b>  | <b>3</b>  |
| <b>GLOSSARY</b>  | <b>7</b>  |
| <b>TABLES</b>  | <b>7</b>  |
| <b>FIGURES</b>   | <b>7</b>  |
| <b>EXECUTIVE SUMMARY</b>   | <b>8</b>  |
| Eighty-two submissions received  | 8         |
| Question-based thematic analysis by sector   | 8         |
| Analysis of key themes by sector   | 8         |
| Summary of key themes  | 8         |
| The need for a refocus and rethink was generally supported, but there were divergent views on the preferred direction of change  | 8         |
| Submitters considered that harm minimisation efforts could be significantly enhanced by using emerging technologies  | 9         |
| The proposed management of the \$5m underspend was polarising  | 9         |
| The proposed funding allocations drew comments that were often siloed by sector  | 10        |
| There was broad support for the development of comprehensive culturally-specific health promotion, treatment and support services                                      | 10        |
| The convergence of online gaming and gambling was particularly concerning, especially because of the implications for youth  | 10        |
| Sectors opinions and preferences varied concerning the expenditure/presentation weightings   | 10        |
| Online gambling providers with business in New Zealand, including those based outside New Zealand, should all be subject to the levy                                   | 11        |
| Removing NCGM venues from lower socioeconomic areas was broadly supported, but there was little support for incentivising moves to higher socioeconomic areas          | 11        |
| <b>1. INTRODUCTION</b>   | <b>12</b> |
| 1.1. Purpose of this report  | 13        |
| 1.2. Methodology   | 13        |
| 1.3. Summary of submitters   | 14        |
| 1.3.1. Number and type of submitters   | 14        |
| 1.4. General comments on submissions received  | 16        |
| 1.5. How to navigate this report   | 17        |
| <b>2. THE DRAFT STRATEGIC DIRECTION</b>  | <b>18</b> |
| 2.1. Degree of support for the draft strategic direction   | 18        |
| 2.1.1. Roughly half of the submitters supported the draft strategic direction to some degree   | 18        |
| 2.1.2. Some submitters had concerns about the proposed strategic direction   | 20        |
| 2.1.3. Some submitters agreed that the strategic direction adequately reflected changes in the gambling environment  | 31        |
| 2.1.4. Others stated that the strategic direction needed strengthening to recognise new challenges and opportunities in the gambling environment                       | 32        |
| 2.2. The degree of support for draft objectives and priorities for action  | 33        |
| 2.2.1. Some objectives were identified as more important than others   | 33        |
| 2.2.2. Priority actions to reduce inequality and inequity were broadly supported, with Service Providers strongly advocating for culturally-specific supports services | 35        |
| 2.2.3. Additional objectives and priority actions were suggested, especially technological enhancements for harm minimisation  | 39        |

|           |   |           |
|-----------|---|-----------|
| <b>3.</b> | <b>THE DRAFT SERVICE PLAN</b>   | <b>42</b> |
| 3.1.      | The degree of support for the proposed funding allocation   | 43        |
| 3.1.1.    | Submitters argued for and against the proposed funding appropriation  | 43        |
| 3.1.2.    | For NCGM sector submitters, reduced presentations and uninspiring spending proposals made the proposed funding appropriation inappropriate              | 44        |
| 3.1.3.    | Opinions about the size of the appropriation were split by sector   | 46        |
| 3.1.4.    | High-level change for the funding of gambling harm minimisation was sought by some submitters   | 46        |
| 3.2.      | The degree of support for the proposed Service Plan   | 47        |
| 3.2.1.    | Collaborative, innovative treatments, that were culturally tailored to priority populations, were requested   | 47        |
| 3.2.2.    | Accountability, prevention, and collaboration were important to submitters  | 47        |
| 3.3.      | The degree of support for Public Health Services draft priorities   | 48        |
| 3.3.1.    | Additional funding and assurances that priority populations will benefit were requested   | 48        |
| 3.4.      | The degree of support for Intervention Services draft priorities  | 50        |
| 3.4.1.    | A wide range of additional intervention activities were requested   | 50        |
| 3.4.2.    | NCGM sector submitters withheld support for a range of intervention activities  | 52        |
| 3.5.      | The degree of support for Research and Evaluation draft priorities  | 53        |
| 3.5.1.    | A range of research and evaluation activities were supported by most sectors  | 53        |
| 3.5.2.    | There was cross-sector agreement about research and evaluation priorities   | 54        |
| 3.6.      | Ministry Operating Costs  | 54        |
| <b>4.</b> | <b>THE LEVY FORMULA AND ALTERNATE LEVY WEIGHTINGS</b>   | <b>55</b> |
| 4.1.      | The degree of support for player expenditure forecasts  | 55        |
| 4.1.1.    | Forecasts were considered unrealistic, because they do not reflect the full scope of harmful products or the impact of that harm to individual gamblers | 55        |
| 4.2.      | The degree of support for the various weighting options   | 56        |
| 4.2.1.    | The NCGM Sector and some Gambling Industry (other) submitters preferred the 30/70 weighting   | 57        |
| 4.2.2.    | Gambling Industry (other) submitters preferred the 10/90 weighting  | 59        |
| 4.2.3.    | A Health sector submitter preferred the 20/80 weighting   | 60        |
| 4.2.4.    | Alternative weighting options were suggested  | 60        |
| 4.2.5.    | Other comments about weightings were made   | 61        |
| 4.3.      | The degree of support for the levy rates  | 61        |
| 4.3.1.    | The use of presentation data in the levy formula is contested by NCGM sector and Service Provider submitters  | 62        |
| 4.3.2.    | There is some support for increased complexity in levy setting for the NCGM sector  | 62        |
| 4.3.3.    | A Gambling Industry (other) submitter commented that the levy does not reflect casino host responsibility initiatives                                   | 63        |
| 4.3.4.    | Additional considerations were proposed for setting levy rates  | 63        |
| 4.3.5.    | Research and evaluation costs should be borne equally by all four gambling sectors  | 64        |
| <b>5.</b> | <b>POLICY IN RELATION TO NCGM VENUES AND THE LEVY FORMULA</b>   | <b>65</b> |
| 5.1.      | The degree of support for incentivised relocation of NCGM venues  | 65        |
| 5.1.1.    | There was broad support for allowing NCGM venues to relocate, however, incentivisation was not generally supported                                      | 65        |
| 5.2.      | Structural barriers to relocating NCGM venues were identified   | 67        |
| 5.3.      | Incentives to support relocation were suggested   | 69        |

|           |  |           |
|-----------|--|-----------|
| 5.4.      | The degree of support for the levy formula policy  | 71        |
| 5.4.1.    | Suggestions were made for improving the levy formula   | 71        |
| 5.4.2.    | Service Providers identified other considerations which needed to be included when developing the formula                                  | 73        |
| 5.4.3.    | A Local Government submitter commented that the financial burden of administering the Act needs to be reduced                              | 73        |
| 5.4.4.    | Some submitters did not understand the formula   | 73        |
| <b>6.</b> | <b>OTHER ISSUES RAISED BY SUBMITTERS</b>   | <b>74</b> |
| <b>7.</b> | <b>THEMATIC ANALYSIS BY SECTOR</b>   | <b>76</b> |
| 7.1.      | Use of presentation rates in calculating the levy  | 76        |
| 7.1.1.    | Service Provider submitters did not support reliance on presentations  | 76        |
| 7.1.2.    | NCGM sector submitters considered there should be less emphasis on presentations   | 76        |
| 7.1.3.    | Gambling Industry (other) submitters supported a higher presentations weighting  | 76        |
| 7.1.4.    | Local Government submitters supported a higher presentations weighting   | 77        |
| 7.2.      | Player expenditure forecasts were considered unrealistic   | 77        |
| 7.2.1.    | Service Provider submitters  | 77        |
| 7.2.2.    | Individuals  | 77        |
| 7.2.3.    | Gambling Industry (other) submitters   | 77        |
| 7.3.      | Culturally specific services are required for Māori  | 77        |
| 7.3.1.    | Service Provider submitters  | 77        |
| 7.3.2.    | Health sector submitters   | 78        |
| 7.3.3.    | Individual   | 78        |
| 7.4.      | Culturally specific services are required for Pasifika   | 78        |
| 7.4.1.    | Service Provider submitters  | 78        |
| 7.4.2.    | Health sector submitters   | 78        |
| 7.4.3.    | Individual   | 78        |
| 7.5.      | Culturally specific services are required for Asian populations  | 78        |
| 7.5.1.    | Service Provider submitters stressed that gambling is perceived very differently in Asian cultures compared to western or Pacific cultures | 78        |
| 7.5.2.    | Individuals  | 79        |
| 7.6.      | Increasing online gambling was a cross-sector concern  | 79        |
| 7.6.1.    | Service Provider submitters focused on an increasing treatment need  | 79        |
| 7.6.2.    | Local Government submitters noted this an emerging concern   | 79        |
| 7.6.3.    | NCGM sector submitters were concerned that providers are not contributing to the levy  | 79        |
| 7.6.4.    | Gambling Industry (other) submitters encouraged more research  | 80        |
| 7.6.5.    | Health Sector submitters encouraged more research  | 80        |
| 7.6.6.    | Individuals were concerned about the lack of regulation  | 80        |
| 7.7.      | Young people and gambling  | 80        |
| 7.7.1.    | Service Provider submitters want a greater focus on youth in the Strategy  | 80        |
| 7.8.      | Advertising of gambling services and of support services: each need attention  | 80        |
| 7.8.1.    | Service Provider submitters want to restrict the promotion of gambling   | 81        |
| 7.8.2.    | NCGM sector submitters noted the relationship between advertising and problem gambling   | 81        |
| 7.8.3.    | Local Government submitters sought more information  | 81        |
| 7.8.4.    | Health sector submitters sought more information   | 81        |
| 7.8.5.    | Individual submitters made practical suggestions to reach people in need of help   | 81        |
| 7.9.      | Peer support was backed, but there were reservations about residential services  | 82        |

|  |  |           |
|--|--|-----------|
| 7.9.1.                                     | Service Provider submitters were supportive of both proposals                                    | 82        |
| 7.9.2.                                     | NCGM sector submitters were more supportive of peer support than residential services            | 82        |
| 7.9.3.                                     | Individuals were generally supportive of peer support  | 82        |
| 7.9.4.                                     | Health sector submitters were generally supportive   | 82        |
| 7.9.5.                                     | Gambling Industry (other) submitters were generally supportive                                   | 83        |
| 7.10.                                      | Venue relocation and incentivisation   | 83        |
| 7.10.1.                                    | Service Provider submitters did not support incentivisation                                      | 83        |
| 7.10.2.                                    | NCGM sector submitters highlighted structural barriers to relocating                             | 83        |
| 7.10.3.                                    | Health sector submitters opposed incentivisation   | 84        |
| 7.10.4.                                    | Local Government submitters acknowledged structural barriers and did not support incentivisation | 84        |
| 7.10.5.                                    | Gambling Industry (other) submitters noted structural barriers                                   | 85        |
| 7.10.6.                                    | Individuals did not support relocation or incentivisation  | 85        |
| <b>APPENDIX A – LIST OF SUBMITTERS</b>     |  | <b>86</b> |
| <b>APPENDIX B – CONSULTATION QUESTIONS</b> |  | <b>88</b> |

**GLOSSARY**

- DIA:** Department of Internal Affairs
- HPA:** Health Promotion Agency
- The Ministry:** The Ministry of Health
- MVE:** Multi-venue Exclusion
- NCGM:** Non-casino Gaming Machine
- NZRB:** New Zealand Racing Board
- PCOMS:** Partnering for Change Outcomes Measurement System
- PGSI:** Problem Gambling Severity Index

**TABLES**

|   |    |
|---|----|
| Table 1: Secondary category by ethnicity  | 15 |
| Table 2: Yes/No responses to questions concerning the strategic direction   | 18 |
| Table 3: Number of submissions, by submitter classification, concerning the Strategic Framework   | 18 |
| Table 4: Number of submissions, by sector, that commented on the objectives to explain why they either did not support or gave qualified support to the draft Strategic direction | 21 |
| Table 5: Questions about the draft Service Plan from the consultation document  | 42 |
| Table 6: Number of submissions, by sector, that addressed the Service Plan  | 42 |
| Table 7: The proposed funding allocation by service area over three years   | 43 |
| Table 8: Indicative detailed costings for the \$5 million underspend  | 43 |
| Table 9: Yes/No responses to questions concerning the levy rates and formula  | 55 |
| Table 10: Number of submissions, by sector, that addressed questions about the levy   | 55 |
| Table 11: Yes/No responses to questions concerning incentivising NCGM venues to relocate  | 65 |
| Table 12: Number of submissions, by Sector, that commented on the proposed NCGM incentivised moves  | 65 |
| Table 13: List of submitters, sorted by submitter unique ID   | 86 |
| Table 14: List of submitters, sorted alphabetically   | 87 |

**FIGURES**

|  |    |
|--|----|
| Figure 1: Organisation submitters by sector type | 15 |
|--|----|

## EXECUTIVE SUMMARY

### Eighty-two submissions received

Eighty-two submissions were received on the Ministry of Health's Strategy to Prevent and Minimise Gambling Harm 2019/20 to 2021/22 consultation document (the Strategy). This is almost double the number of submissions received during the 2015 consultation. Submissions were received from a range of submitters:

- Twenty-two from the Non-Casino Gaming Machine<sup>1</sup> (NCGM) sector (19 societies, two pubs, and one club)
- Twenty-one from the Service Provider sector (15 clinical treatment providers, four other public health providers, and two training providers)
- Thirteen from the Health sector (five District Health Boards (DHB), two public health agencies, and six other organisations that have a health focus)
- Eight from the Gambling Industry (other) (four gambling technology-related organisations, two casino operators, Lotto NZ, and the New Zealand Racing Board)
- Six from Local Government, and
- Twelve from individuals.

### Question-based thematic analysis by sector

All submissions were coded to a question-based core coding frame using NVivo 12. Within this database, submissions were thematically coded to iteratively develop a comprehensive thematic coding frame based on the questions posed in the consultation document. The analysis was supported by queries developed within NVivo so that responses to some questions (identified by the Ministry) could be analysed by sector or other classification attributes.

### Analysis of key themes by sector

Following identification of key themes, which often crossed multiple questions, a further section was added, examining these themes by sector, to complement the 'within-question' analysis.

### Summary of key themes

All 82 submissions contained relevant comments. Submitter's comments largely focused on what else could be included in the Strategy to reflect changes in the gambling environment, the detail of the levy weighting, or related policy commentary. Key themes from the submissions are summarised below.

#### **The need for a refocus and rethink was generally supported, but there were divergent views on the preferred direction of change**

About half the submitters expressed support for the draft Strategic Direction, with strongest support coming from the Service Provider, Health, and Local Government sectors and individuals.

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<sup>1</sup> Also known as Class 4 electronic gaming machines

Some submitters, particularly from the NCGM sector, while being supportive of the Ministry's desire for a refresh, considered that the draft Strategic Direction did not go far enough, with some commenting that there was too much that was 'more of the same'.

Whilst some submitters - Local Government sector submitters in particular - agreed that the draft Strategic Direction adequately reflected changes in the gambling environment; submitters from the Service Provider, Health, NCGM and Gambling Industry (other) sectors considered that it needed strengthening, particularly to recognise new challenges as well as opportunities afforded by technology – such as the challenge of increasing online gambling, which is discussed below; and the opportunity to better utilise technology to support harm minimisation efforts, which is also discussed below.

### **Submitters considered that harm minimisation efforts could be significantly enhanced by using emerging technologies**

Objective 8 – which includes a focus on harm minimisation technologies – was especially well supported by submitters from the NCGM, Service Provider, and Gambling Industry (other) sectors.

There was some call from NCGM sector and Gambling Industry (other) submitters for the Ministry to establish a technology fund that would provide financial assistance for gambling venues to invest in facial recognition software, in support of exclusion order systems that are often hampered by the lack of such technology – especially in smaller venues.

A further indication of support for the better use of technology was the prioritisation by submitters of the *Emerging Issues* category of potential research and evaluation activities. This category is made up of research proposals that focus on the use of the internet (online gambling); and the convergence of gaming and gambling: a situation that gives rise to a problem addressed further below – increasing gambling and presentations by youth.

### **The proposed management of the \$5m underspend was polarising**

The proposal to use the \$5m underspend in addition to the levy was rejected primarily by submitters from the NCGM and Gambling Industry (other) sectors. The level of concern was sufficiently significant that some submitters suggested that the proposal was illegal.

There were suggestions that the underspend should be refunded; that the Ministry should use the money to establish a 'technology fund', and/or that the levy calculation formula should be clarified to avoid such ambiguity in the future.

However, for other submitters (such as Service Providers), the proposal to use the underspend to top up the funding anticipated through the appropriation made sense and was uncontentious. For some, this approach would allow for more treatment services; and for others, the appropriation alone appeared to be insufficient to carry out the proposed activities.

Predominantly NCGM sector and Gambling Industry (other) submitters considered that the levy formula could be improved, and they made suggestions for doing so, often concerning the interpretation of variables R and C.

It appeared that some submitters had accessed more information than others concerning the proposed use of the \$5m underspend. Although additional information shared at consultation forums was made available via the Ministry website during the consultation period, it was apparent from some of the comments that some submitters had not accessed it either via the website or through the forums. As a result, the submissions have been developed with varying background material in mind.

### **The proposed funding allocations drew comments that were often siloed by sector**

Submitters from several sectors (Service Provider, Health and Local Government) were concerned that the proposed funding was inadequate for workforce needs. They pointed out that treatment provider pay needs to reflect the qualifications needed for the work. Submitters from these sectors also argued for more funding to promote treatment services, and to develop models of care suited to ethnically-defined populations.

Concerns that funding needs to be directed toward activities that address inequities were frequently expressed by submitters from the Service Provider, Health, and Local Government sectors. They sought assurances that proposed research will make a positive difference for people from priority populations who are experiencing gambling harm; and/or that it will advance harm minimisation.

In contrast, a subset of NCGM submitters considered that the proposed secondary analysis of the National Gambling Study and the proposed meta-analysis of the Health and Lifestyle Survey data were unable to add anything new to the present understandings about harm minimisation, or which populations groups were more at risk of harm from gambling. They were additionally dubious about outcomes because of the age of the data in the proposed meta-analysis and secondary analysis. However, these views were confined to one sector. NCGM submitters also argued for a separate fund to be established to assist venues with the adoption of harm minimisation technologies, such as facial recognition software that would enhance enforcement of exclusions.

A group of submitters from the NCGM sector also requested the Ministry cease funding service providers whom they considered to be undertaking 'misleading advocacy' such as promoting 'sinking lid' policies, objecting to liquor license applications, and other activities they considered contrary to the aims of harm minimisation.

### **There was broad support for the development of comprehensive culturally-specific health promotion, treatment and support services**

Submitters from across the sectors considered that Māori, Pasifika, and Asian populations experience a greater burden of gambling harm than other populations. Further, Service Providers recognised that the gambling experience and the treatment needs differ by sub-group. It was considered that no further gains can be made in the treatment and support of those experiencing gambling harm by taking 'one-size-fits-all' or 'mainstream' approaches. Dedicated support services were called for, for each population subgroup, including 24/7 online and helpline support services, health promotion literature, and advertising – all in first languages.

### **The convergence of online gaming and gambling was particularly concerning, especially because of the implications for youth**

The need for treatment services suited to working with young people was identified. The opinion that early and often inadvertent exposure to gambling via online games was a threat to youth and therefore had potential to significantly increase demand for treatment services was behind the broad support amongst submitters for *Emerging Issues* research proposals. Some treatment providers noted that they are already providing services to young teens. The inadvertent nature of increased gambling amongst youth also prompted some submitters to comment that there could be benefit in targeted health education concerning gambling.

### **Sectors opinions and preferences varied concerning the expenditure/presentation weightings**

Almost all the submissions that addressed this section were from either the NCGM sector or the Gambling Industry (other) sector. Twenty-three submitters identified a preferred weighting:

- seventeen submitters (mostly NCGM sector) preferred the 30/70 weighting, and

- five submitters (mostly Gambling Industry (other) sector) preferred the 10/90 weighting
- one submitter (Health sector) preferred the 20/80 weighting.

Two submitters favoured a lesser weighting on presentations, but they had no preference between 20/80 or 30/70.

Submitters who favoured 30/70 and submitters who favoured 10/90 each used a rationale of 'fairness', with competing notions of what is and is not *fair* being argued: namely, the extent to which it is considered appropriate and fair to include presentations in the calculation. The different schools of thought drew on conflicting bodies of evidence and common-sense notions to back their arguments.

Two submitters (both NCGM sector) suggested an alternative weighting based on 100 percent expenditure and 0 percent presentations, arguing that higher presentation numbers are a positive rather than a negative. Another submitter (Service Provider) suggested an alternative weighting of 50/50, arguing that this weighting would ensure a more equal share across the gambling modes.

### **Online gambling providers with business in New Zealand, including those based outside New Zealand, should all be subject to the levy**

There was cross-sector awareness and concern about increasing levels of online gambling in New Zealand, and it was considered unfair that providers outside of New Zealand were not subject to the levy. As a result, people requiring treatment due to gambling harm from online gambling are getting services that are funded through other gambling modes.

### **Removing NCGM venues from lower socioeconomic areas was broadly supported, but there was little support for incentivising moves to higher socioeconomic areas**

Submitters broadly supported the proposal to allow NCGM venues to relocate, with 43 submitters either supporting or giving qualified support. However, the accompanying comments from Service Providers, Local Government, Health sector and NCGM sector submitters suggested there was little support for incentivisation. Instead, comments tended to favour 'sinking lid' policies, and to note that relocation was contrary to public health aims.

NCGM and Gambling Industry (other) sector submitters identified structural barriers to relocating NCGM venues, particularly local authority policies.

Some NCGM submitters proposed incentives to support relocation, such as increasing the bet size, the prize size, and the number of machines.

## 1. INTRODUCTION

Cabinet allocated the Ministry of Health (the Ministry) responsibility under the Gambling Act 2003 to develop and implement an integrated, public health focused problem gambling strategy at least every three years [sections 317 and 318 of the Gambling Act refer]. Through the Act, the Crown recovers the cost of developing and implementing the strategy by way of a 'problem gambling levy', set by regulation at a different rate for each of the main gambling sectors (i.e., the New Zealand Racing Board, Lotteries Commission, casinos and non-casino gaming machines (NCGMs)). The strategy must include:

- Measures to promote public health by preventing and minimising the harm from gambling
- Services to treat and assist problem gamblers and their families and whānau; and
- Independent scientific research associated with gambling (including longitudinal research on social and economic impacts), and evaluation.

The Ministry uses insights from a needs assessment to outline proposed services to be delivered and indicative budgets for the next three years.

On 20 August 2018, the Ministry released a consultation document *Strategy to Prevent and Minimise Gambling Harm 2019/20 - 2021/22* (the Strategy). This document sought feedback on the:

- Draft six-year Strategic Framework 2019/20 to 2024/25
- Draft three-year Service Plan 2019/20 to 2021/22
- The proposed funding levels for the Ministry (in relation to gambling harm prevention and minimisation activities)
- Proposed new problem gambling levy rates and weighting options for each sector for 2019/20 to 2021/22, and policy on the levy formula, and
- Policy regarding the concentration of NCGMs in lower socioeconomic areas.

The consultation document included fifteen questions (questions 1-15) and four sub-questions (A-D) to guide submitters' feedback in relation to these areas:

- Questions 1-5 asked stakeholders about the draft Strategic Framework
- Questions 6-10 asked stakeholders about the draft Service Plan and funding
- Questions 11-14 asked stakeholders about the levy formula and levy rates
- Sub-questions A-C asked stakeholders about the policy in relation to NCGMs
- Sub-question D asked stakeholders about the reasonableness of the levy formula as a reflection of the relative harm caused by each gambling sector, and
- Question 15 asked if there was anything else that stakeholders would like to tell the Ministry about the draft strategic direction or preventing and minimising gambling harm more generally.

Allen and Clarke Policy and Regulatory Specialists (*Allen + Clarke*) was contracted by the Ministry to analyse the written submissions and provide all feedback in a finalised narrative report.

## 1.1. Purpose of this report

This report summarises views submitted on the Ministry's draft Strategy both by thematic area and by category of submitter. Evidence provided by submitters is also described where relevant.

This report will be used by the Ministry to inform the development of the final direction of the Strategy and its priorities. After considering the feedback in this report, and making any necessary revisions, the Ministry will submit its draft Strategy and levy rates to the Gambling Commission in accordance with section 318 of the Gambling Act 2003. The Gambling Commission will undertake an analysis, convene a consultation meeting and provide its own advice to the Associate Minister of Health and the Minister of Internal Affairs. Cabinet will subsequently make decisions on the shape of the Strategy and the levy rates for the next three-year period (2019/20 – 2021/22).

The consultation process about the proposals to refresh the strategy and associated levy ran for 6 weeks from 20 August to 28 September 2018. The consultation exercise targeting affected stakeholders from the gambling industry, service providers, affected communities and interest groups via email and social media. There were 10 public meetings held over 30 hours and attended by 200 people. The meetings were themed to hear from Māori, Pacific, Asian, Consumer, and Industry viewpoints and the general public.

Written notes of the verbal feedback received during the public meetings were taken by the Ministry and supplied to *Allen + Clarke*.

Due to the high level of interest at the meetings about elements of the consultation, the Ministry published additional information on its website on 20 September 2018 to assist written submitters and to respond to questions raised during and after the meetings with the Ministry. The Ministry extended its consultation period by a week to 5pm, 28 September 2018 to allow submitters time to consider the additional information. In particular, the Ministry received questions regarding the proposal to carry over \$5 million of underspent appropriation into the next Levy period for the purpose of:

- Piloting new ways of working for public health and clinical intervention services in geographical areas or communities that are currently under-served (\$3 million over 3 years)
- Piloting peer support services (\$800,000 over 3 years)
- Piloting a small amount of residential care for gambling harm (\$700,000 over 3 years)
- Evaluation of the pilots (\$500,000 over 3 years).

The Ministry clarified that in practice, this means the total funding required to fulfil the proposed Strategy is \$60.339 million over three years. However, the Ministry proposed funding this through:

- the Problem Gambling Levy recouping the cost of \$55.339 million
- the Ministry carrying over \$5 million of unspent appropriation.

The analysis of the written submissions in this report, and the verbal feedback received during the meetings is being considered by the Ministry and will inform the Ministry's response to the submissions.'

## 1.2. Methodology

All submissions were supplied to *Allen + Clarke* in electronic format. Submissions were received by the Ministry via Citizen Space (a cloud-based consultation software) and direct email submission, according to submitter preference. Submitters were asked to identify if they were an organisation (and type) or individual and could choose from a standard set of possible options. This

categorisation was supplemented by a Ministry assessment if the submitter type was not clear or not provided, or to determine a primary classification if the submitter had nominated multiple types. All submissions were collated and allocated a unique identifier by the Ministry before being provided to *Allen + Clarke*.

Once received by *Allen + Clarke*, submissions were uploaded to NVivo 12 qualitative analysis software and coded to a question-based coding frame. From this, specific reports by both theme and individual submitter were drawn and used to inform this report.

### 1.3. Summary of submitters

This section summarises the submitters who commented on the consultation document, *Strategy to Prevent and Minimise Gambling Harm 2019/20 - 2021/22* (the Strategy).

#### 1.3.1. Number and type of submitters

A total of 82 submissions were received:

- 70 submissions<sup>2</sup> from organisations, and
- 12 submissions from individuals.<sup>3</sup>

The **primary** type of organisation (sector) and the number of submitters in each sector are described in Figure 1.

The ‘NCGM sector’ includes NCGM societies, clubs, and public houses. In this document ‘sector’ is added to differentiate between discussion about NCGM venues, and submissions that have been categorised to the NCGM sector.

‘Service Providers’ are organisations that offer treatment to people who are experiencing harm from gambling. For the purposes of this analysis, AUT has been counted as a Service Provider.

The ‘Health sector’ includes organisations such as District Health Boards and Regional Public Health entities. In this document ‘sector’ is added to enhance readability.

‘Gambling Industry (other)’ groups the gambling-associated organisations except those covered by NCGM sector, above. This includes technology providers.

‘Local Government’ covers councils.

‘Individual’ is the category that groups submissions received from private individuals.

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<sup>2</sup> 01,02,03,05,06,07,08,09,10,11,12,13,14,15,16,17,18,19,20,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,39,40,41,42,43,44,45,46,50,51,52,53,54,55,56,57,58,59,60,61,63,64,65,66,C02,C04,C05,C06,C07,C08,C10,C11,C12,C13,C16

<sup>3</sup> 04,21,38,47,48,49,62,C01,C03,C09,C14,C15

Figure 1: Organisation submitters by sector type

| Primary organisation type   |  | Number of submissions received |
|---|--|--------------------------------|
|  NCGM Sector               |  | 22 submitters                  |
|  Service Provider          |  | 21 submitters                  |
|  Health Sector             |  | 13 submitters                  |
|  Gambling Industry (Other) |  | 8 submitters                   |
|  Local Government         |  | 6 submitters                   |

As well as the ability to self-identify from a range of different categories (as illustrated in Figure 1), submitters were able to identify a specific ethnic group. Eighteen organisations and individuals<sup>4</sup> identified themselves as representing the interests of specific cultural and ethnic populations. These are described in Table 1 (below).

Table 1: Secondary category by ethnicity

| Ethnic group              | Number of submissions identifying with ethnic group |
|---------------------------|---|
| Māori                     | Five submitters <sup>5</sup>                        |
| Asian                     | Five submitters <sup>6</sup>                        |
| Pasifika                  | Three submitters <sup>7</sup>                       |
| Māori and Pasifika        | Three submitters <sup>8</sup>                       |
| Māori, Pasifika and Asian | Two submitters <sup>9</sup>                         |

<sup>4</sup> 01,08,09,13,37,44,45,46,47,53,56,62,65,C03,C05,C06,C08,C10

<sup>5</sup> 09,56,62,C06,C08

<sup>6</sup> 01,08,45,46,47

<sup>7</sup> 13,53,65

<sup>8</sup> C03,C05,C10

<sup>9</sup> 37,44

## 1.4. General comments on submissions received

The comments received from submitters were diverse, focusing on a range of topics. Most submitters discussed those areas in which they had a specific interest and did not respond to the other questions posed by the Ministry.

Most submissions were unique; however, some NCGM sector submitters at least in part and sometimes substantially drew on the submission drafted by the Gaming Machine Association of New Zealand<sup>10</sup> (GMANZ) to develop their own submission.

For three NCGM sector submitters<sup>11</sup> there was substantial overlap with the GMANZ submission, with much of the content of these submissions being identical to tracts within the GMANZ submission. These submissions were coded to the same nodes of the coding frame as the GMANZ submission in 18/20 nodes, 20/24 nodes, and 18/22 nodes respectively. (The larger number is the total number of nodes the submission was coded against.) This means that most of what these submissions said was thematically aligned with (and likely to be identical to) what was said by GMANZ.

There was also considerable coding overlap between the GMANZ submission and six other NCGM sector submissions<sup>12</sup>, but the degree of overlap was substantially less than for those described above. For these six submissions, there was thematic overlap in 10/14 nodes, 12/15 nodes, 10/16 nodes, 13/29 nodes, 10/19 nodes and 13/21 nodes respectively. As the data illustrates, three of these submissions<sup>13</sup> included numerous themes that were not present in the GMANZ submissions. This is a contrast to the three submissions described above.

For the remainder of the submissions<sup>14</sup> from the NCGM sector, the themes overlap was less than ten, and there was either a reasonable balance between the overlap and the non-overlapping themes<sup>15</sup>, or there was a very small overlap and a considerable number of themes that did not overlap.<sup>16</sup>

The consultation document offered submitters the opportunity to provide opinions, facts and commentary on the Ministry's approach to preventing and minimising gambling harm over the next three years, as presented in the Strategy. The consultation questions were presented in four parts:

1. The first part, *Strategic direction*, invited stakeholders to comment on the strategic direction, objectives and priority activities.
2. The second part, *Service plan and funding*, covered the content of the service plan and indicative budgets.
3. The third part, *Levy formula and levy rates*, addressed expenditure forecasts, expenditure/presentation weightings, and the estimated levy rates for each sector.
4. The fourth part, *Policy in relation to electronic gaming machines (NCGMs) and the levy formula*, sought stakeholder views about incentivising NCGM venues to relocate away from low socioeconomic areas, and about the extent to which the present levy formula reflects the relative harm caused by each gambling sector.

Many of the comments about the Strategic direction (part 1) and the Service Plan (part 2) were inter-related, with submitters commenting on aspects of both in their responses. Commentary

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<sup>10</sup> 18

<sup>11</sup> 16,28,63

<sup>12</sup> 01,03,14,50,64,C04

<sup>13</sup> 50,64,C04

<sup>14</sup> 02,05,06,10,17,19,26,34,41,51,C07

<sup>15</sup> 02,06,10,19,26,34,41,51

<sup>16</sup> 05,17,C07

presented by submitters that was relevant to multiple sections, for example, factors that should be considered during the levy calculation and included in the Strategic direction, are discussed in the relevant sections of this report. To ensure that comments were reflected to their best advantage, the analysis discusses submitters' points under the sections of the report that best align to what they have indirectly recommended, which may be different to how the submitter categorised it in their submission. All original meaning intended by the submitter has been retained.

## **1.5. How to navigate this report**

This report has been drafted and arranged thematically, based on the structure of the Ministry's consultation document. Where submitters provided an answer to a question that fitted better elsewhere in the report, the analysis was amended to reflect that.

This report contains seven parts.

1. Part 1 outlines the purpose and structure of the report, identifies the methodology used in the submissions' analysis, and provides an overview of submitters and their submissions.
2. Part 2 describes the submissions received on the draft Strategic direction, including commentary about each of the 11 objectives.
3. Part 3 describes the submissions received on the draft three-year Service Plan, including the proposed funding allocation and the key initiatives or programmes planned for 2019/20 to 2021/22: public health services, intervention services, and research and evaluation.
4. Part 4 summarises submitters' comments on the problem gambling levy rates, including the levy weightings, and the method for calculating levy rates. It also summarises submitters' comments on whether the current levy formula provides a reasonable way to reflect the relative harm caused by each gambling sector.
5. Part 5 summarises submitters' comments on the policy in relation to the concentration of NCGMs in low socioeconomic areas.
6. Part 6 describes the other issues raised by submitters, including editorial issues and issues that fall outside of the scope of the consultation.
7. Part 7 draws on the analysis reported in Parts 2 to 6 in order to explore the way the six sectors addressed the common themes that emerged through the submissions analysis.

Appendix A names the individuals and each organisation who contributed to the consultation process by way of written submission, unless a specific request was made to withhold names of individual submitters.

Appendix B provides a list of the fifteen questions and four sub-questions outlined in the consultation document.

Submitters are typically not identified in this report, except by name in Appendix A, and by category of submitter in the body of the report; however, in a few cases, identifying an organisation was unavoidable.

## 2. THE DRAFT STRATEGIC DIRECTION

This part of this report outlines the commentary received from submitters on the draft Strategic direction.

Seventy-seven submitters responded to at least some of the questions about the draft strategic direction.

Five questions were asked, all of which included ‘Yes/No’ responses. Table 2 shows the wording of these questions and the number of submitters who responded, by response. Sometimes the narrative response suggested that support was qualified or conditional, in which case the ‘Yes’ response was altered to ‘Qualified Support’, at the request of the Ministry.

**Table 2: Yes/No responses to questions concerning the strategic direction**

| Question   | Yes | No | Qualified Support | Total     |
|--|-----|----|-------------------|-----------|
| 1. Do you support the strategic direction outlined in the proposed strategy?   | 36  | 13 | 12                | <b>61</b> |
| 2. Does the draft strategic plan adequately reflect changes in the gambling environment?   | 21  | 17 | 2                 | <b>40</b> |
| 3. Are there any objectives or priority actions that you feel are more important or less important than the others?  | 41  | 3  | 0                 | <b>44</b> |
| 4. Do you think the inclusion of the priority actions for reducing inequality in Objectives 9 and 10 will help reduce gambling harm for the groups identified? | 17  | 22 | 0                 | <b>39</b> |
| 5. Are there other actions to prevent and minimise gambling harm that should be included as priority actions?  | 38  | 5  | 0                 | <b>43</b> |

The consultation document sets out the statutory requirements for an integrated problem gambling strategy and the aim for gambling harm minimisation, specifying 11 strategic objectives. Responses were received from across the six sector groups, as detailed in Table 3.

**Table 3: Number of submissions, by submitter classification, concerning the Strategic Framework**

| NCGM sector | Gambling Industry (other) | Service Providers | Health sector | Local Government | Individuals |
|-------------|---------------------------|-------------------|---------------|------------------|-------------|
| 20/22       | 8/8                       | 21/21             | 12/13         | 4/6              | 12/12       |

### 2.1. Degree of support for the draft strategic direction

#### 2.1.1. Roughly half of the submitters supported the draft strategic direction to some degree

Forty-eight submitters expressed support for the draft strategic direction. Of these, 36 provided a simple “Yes” answer to Question 1, and 12 expressed “Qualified Support” for the draft strategic

direction – that is, they answered that they supported it, but also commented on how the draft strategic direction could be enhanced.

Submitters from all sectors expressed support for the overall strategic direction. Service Providers,<sup>17</sup> Health sector submitters,<sup>18</sup> Local Government<sup>19</sup> and individuals<sup>20</sup> were the strongest supporters of the draft Strategy, with some support from the NCGM Sector and Gambling Industry (other).<sup>21</sup>

Specific positives about the proposed strategic direction raised by submitters included support for the:

- introduction of peer support programmes on a voluntary basis (four Service Providers and two NCGM sector submitters)<sup>22</sup>
- key principles which guided the development of the Strategic Framework, particularly to reflect the relationship between the Crown and Māori under Te Tiriti o Waitangi, and to achieve health equity through a range of focus areas (two Health sector submitters, one Local Government and one Service Provider)<sup>23</sup>
- introduction of residential care services for the most vulnerable clients (three Service Providers)<sup>24</sup>
- need for a rethink, refocus and revitalisation of the Strategic Framework (two NCGM sector submitters, one Health sector, and one individual)<sup>25</sup>
- addressing the high relapse rate (NCGM)<sup>26</sup>
- acknowledgement of individuals as gambling harm minimisation stakeholders, by including individuals in the consultation process (individual)<sup>27</sup>
- adoption of new harm minimisation tools that will be cost-effective and target problem gamblers without unduly impacting casual and recreational gamblers who are not at risk of harm (NCGM)<sup>28</sup>
- recognition that problem gambling is often accompanied by other issues, prompting an emphasis on linking problem gambling services with other social and health services, (one Health sector submitter),<sup>29</sup> and
- benefits to a larger number of people who have low or moderate gambling risk, and not just a focus on acute problem gamblers (one NCGM).<sup>30</sup>

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<sup>17</sup> 15,37,44,56,60,C02,C08

<sup>18</sup> 03,27,30,32,3334,36

<sup>19</sup> 12,25,29

<sup>20</sup> 04,38,62

<sup>21</sup> 42,43,55

<sup>22</sup> 05,14,15,54,C02,C08

<sup>23</sup> 25,27,36,53

<sup>24</sup> 15,54,C02

<sup>25</sup> 01,14,33,38

<sup>26</sup> 01

<sup>27</sup> 04

<sup>28</sup> 08

<sup>29</sup> 32

<sup>30</sup> 50

## 2.1.2. Some submitters had concerns about the proposed strategic direction

### *Submitters from across all sectors expressed interest in new and innovative approaches*

Submitters expressed some concerns about the strategic direction, particularly requesting a more innovative, targeted approach to dealing with gambling harm. Nineteen submitters expressed concerns about the strategic direction, suggesting improvement (11 NCGM sector submitters,<sup>31</sup> three Gambling Industry (other) submitters,<sup>32</sup> two Health sector submitters,<sup>33</sup> two Service Providers<sup>34</sup> and one individual<sup>35</sup>).

Eight NCGMs considered that although investment over the past 10 years had been significant, the problem gambling rate has remained the same,<sup>36</sup> and the Ministry has been slow to get basic items right (for example, the multi-venue exclusion (MVE) administration service was only established in May 2018, and only on a trial basis).<sup>37</sup> These NCGM sector submitters supported a bolder change than the one proposed,<sup>38</sup> including a more targeted or focused approach,<sup>39</sup> with a practical, clear plan, objectives and timeframes<sup>40</sup> to further reduce the problem gambling rate.

Five NCGMs wanted to see a national database of excluded persons, an electronic MVE order system, and funding support for gaming societies and the treatment providers that wish to use new technology such as facial recognition.<sup>41</sup> One Gambling Industry (other) submitter also advocated for these technological aspects.<sup>42</sup>

A further three Gambling Industry (other)<sup>43</sup> submitters stated that the current model had ceased to produce results, with the problem gambling rate remaining static, and research neither providing new information, nor suggesting that gambling treatment could be improved. Two Health sector submitters supported this view, recommending that the public health approach be strengthened across relevant objectives, focusing on the continuum of harm created through gambling participation, rather than focusing at the extreme end of the problem gambling spectrum.<sup>44</sup>

Two further NCGMs argued that the most impact is in addressing the high relapse rate<sup>45</sup> and system inefficiencies.<sup>46</sup>

Two Gambling Industry (other) submitters stated that there should be a change of focus<sup>47</sup> to a new model where gaming societies are encouraged to further the harm minimisation work that is being undertaken at a venue level, and suggested:

- installing additional harm minimisation tools at venues if there is financial support via the levy to do so,<sup>48</sup> or
- new intervention services such as residential care for gambling harm.<sup>49</sup>

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<sup>31</sup> 01,02,03,10,16,18,28,41,63,64,C04

<sup>32</sup> 07,35,43

<sup>33</sup> 24,27

<sup>34</sup> 40,44

<sup>35</sup> C03

<sup>36</sup> 02,10,16,18,28,63,64,C04

<sup>37</sup> 02

<sup>38</sup> 02,03,41

<sup>39</sup> 16,18,28,63,C04

<sup>40</sup> 16,18,28,63,C04

<sup>41</sup> 16,18,28,63,C04

<sup>42</sup> 07

<sup>43</sup> 07,35,43

<sup>44</sup> 24,27

<sup>45</sup> 01

<sup>46</sup> 03

<sup>47</sup> 35,43

<sup>48</sup> 35

<sup>49</sup> 43

Another Gambling Industry (other) submitter sought an increased overall spend to achieve the goal of further reducing gambling-related harm.<sup>50</sup>

One Service Provider considered that the strategic direction did not include much substantive change compared to the original plan in 2005 and was dubious about whether substantial progress had been made towards the intended goals. The Service Provider questioned whether the current approach truly reflects a public health approach, and whether progress had been made in reducing the dependence of community organisations on funds received from gambling.<sup>51</sup> This Service Provider also suggested learning from progress and barriers in related areas, with more extensive and meaningful consultation with consumers, researchers and practitioners, and establishing indicators for the short- to medium-term priorities for each objective.<sup>52</sup> Another Service Provider considered that there should be a greater focus in the strategic direction on whole-of-government solutions, particularly regarding crime associated with gambling, such as domestic violence.<sup>53</sup>

One Health sector submitter also suggested more work in the areas of vulnerable, at-risk populations to understand the current barriers to accessibility and provision of harm minimisation services.<sup>54</sup>

An individual submitter also supported a new approach on the basis that more of the same is not producing different results.<sup>55</sup>

***There was constructive critique of all 11 objectives***

Most of the comments about the objectives were from either Service Providers or Individuals; there are no comments in this section from the Gambling Industry (other) (see Table 4, below).

**Table 4: Number of submissions, by sector, that commented on the objectives to explain why they either did not support or gave qualified support to the draft Strategic direction**

| NCGM | Gambling Industry (others) | Service Providers | Health Services | Local Government | Individuals |
|------|----------------------------|-------------------|-----------------|------------------|-------------|
| 5/22 | 0/8                        | 8/21              | 6/13            | 1/6              | 1/12        |

Twenty-one submitters commented on one or more of the proposed objectives (eight Service Providers,<sup>56</sup> six Health sector submitters,<sup>57</sup> five NCGM sector submitters,<sup>58</sup> one Local Government submitter<sup>59</sup> and one individual<sup>60</sup>).

*Objective 1: There is a reduction in gambling-harm-related inequities between population groups (particularly Māori and Pacific peoples, as the populations that are most vulnerable to gambling harm)*

Two Service Providers wanted to see more focus on the family, whānau and communities in actions under Objective 1 to reduce the burden of gambling-related harm,<sup>61</sup> and noted that the needs of

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<sup>50</sup> 07  
<sup>51</sup> 40  
<sup>52</sup> 40  
<sup>53</sup> 44  
<sup>54</sup> 27  
<sup>55</sup> C03  
<sup>56</sup> 39,40,44,45,46,56,60,C13  
<sup>57</sup> 24,27,30,33,57,66  
<sup>58</sup> 03,04,05,14,17  
<sup>59</sup> 31  
<sup>60</sup> 21  
<sup>61</sup> 39,44

Māori are varied.<sup>62</sup> One Service Provider<sup>63</sup> wanted to see recognition of the continuing impact of colonisation on Māori, and suggested earlier engagement (that is, before public consultation) with whānau, hapū and iwi in developing the Strategic Framework; and the inclusion of Māori leadership and representation in finalising the Strategy.

Service Providers suggested that actions associated with this objective could be more specific and/or targeted, including:

- **supply controls** such as reducing permitted numbers of machines per venue from 19 to nine, and reducing the density of NCGMs in high deprivation communities<sup>64</sup>
- **technology solutions** such as facial recognition using a single platform for all land-based gambling providers and services to use, and product controls that build in design features to NCGMs that limit time and spend<sup>65</sup>
- **leadership** such as more participation by Māori leadership on the locations of NCGMs in iwi rohe, a requirement that local government be required to consult with Māori and Pasifika social service leaders on NCGM impacts when reviewing alcohol licences<sup>66</sup>
- **training** such as better training and host responsibility for venue owners not born in New Zealand<sup>67</sup> and provision of multi-media training kits to support staff<sup>68</sup>
- **regulation** such as restrictions on culturally-targeted marketing campaigns by casino, Lotto NZ and the New Zealand Racing Board,<sup>69</sup> and
- **digital solutions for support services** such as a digital platform for Māori and Pasifika treatment providers to increase their reach and support, and to be used by services with Māori and Pasifika clients.<sup>70</sup>



Māori leadership needs to be involved in decisions about the locations of NCGMs in iwi rohe, and local government needs to consult with Māori and Pasifika social service leaders on NCGM impacts when reviewing alcohol licences

Three Service Providers catering to Asian clients highlighted the vulnerability of various Asian populations in New Zealand<sup>71</sup> – a population mentioned in the description of the objective and in one of the short-term actions, but not specifically in the Objective 1 title. They noted the different drivers of Asian gambling harm compared to Māori and Pasifika populations, relating to settlement, language barriers and disconnection from family, particularly for those sub-populations such as young international students, who face pressure and isolation and are understood to turn to online gambling as an emotional escape. Submitters described the significant harm that problem gambling can lead to, including suicide, bankruptcy and psychosocial issues. Submitters suggested actions to address Asian populations’ problem gambling, which are discussed in detail in the section on the

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<sup>62</sup> 56  
<sup>63</sup> 56  
<sup>64</sup> 44  
<sup>65</sup> 44  
<sup>66</sup> 44  
<sup>67</sup> 44  
<sup>68</sup> 21  
<sup>69</sup> 44  
<sup>70</sup> 44  
<sup>71</sup> 44,45,46

inclusion of priority actions to reduce inequality and inequity for specific groups, below at section *Priority actions intended inequality and inequity were broadly supported.*

An individual submitter also wanted to see more focus on family, whānau and communities, and better host responsibility training.<sup>72</sup>

*Objective 2: Māori have healthier futures, through the prevention and minimisation of gambling harm*

Service Providers in particular recognised the benefit of dedicated services, or “Māori services for Māori”,<sup>73</sup> and that services need to be available for gamblers as well as their family and whānau.<sup>74</sup> They also noted the need for a significant reduction in the density of NCGMs in high deprivation communities, and for Māori to know that there is a choice of treatment service available.<sup>75</sup> Suggested specific actions to achieve this objective included:

- Consultation with Māori on any new NCGM licence renewal or venue relocation<sup>76</sup>
- Promotion of services other than the Gambling Helpline<sup>77</sup>
- More availability of peer support using social media to aid access and mitigate the risk of relapse,<sup>78</sup> and
- Support for the Māori workforce to apply their own cultural methods and models of practice to provide more equitable support in minimising gambling harm.<sup>79</sup>

One NCGM submitter suggested re-framing the objective as “everyone involved in gambling understands the range of gambling harms that can affect individuals, families/whānau and communities and knows how to seek help as and when needed”, on the basis that everyone is entitled to a better future, and specific at-risk population needs should be addressed under Objective 1.<sup>80</sup>

One individual noted support for Objective 2 without offering further comment.<sup>81</sup>

*Objective 3: People participate in decision-making about activities in their communities that prevent and minimise gambling harm*

Service Providers supported existing initiatives to encourage community participation, such as the Gambling Harm Awareness Week Campaign,<sup>82</sup> and support for whānau, hapū and iwi to have greater input in their communities.<sup>83</sup> One service provider commented that input from Māori should reflect a co-management model of partnership as intended under Te Tiriti o Waitangi principle of partnership.<sup>84</sup>

One Service Provider noted the need for more transparency at the local government level around opportunities for participation and submissions on local gambling policies, including hearing the voices of Māori, Pasifika and Asian communities on these issues.<sup>85</sup> Another Service Provider stressed the need for more information on specific actions over the next three years on how the “language barriers, lack of knowledge and lack of understanding” in the underlying principle would

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<sup>72</sup> 21

<sup>73</sup> 44

<sup>74</sup> 21,39,44

<sup>75</sup> 44

<sup>76</sup> 56

<sup>77</sup> 39

<sup>78</sup> 44

<sup>79</sup> 56

<sup>80</sup> 17

<sup>81</sup> 04

<sup>82</sup> 44

<sup>83</sup> 56

<sup>84</sup> 56

<sup>85</sup> 44

be addressed to empower individuals and their communities to engage and participate effectively.<sup>86</sup> It was considered that more transparency is needed at the local government level on how money lost through gambling in high deprivation areas is distributed back in those communities, for example, through regular reporting.<sup>87</sup>

A Health sector submitter<sup>88</sup> supported this objective in combination with Objective 4 (health policy) and noted that decision-making is distributed inequitably from one community to the next, for example, there are more NCGMs in poorer areas. This submitter also raised concerns about awareness of grant distribution being part of this objective, given the evidence that gambling-funded grants are inequitable because they distribute money away from highly deprived communities, and suggested further research to inform recommendations in this area. Another Health sector submitter<sup>89</sup> suggested amending the wording of the objective to place more emphasis on people not just participating in activities but also those who are setting the direction at the local level around the role of gambling in their community. That is, people participate in the decision-making about the provision of gambling in their communities along with activities that prevent and minimise gambling-related harm.

One Local Government submitter recommended that actions under this objective be expanded to include specific methods of increasing participation in decision-making and the allocation of gambling profits of vulnerable communities.<sup>90</sup>

An individual submitter showed strong support for the objective, noting the more community awareness and discussion the better, and the need for central government leadership.<sup>91</sup>

*Objective 4: Healthy policy at the national, regional and local level prevents and minimises gambling harm*

One Service Provider supported the strategic direction as generally fit for purpose and noted the value of targeted funding via the levy to spend on preventing minimising harm.<sup>92</sup> However, this submitter considered that the co-dependency of having community interests being supported by NCGMs weakens the effectiveness of the Strategy and in some high deprivation areas is likely to be exacerbating harm, and the reliance on presentations to services as a measure of the prevalence of harm considerably understates that harm extends from individuals to families. The submitter suggested that establishing whether a venue's primary purpose is NCGMs should be measured by revenue rather than a general consideration of activity, to provide greater clarity for regulators. Another submitter stated that they would like to ensure a healthy policy is applied to all the gambling venues, that is NCGMs, casinos, lotto and racing, with the support of the Ministry and the Department of Internal Affairs (DIA).<sup>93</sup>

One Health sector submitter considered that the objective needs to be strengthened to incorporate a health equities approach, and be reframed to read "healthy policy, incorporating a health equities approach, at the national regional and local level prevents and minimised gambling-related harm."<sup>94</sup>

A Local Government submitter considered that priority actions should include specificity around working with local authorities to ensure that they are able to access quality information within their

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<sup>86</sup> 40

<sup>87</sup> 44

<sup>88</sup> 66

<sup>89</sup> 24

<sup>90</sup> 31

<sup>91</sup> 04

<sup>92</sup> 44

<sup>93</sup> 56

<sup>94</sup> 24

local areas in the short- to medium-term.<sup>95</sup> The submitter also recommended additional funding should be included within the three-year service plan expressly for monitoring and research about the effectiveness of individual local authority gambling venue policies which impact on NCGMs.

An individual strongly supported this objective, suggesting a strong central government role to remove differences between regions.<sup>96</sup>

*Objective 5: People understand and acknowledge the range of gambling harms that affect individuals, families/whānau and communities*

Two Service Providers acknowledged the importance of funded public health services that support and empower individuals and affected families, whānau and communities.<sup>97</sup> They also recommended marketing and health promotion messages be led by people with lived experience, rather than service/organisation/internal led, to raise awareness of the range of gambling harms that affect people, and avoid generic messages that do not reflect the diversity of cultures within the prioritised populations. More investment should be made in culturally specific, language-based campaigns for Māori, Pasifika and Asian peoples.<sup>98</sup>

Another Service Provider supported linking problem gambling treatment services and other social and health services, as identified in the priority actions, given the impact of problem gambling on health outcomes, social services, financial capability, housing and education.<sup>99</sup> The submitter also emphasised the need to acknowledge the broader spectrum of gambling impact, disagreeing with the statement under Objective 5 that only a significant minority struggle with gambling. The submitter recommended referencing the Auckland University of Technology (AUT) Burden of Gambling Harm study for a broader understanding of the impact, emphasising the fact that although only a small proportion of the population is at high risk, more of the population is at low to moderate risk.<sup>100</sup>



Link problem gambling treatment services and other social and health services, given the impact of problem gambling on health outcomes, social services, financial capability, housing and education.

One Service Provider suggested more research into the broader economic and social costs related to harmful gambling;<sup>101</sup> and another suggested more public information on the costs of gambling harm to families, employers, on mental health and addictions, and especially on children.<sup>102</sup>

An individual submitter supported this objective, noting that it had similar wording to Objective 3.<sup>103</sup>

*Objective 6: A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm*

Two NCGM submitters noted that peer support programmes work well in the alcohol and drug sectors and that similar positive results could be achieved from a gambling peer support

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<sup>95</sup> 31  
<sup>96</sup> 04  
<sup>97</sup> 44,56  
<sup>98</sup> 44,56  
<sup>99</sup> 39  
<sup>100</sup> 39  
<sup>101</sup> 39  
<sup>102</sup> 44  
<sup>103</sup> 04

programme.<sup>104</sup> These submitters recommended providing peer support on a voluntary, or minimal cost basis to keep costs low.

Service Providers agreed on the need for a skilled workforce. One suggested inserting wording in the objective to reinforce the need for a skilled, culturally diverse and culturally trained workforce.<sup>105</sup> One Service Provider also noted that Māori clients using mainstream services have access to culturally competence counsellors, including Māori counsellors.<sup>106</sup> This Service Provider also commented that wage pressures in the mental health and addictions workforce impact on the ability to recruit and re-train qualified personnel, especially those qualified to work with the priority populations. The current Full Time Equivalent (FTE) funding model limits the ability for service providers to be flexible with the workforce and how it is deployed.<sup>107</sup> This submitter considered that there is a need for more counsellors and public health trained professionals to be able to work in a culturally and linguistically appropriate way, particularly for the Asian community, where the submitter considered that demand far outstrips the ability to provide support. Investment should continue in building a quality service for Asian people experiencing gambling harm, which works across languages and cultural support areas with high Asian populations. All services should also be funded to work with Māori and Pasifika clients and be held accountable for that in key performance indicators.<sup>108</sup>

Another Service Provider noted that in the current training culture, the training and development function is centralised, with Abacus and Te Kākano controlling the resources for learning. In a learning culture, learning is decentralised, and the entire organisation is engaged in facilitating and supporting learning, in and outside the workplace. This submitter wanted support for exploring a learning culture model for training, to assist in creating a more self-directed learning and problem-solving approach.<sup>109</sup> This Service Provider also noted that there should be a special focus when designing and delivering training for Māori, Pasifika and Asian populations. Trainers delivering clinical and public health training should have either worked extensively and effectively in these communities or have indigenous knowledge and linkages through whakapapa or kaupapa affiliations.<sup>110</sup>

There was some support for the peer support model (in addition to the support mentioned above in Section 2.1, where submitters expressed their support without providing additional comment). This is a similar model to what has been in place in Pasifika culture and journeys for a long time, in the concept of “Mafuta” or “Mafutaga”, which offers both a collective and relational approach. An example<sup>111</sup> given was a women’s led group: Mafutaga a Tine (mother’s group), which has had some success in addressing the barriers to treatment that Pasifika women face. Such groups were seen to:

- Minimise stigma and individual judgments
- Increase social connectedness
- Provide advice to younger families contemplating gambling
- Enable them to seek appropriate intervention through self-referrals, and
- Help to prevent relapse.

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<sup>104</sup> 05,14

<sup>105</sup> 56

<sup>106</sup> 44

<sup>107</sup> 44

<sup>108</sup> 44

<sup>109</sup> 56

<sup>110</sup> 56

<sup>111</sup> 60

A Health sector submitter suggested strengthening Objective 6 to include all kaiāwhina [support workers] (unregulated) roles and prioritise Māori leadership within the development of the workforce.<sup>112</sup>

Two individual submitters supported this objective and provided further comment.<sup>113</sup> One commented on the potential of the peer support concept in facilitation, sponsor/buddy relationships and client contact, while noting the challenges of a limited pool of such a workforce, the need to consider privacy and confidentiality aspects, and the need for appropriate training of peer support workers.<sup>114</sup> The other individual noted that the peer support role could potentially be merged with the consumer advisor role, given similarities in the tasks that they would be undertaking.<sup>115</sup>

*Objective 7: Services enhance people's mana and build life skills and resiliency to improve healthy choices that prevent and minimise gambling harm*

One Service Provider noted that 'mana' is not defined in any part of the document. The Service Provider considered this to be problematic, given that mana encompasses many interrelated concepts, including tapu and mauri, that only make sense when considered as a whole.<sup>116</sup>

Another Service Provider supported the way that the levy enables services to work with people affected by problem gamblers, and provide choice for clients to include groups, which can work for Pasifika and Asian clients, and Māori in some settings.<sup>117</sup> This Service Provider also noted that the Problem Gambling Severity Index (PGSI) is a useful screening tool and the Partnering for Change Outcomes Measurement System (PCOMS) provides a client-centred measure of change, but considered that the PGSI needs better granularity to effectively measure change for the gambler and whānau.<sup>118</sup> However, the Service Provider also noted that the focus on outputs creates adverse incentives. If the Ministry purchase "treated clients", this would enable services to use whatever treatment tools (sessions, digital etc.) which were most effective for the individual and their whānau. The submitter considered that this would also incentivise relapse management. The Service Provider went on to comment that the environment for the gambler remains challenging with NCGM density, casino behaviours, poverty, isolation and distress all being factors. This needs to change for treatment to be enduring and to prevent relapse.<sup>119</sup>

One Health sector submitter agreed that these services are important to those experiencing gambling-related harm, suggesting extending a similar offering to those choosing to profit from gambling, providing them with support to improve healthy choices. Research into this could help to better understand the drivers of behaviour in the industry.<sup>120</sup>

Two individuals commented on this objective.<sup>121</sup> One of them supported the objective and suggested installing clocks in gambling venues.<sup>122</sup> The other commented on the challenge of the underlying principle of "one team/Kotahi te tīma", including the tender process for services and other related sectors reforms (for example, the amalgamation of the alcohol and other drugs and gambling sectors under the Addictions umbrella, and the proposal to explore the potential for

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<sup>112</sup> 66

<sup>113</sup> 04,21

<sup>114</sup> 04

<sup>115</sup> 21

<sup>116</sup> 56

<sup>117</sup> 44

<sup>118</sup> 44

<sup>119</sup> 44

<sup>120</sup> 30

<sup>121</sup> 04,21

<sup>122</sup> 04

Residential Care for Gamblers), which pose questions around differences in funding across sectors.<sup>123</sup>

*Objective 8: Gambling environments are designed to prevent and minimise gambling harm*

One Service Provider noted that the Act has strong regulation and enforcement powers.<sup>124</sup> However, the Service Provider considered that:

- The Ministry has insufficient powers to enforce actions that support the Strategic Framework
- DIA monitoring of NCGMs is insufficient to identify venues not exercising host responsibility, and
- The Gambling Commission uses narrow definitions of impact and harm that mean gambling providers have little or no accountability, because the Commission relies solely on presentation to services as an indicator.

The Service Provider emphasised that “lack of information does not demonstrate lack of harm”.<sup>125</sup> The submitter also noted the challenge of variation in NCGM venue design which makes monitoring gambling behaviour difficult or impossible in some areas. The same Service Provider also recommended that some purposes of the Act should be weighted to provide:

- More effective guidance to regulators
- Closure of loopholes that allow promotion of overseas gambling websites; and
- Investigation into what is enabling the increased spend in NCGMs despite fewer machines.

This Service Provider, and another, also mentioned NCGMs, wanting the strategic direction to focus more on the harm that NCGMs are doing, and seek to severely reduce this.<sup>126</sup>

Another Service Provider considered that active on-site gambling support services should be mandated, to strengthen the link between support services and gambling venues, which would help address the current barrier of gambling harm services engaging with gambling venues. They suggested a lead support person in regions to ensure connection between service providers and venues.<sup>127</sup>

A Health sector submitter supported the Ministry’s intention to support the DIA to judiciously and effectively use its regulation tool to deal with operators or venues that do not meet legal requirements.<sup>128</sup> Another Health sector submitter supported the DIA’s ‘secret shopper’ research as a means of monitoring host responsibility and an opportunity to enhance enforcement.<sup>129</sup>

One of these Health sector submitters also recommended that the objective have a stronger focus on prevention, and stronger actions such as reducing access to NCGMs through prioritising a true sinking lid approach in policy, and empowering communities in decision-making about provision of gambling in their communities.<sup>130</sup> The other Health sector submitter wanted to see more robust auditing/monitoring of venues’ reliance on gambling, so that the DIA can curb non-compliant, unsustainable behaviours, and also suggested using machine design adjustments to reduce harm,

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<sup>123</sup> 21

<sup>124</sup> 44

<sup>125</sup> 44

<sup>126</sup> 44,C13

<sup>127</sup> 56

<sup>128</sup> 24

<sup>129</sup> 30

<sup>130</sup> 24

for example muting machines and banning alcohol sale.<sup>131</sup> The submitter considered that interventions associated with alcohol use are of particular interest, given the comorbidity of problem gambling with alcohol consumption. Another Health sector submitter also wanted stronger preventative measures under this objective, given the clear evidence that areas of high deprivation experience more gambling harm from NCGMs.<sup>132</sup> This submitter recommended policy or regulations to support those who are identified as being most at risk of interactive online gambling, as it evolves and increases.

A Local Government submitter also discussed the location of venues in relation to this objective.<sup>133</sup> It recommended adding consideration of locations to the objective (such as “Gambling environments are designed and located to prevent and minimise gambling harm”), given the evidence that gambling-related harm is significantly higher in deprived areas.

Two individuals also commented on this objective.<sup>134</sup> One noted that simple actions should be included, such as installing clocks or timers in gambling environments.<sup>135</sup> The other considered that important roles should be captured in the actions of both the local authority (in promoting safe gambling venues, since it approves the venues and can put sinking lids in place) and the Gambling Commission (as the ultimate authority below the Courts and Government).<sup>136</sup> This individual also commented that simplification of the various bodies involved in the gambling process could bring transparency.

*Objective 9: Services raise awareness about the range of gambling harms that affect individuals, families/whānau and communities*

NCGM submitters were critical of actions related to services. One NCGM implied that treatment providers are more focussed on designing ways to close down gaming venues than treating clients,<sup>137</sup> while another suggested, in terms of action relating to improving access, that rather than setting up new offices in small towns with anticipated low volume of demand, counsellors located in the nearest larger city could travel to the township on an as-needed basis.<sup>138</sup> A third NCGM did not support more money being spent setting up new Problem Gambling Foundation offices and employing new staff in remote rural areas of New Zealand, on the basis that it did not consider it to be cost-effective.<sup>139</sup>

One Service Provider noted that the current public health contracts enable services to raise awareness relatively well.<sup>140</sup> However, it also considered that:

- There are insufficient resources allocated to effectively raise awareness for Asian communities
- Pasifika clients need own-language resources, particularly on social media, and
- There need to be better services available than the current HPA ‘one-size-fits-all’ campaigns.

In particular, this submitter considered that Lotto NZ should not advertise during primetime and when children are likely to be exposed to promotions, and that the NZRB should not be allowed to

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<sup>131</sup> 30

<sup>132</sup> 33

<sup>133</sup> 31

<sup>134</sup> 04,21

<sup>135</sup> 04

<sup>136</sup> 21

<sup>137</sup> 03

<sup>138</sup> 05

<sup>139</sup> 14

<sup>140</sup> 44

promote sports odds in mainstream media or during major sports fixtures where children are likely to be exposed to those promotions.<sup>141</sup>

Another Service Provider considered that this objective was insufficient to reduce inequity.<sup>142</sup>

A Health sector submitter recommended rewording this objective to avoid a misunderstanding that it is the responsibility of counselling services to raise awareness of the range of gambling harms that affect individuals, families, whānau and communities, with alternative words to reflect the collaborative role of the Ministry, the DIA and the HPA in raising awareness of gambling harm at all levels.<sup>143</sup> Another Health sector submitter also recommended a rewording of the objective, to replace “awareness activities” (in this objective and throughout the Strategic Framework and Service Plan) with “behaviour change activities”.<sup>144</sup>

One individual supported this objective, and did not provide any further comment.<sup>145</sup>

*Objective 10: People access effective treatment and support services at the right time and place*

One Service Provider commended the well-established land-based counselling services, the Gambling Helpline promoted in the HPA publicity, and that services are mandated to work with affected others.<sup>146</sup> However, this submitter also noted that reliance on the Gambling Helpline has reduced referrals, and that clients report not being able to access the support they expected when it is needed between different cultures and populations. It went on to suggest that the actions under this objective could be more explicit about services that can support clients 24/7 using digital tools, to promote access and availability in different languages (which requires more resources). Another Service Provider recommended inserting “culturally appropriate and culturally targeted” into the objective, noting the overall focus of the Strategy on targeted service provision.<sup>147</sup>

Two Health Service submitters supported the commitment to dedicated Māori, Pasifika and Asian services, and culturally appropriate service provision.<sup>148</sup> In acknowledging the challenges in reaching rural areas, one of these submitters suggested exploring whether its psychological wellbeing service provision model, developed following the Hurunui/Kaikoura earthquakes, could be a source for a mobile, community-linked service.<sup>149</sup>

One individual supported this objective and suggested installing CCTV cameras in venues to highlight problem gamblers and direct them towards treatment earlier.<sup>150</sup>

*Objective 11: A programme of research and evaluation establishes an evidence base that underpins all activities to prevent and minimises gambling harm*

Two Service Providers supported a dedicated research fund with a focus on priority populations, including culturally appropriate support.<sup>151</sup> One of these submitters<sup>152</sup> noted shortcomings of current research, including:

- Little research into the causes of high prevalence problem gambling among priority populations (for example, mental health and poverty), and

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<sup>141</sup> 44

<sup>142</sup> 56

<sup>143</sup> 24

<sup>144</sup> 57

<sup>145</sup> 04

<sup>146</sup> 44

<sup>147</sup> 56

<sup>148</sup> 27,30

<sup>149</sup> 30

<sup>150</sup> 04

<sup>151</sup> 44,56

<sup>152</sup> 44

- A lack of practical application or policy impact from completed research (except the Needs Assessment).

The same Service Provider recommended a research focus on collecting baseline data on online gambling to track changes and identify intervention opportunities, and tracking changes in Lotto spend to identify the impact of new Instant Play Games. Another Service Provider suggested developing an evidence base showing the effectiveness of the Māori, Pasifika and Asian workforce at providing support using their cultural methods and models.<sup>153</sup>

A Health sector submitter<sup>154</sup> supported this objective, and offered two ideas for future research:

- Gaps in local level knowledge about gambling-related harm, and
- Research on developing sustainable community funding models not built on harm.



Improved technology means that online gambling is likely to increase, and the sector could be a growing area of concern in the future.

This submitter further recommended that any funding for future research is not derived from the gambling industry to maintain academic integrity.

One individual supported this objective without providing further comment.<sup>155</sup> Another individual noted that while the proposal of research on relapse has merit, the real need and challenge is research to discover why over 90 percent of problems gamblers are not presenting for treatment.<sup>156</sup>

### **2.1.3. Some submitters agreed that the strategic direction adequately reflected changes in the gambling environment**

One Local Government submitter<sup>157</sup> agreed that overall, the gambling environment is much the same as it was three years ago. However, the submitter also noted that an emerging concern is the potential rise in international online gambling, and associated gambling-related harm. While the submitter observed that participation levels are still relatively low compared to other forms of gambling, the prevalence of problem gambling among those who gamble via overseas internet gambling is 11.5 percent, which was considered high in comparison to other gambling modes. The submitter considered that coupled with technology improvements, it can be expected that participation in online gambling will increase, and the sector could be a growing area of concern in the future.

Another Local Government submitter particularly supported the increased focus on reducing inequalities and inequities in proposed Objectives 9 and 10.<sup>158</sup> The differences in levels of gambling harm among different population groups have been well documented, and the submitter commended the Ministry for placing increased focus on developing and implementing initiatives that make problem-gambling services more accessible and more culturally appropriate. The submitter also acknowledged the concern of possible online gambling growth, and supported the identification of this as an issue in the draft strategic direction, particularly the inclusion of “the use

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<sup>153</sup> 56

<sup>154</sup> 24

<sup>155</sup> 04

<sup>156</sup> 21

<sup>157</sup> 12

<sup>158</sup> 29

of internet or other digital distribution platforms to provide access to gambling opportunities” as a theme in the Ministry’s research and evaluation work programme.

One Service Provider considered that changes in the gambling environment were adequately reflected,<sup>159</sup> but also noted that more emphasis should be put on running a pilot programme in Whanganui to create a new service model to address the gaps around Māori, Pasifika and Asian populations. Another Service Provider also agreed,<sup>160</sup> particularly noting that it highlights the harms experienced by Māori, Pasifika and Asian communities and people living in high deprivation areas.

One NCGM sector submitter agreed,<sup>161</sup> and stated that it was good to see that research into online gambling and new technology, such as facial recognition, have been included as priorities.

#### **2.1.4. Others stated that the strategic direction needed strengthening to recognise new challenges and opportunities in the gambling environment**

Submitters considered that aspects of the strategic direction relating to the evidence base and service delivery models could be strengthened to better meet the needs and challenges of the current gambling environment.

A stronger and more innovative prevention focus has broad support. While raising awareness of gambling harm among other health and support services was considered important,<sup>162</sup> new approaches were also suggested by Service Providers and the Health sector, as well as NCGMs and Gambling Industry (other) submitters, such as:

- Pilot programmes for one-stop-shop public health and intervention support<sup>163</sup>
- Activities beyond awareness raising that enabled individuals and families/whānau to make positive changes,<sup>164</sup>
- Funding for early identification, intervention<sup>165</sup> and education of gamblers on how to manage their gambling spend.<sup>166</sup>

One Gambling Industry (other) submitter suggested using predictive modelling of gambling account behaviour to identify potential problem gamblers, and improve early intervention rates.<sup>167</sup>

With the increase in online gaming and gambling, two submitters (NCGM and health sectors) highlighted the need for research to develop a robust evidence base,<sup>168</sup> and three Service Providers submitters argued for the development and piloting of online treatment and support services.<sup>169</sup> Three Service Providers<sup>170</sup> agreed that online options should not replace face-to-face delivery models in any region, while NCGM sector and Gambling Industry (other) submitters<sup>171</sup> strongly opposed resources being spent on new offices for treatment providers in remote rural areas.

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<sup>159</sup> 37

<sup>160</sup> C08

<sup>161</sup> 50

<sup>162</sup> 40,44

<sup>163</sup> 37

<sup>164</sup> 57

<sup>165</sup> 17

<sup>166</sup> 51

<sup>167</sup> 43

<sup>168</sup> 17,36

<sup>169</sup> 39,44,45

<sup>170</sup> 11,39,44

<sup>171</sup> 03,05,14,16,26,35,50

Leveraging technology in research and delivery was another common theme across submitters. NCGM sector submitters<sup>172</sup> advocated for prompt attention in piloting facial recognition technology and harm minimisation technology in treatment providers' offices and at venues, dependent on funding to make such changes.<sup>173</sup>

Six NCGM sector submitters<sup>174</sup> and one individual<sup>175</sup> considered further research into at-risk populations was unnecessary, as the focus should be on actions, given the existing evidence base. However, one Service Provider<sup>176</sup> advocated for more research to understand the needs of specific population groups. Two Health sector submitters<sup>177</sup> and another Service Provider<sup>178</sup> argued for appropriately proportionate funding for at-risk groups.

The move towards accountable and outcome-based funding models was also supported, with one Service Provider<sup>179</sup> noting that funding levels for provider contracts should be reviewed to avoid perverse measures of outputs.

## 2.2. The degree of support for draft objectives and priorities for action

Twenty-five submitters commented on Question 3 in relation to the importance of the objectives and priority actions (nine Service providers,<sup>180</sup> seven NCGM sector submitters,<sup>181</sup> three Local Government submitters,<sup>182</sup> three individuals,<sup>183</sup> two Health sector submitters<sup>184</sup> and one Gambling Industry (other)<sup>185</sup>).

### 2.2.1. Some objectives were identified as more important than others

Objective 1 was identified as important by two Service Providers,<sup>186</sup> given the need to service high-needs populations such as Asian populations;<sup>187</sup> and by a Health sector submitter in an area with a high Māori population and high levels of deprivation.<sup>188</sup>

Objective 2 was considered important by:

- A Service Provider in a community with a high Māori population, to show a commitment to a bi-cultural way of working and respecting Te Tiriti o Waitangi principle of equity<sup>189</sup>
- A Health sector submitter, as a way to achieve health equity in access to health services<sup>190</sup>
- A Local Government submitter in an area with a high Māori population,<sup>191</sup> and
- One individual, who provided no further comment.<sup>192</sup>

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<sup>172</sup> 08,50,C04

<sup>173</sup> 26

<sup>174</sup> 02,16,43,51,63,C04

<sup>175</sup> C03

<sup>176</sup> 53

<sup>177</sup> 13,65

<sup>178</sup> C13

<sup>179</sup> 44

<sup>180</sup> 20,37,39,45,46,C10,C11,C12,C13

<sup>181</sup> 02,05,14,17,26,50,C04

<sup>182</sup> 12,25,29

<sup>183</sup> 21,38,62

<sup>184</sup> 27,33

<sup>185</sup> 42

<sup>186</sup> 45,46

<sup>187</sup> 45

<sup>188</sup> 25

<sup>189</sup> C10

<sup>190</sup> 27

<sup>191</sup> 25

<sup>192</sup> 62

Regarding Objective 3, a Health sector submitter<sup>193</sup> noted that it can be challenging for everyone to take part in the process, because the format of decision-making processes creates barriers to people from all walks of life. A Local Government submitter<sup>194</sup> commented that Objective 3 is particularly important to local authorities, because they have obligations to prepare policies on NCGMs and NZRB venues, and public consultation is a key component of policy development.

Two Local Government submitters<sup>195</sup> and one Service Provider<sup>196</sup> submitted that Objective 4 is of importance, because:

- It sets out the commitment to continue to provide information to assist territorial authorities when they are reviewing gambling policies,<sup>197</sup> and
- New Zealand does not currently have an effective policy framework.<sup>198</sup>

No submitters mentioned Objective 5 as being any more or less important than other objectives.

Two NCGM submitters<sup>199</sup> and two individuals<sup>200</sup> expressed support for the peer support elements of Objective 6. A Local Government submitter also considered this objective important, given the scarcity of providers in their district.<sup>201</sup> A Service Provider also considered that this objective was important.<sup>202</sup>

Two Service Providers<sup>203</sup> submitted that Objective 7 is important because enhancing people's life skills and resilience enables them to make better decisions, and solutions are with people in their own communities. An individual<sup>204</sup> also considered that Objective 7 was of high importance.

Five NCGM,<sup>205</sup> three Service Providers<sup>206</sup> and one Gambling Industry (other) submitters supported the focus of Objective 8 on harm minimisation technology, including a secure national database of people subject to exclusion orders. Another Service Provider<sup>207</sup> also supported Objective 8 in terms of its focus on safer gambling environments and using technology to support people receiving treatment for gambling harm.

A Local Government submitter<sup>208</sup> considered that Objective 9 was important with respect to addressing barriers to service experienced by those who are most in need. More specifically, a Service Provider<sup>209</sup> considered that Objective 9 was particularly important in respect of raising awareness about Asian problem gambling.

A Service Provider<sup>210</sup> and a Local Government submitter<sup>211</sup> considered Objective 10 to be especially importance, due to there being scarce resources in their areas. Another Service Provider<sup>212</sup> put emphasis on this objective because accessing treatment is "clearly an important focus". An NCGM

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<sup>193</sup> 33

<sup>194</sup> 29

<sup>195</sup> 12,29

<sup>196</sup> 39

<sup>197</sup> 12,29

<sup>198</sup> 39

<sup>199</sup> 05,26

<sup>200</sup> 21,38

<sup>201</sup> 25

<sup>202</sup> 37

<sup>203</sup> 46,C11

<sup>204</sup> 38

<sup>205</sup> 02,14,17,50,C04

<sup>206</sup> 37,C12,C13

<sup>207</sup> 39

<sup>208</sup> 33

<sup>209</sup> 46

<sup>210</sup> 39

<sup>211</sup> 25

<sup>212</sup> 20

submitter<sup>213</sup> stated that Objective 10 was important because for those needing help, having immediate access to support and treatment is critical.

A Gambling Industry (other) submitter identified Objective 11 as particularly relevant because it underpins all activities in the Strategic Framework, and there is a need for more robust data.<sup>214</sup> A Local Government submitter<sup>215</sup> agreed that this objective was important, because it supports research and evaluation activities to support local policy decisions.

### **2.2.2. Priority actions to reduce inequality and inequity were broadly supported, with Service Providers strongly advocating for culturally-specific supports services**

Twenty-nine submitters commented on Question 4 in relation to the inclusion of priority actions to reduce inequality and inequity for priority groups (14 Service providers,<sup>216</sup> five individuals,<sup>217</sup> four Health sector submitters,<sup>218</sup> three NCGM sector submitters<sup>219</sup> and three Local Government submitters<sup>220</sup>).

Three Service Providers,<sup>221</sup> one Local Government submitter<sup>222</sup> and one individual<sup>223</sup> expressed support for the priority actions, and two of the Service Providers emphasised that it is important that clients have a choice of services.<sup>224</sup>

Another Local Government submitter<sup>225</sup> commented that the priority actions to reduce inequality and inequity will be an important focus to reduce gambling harm for the groups identified. However, this submitter also noted that hard-to-reach populations sometimes do not have access to the internet, and online tools should only be part of a multi-pronged approach to support hard-to-reach populations.

One NCGM submitter stated that there was not enough information on the priority actions to comment, but that whatever is done needs to have demonstrable outcomes.<sup>226</sup>

#### ***Service Providers and other submitters were clear that there should be culturally-specific support services across all areas, particularly for Māori, Pasifika and Asian groups***

Fourteen submitters, chiefly Service Providers, commented that health promotion material and provision should be more widely available in multiple languages, with service providers that are set up to meet the cultural needs of priority populations.<sup>227</sup> HPA funding allocations should be reviewed and be more reflective of the entire population base, rather than being a 'one-size-fits-all' model.<sup>228</sup> In addition, one Service Providers suggested specific harm minimisation campaigns are needed for Māori, Pasifika, Asian and young people across a range of gambling products, including sport and online gambling.<sup>229</sup> Three Service Providers noted that priority populations experience

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<sup>213</sup> 17

<sup>214</sup> 42

<sup>215</sup> 12

<sup>216</sup> 11,37,39,44,45,46,53,54,60,C05,C08,C10,C11,C12

<sup>217</sup> 04,38,47,48,C15

<sup>218</sup> 13,24,65,C16

<sup>219</sup> 17,C04,C07

<sup>220</sup> 12,25,29

<sup>221</sup> 37,39,C12

<sup>222</sup> 29

<sup>223</sup> 04

<sup>224</sup> 37,39

<sup>225</sup> 25

<sup>226</sup> 17

<sup>227</sup> 13,44,45,46,47,48,53,60,65,C05,C07,C10,C11,C16

<sup>228</sup> 44,45

<sup>229</sup> 44

problems accessing services, and therefore providing culturally and linguistically appropriate information and helpline services is extremely important for reaching priority groups.<sup>230</sup>

One Service Provider also submitted that there should be an increase in co-designing campaigns with on-the-ground public health staff, or deferring funding to contracted public health providers to run campaigns locally.<sup>231</sup> A Local Government submitter agreed, and commented that innovative intervention approaches and more accessible and targeted services responsive to the needs of different populations groups are needed to address persistent gambling harm.<sup>232</sup> One NCGM submitter suggested producing gambling harm literature in te reo and Mandarin,<sup>233</sup> and a Health sector submitter also called for culturally-specific social Service Providers to ensure access to services for all clients who require support.<sup>234</sup>

***Service Providers considered that with Māori harm levels being higher than the general population, there is a clear need to prioritise Māori-specific services, focusing on collective action rather than individual action***

One Service Provider stated that Māori and Pasifika are being harmed by gambling in far greater numbers than other populations (specifically by NCGMs), and stated that all providers of treatment and public health services must be able to work appropriately with Māori.<sup>235</sup> This means that engagement in a culturally specific way needs to be embraced by all, in order for Māori to achieve better outcomes. Another Service Provider<sup>236</sup> pointed out that Māori cannot just be fitted into mainstream models; ongoing support needs to be acknowledged as best practice with time and space allocated to help whānau achieve hauora.

Another Service Provider supported the focus on multi-media and social marketing to drive people to seek help in Objective 11.<sup>237</sup> They considered that the HPA and the Ministry need to contextualise material for local audiences, rather than having a broad approach.

One Service Provider<sup>238</sup> focused on the kaiāwhina workforce, stating that more investment is needed given the immense opportunity to deliver whānau, family and community-based support at the right time, by the right people, particularly actions that reflect the guidance from He Korowai Tangata. This Service Provider expected demand to rise for kaiāwhina as the population grows and ages and as models of care move closer to home. The submitter suggested having comprehensive workforce data that spans both DHBs and community providers would allow for improved workforce planning.

Two other Service Providers commented that the most effective programmes involved peer support by people who have experienced similar issues, for example whānau helping whānau<sup>239</sup> or a programme designed by Māori men for Māori men.<sup>240</sup>

Three Service Providers discussed community involvement, giving ownership of improving community wellness back to the community.<sup>241</sup> One of these submitters proposed that the Ministry consider innovation through employment of kaumatua/kuia who have the skills required to gauge whether cultural competency is being applied appropriately, while incorporating tikanga and pono

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<sup>230</sup> 44,45,60

<sup>231</sup> C10

<sup>232</sup> 12

<sup>233</sup> C07

<sup>234</sup> 13

<sup>235</sup> 44

<sup>236</sup> C05

<sup>237</sup> C10

<sup>238</sup> C16

<sup>239</sup> 38

<sup>240</sup> 54

<sup>241</sup> C05,C08,C10

concepts.<sup>242</sup> One of these Service Providers also recommended that the specific focus on Māori women should be shifted to a wider whānau approach, recognising the importance of the collective and placing a responsibility on all rather than the individual, to reflect that the cornerstone of Whānau Ora is whānau.<sup>243</sup>

One Service Provider emphasised that problem gambling is one of many contributing factors hindering the ability of whānau to progress, and should not be considered in isolation.<sup>244</sup>

***Pasifika harm levels are also higher than the general population, and there is a clear need to prioritise Pasifika-specific communication and services***

One of the main problems expressed by Pasifika Service Providers was the lack of cultural competency in working with high priority populations. There is concern about the lack of Pasifika researchers working on projects that are particularly focused on Pasifika gamblers and affected others. In addition, Service Providers have seen a significant decrease in referrals since the consolidation of helplines including the Gambling Helpline and Pasifika Helpline. The Pasifika Helpline is not serviced by Pasifika staff but by anyone who happens to pick up the call; clients rely on the Pasifika Helpline, particularly during high-risk times like the weekend, but often get no response. A Pasifika-specific helpline pilot was recommended to address this.<sup>245</sup>

Similar to Māori Service Providers, three Pasifika Service Providers also recommended a review of the HPA Strategy to include the development of a Pasifika-specific clinical gambling assessment, and meaningful Pasifika campaigns, including the use of local Pasifika media in campaigns instead of one to fit all needs.<sup>246</sup>

The workforce of the service should reflect the needs more strongly (for Pasifika and Māori in particular), and the distribution of the service should be reviewed to provide services where the need is greatest. Participation should be at the co-design phase, rather than half way through the pilot.<sup>247</sup>

An Individual submitter<sup>248</sup> stressed that there needs to be a commitment to create innovative Peer Education programs that can be used as models for outreach to Pasifika youth and communities. The submitter suggested that there is a disconnect when it comes to dealing with the issue of gambling harm minimisation and the community. This submitter commented that the best way to deal with the issue was by providing materials that are more communicative for the intended audience. This submitter further suggested that for Pasifika people, the use of dramas to deliver specific messages can be quite persuasive: there are differences in the way that Pasifika people like to be communicated with, and these are important to recognise.

***The problem gambling risk and harm profile of Asian New Zealanders is unique, and this needs to be recognised and addressed***

It was stressed by a Service Provider that the Asian population views gambling differently, and cultural competency and workforce development concerning knowledge and sensitivity of how to work with Asian clients is essential.<sup>249</sup> Asian populations are disproportionately affected by problem gambling (particularly in casinos), many in the Asian population are open to exploitation due to lack of information and support, and it is critical that in-language information is available to

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<sup>242</sup> C05

<sup>243</sup> C10

<sup>244</sup> C05

<sup>245</sup> 53,65

<sup>246</sup> 13,53,60

<sup>247</sup> C11

<sup>248</sup> C15

<sup>249</sup> 45

reduce harm and enable informed choices to be made.<sup>250</sup> Systematic barriers to accessibility were identified by a Service Provider:<sup>251</sup>

- Lack of interpreting or culturally/linguistically appropriate services
- Lack of a 24/7 specific language helpline, and
- Incompatible Western mental health treatment models.

Three Service Providers similarly stressed the need for online and telephone support services, noting that these delivery modes reduce stigma, because the caller can remain anonymous. This provides an opportunity for the caller to address their concerns and issues. The Asian Helpline should extend to a 24/7 service to be able to provide the same support and access as mainstream services. Additionally, a web-based service in Asian languages that enables clients to seek correct information and self-help tools whenever needed should be developed urgently.<sup>252</sup>

Within the Asian population, two Service Providers<sup>253</sup> identified specific at-risk groups which need urgent recognition and support. For example, international students are one of the most vulnerable groups to experience poor mental health and addiction.<sup>254</sup> Many international students have high anxiety levels, social isolation or depressive symptoms. Service Providers must accurately understand the needs of Asian international students so that potential barriers can be addressed.<sup>255</sup> A Service Providers noted that Indian women were also as a highly vulnerable group that required special consideration.<sup>256</sup>

A Service Provider Commented that hosts in NCGM venues are not competent in approaching Asian gamblers, and host responsibility needs to be addressed.<sup>257</sup> There is a strong need to provide appropriate training to staff about how to build rapport with Indian clients in particular, by increasing their understanding about the cultural aspects which underpin the South Asian gambler's thinking.<sup>258</sup> This submitter considered that strong measures should be put in place by DIA when venues apply for licensing, such as thorough auditing processes in terms of staff capacities in engaging with clients from a South Asian cultural background.<sup>259</sup>

***There should be more recognition that problem gambling often does not occur in isolation, and a more holistic approach to intervention needs to be taken to treat priority groups***

Two Service Providers<sup>260</sup> considered that the Ministry needs to reflect on the complex nature of addiction issues such as problem gambling. They considered that the development of a gambling problem is not a matter of making poor choices: the contributing factors are often complex. They reiterated that the person, product, and environment it occurs in all need to be considered.<sup>261</sup> It was also considered important to address the reasons behind the gambling, particularly poverty.<sup>262</sup>

Service Provider<sup>263</sup> and NCGM<sup>264</sup> submitters consider that it is clear from the research that rates for problem gamblers are higher for certain ethnic communities, and for those with comorbidity issues

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<sup>250</sup> 44,46

<sup>251</sup> 46

<sup>252</sup> 45,47,48

<sup>253</sup> 45,46

<sup>254</sup> 45,46

<sup>255</sup> 45,46

<sup>256</sup> 46

<sup>257</sup> 45

<sup>258</sup> 46

<sup>259</sup> 46

<sup>260</sup> 11,13

<sup>261</sup> 11

<sup>262</sup> 13

<sup>263</sup> C10

<sup>264</sup> C04

such as smoking, drinking and drugs. The NCGM submitter asserted that no issue should be dealt with in isolation – the best results will occur when all issues are dealt with together.<sup>265</sup> The Service Providers considered that there should be an overall focus on strengths based, resiliency and mental health programmes to support the underlying causes of problem gambling.<sup>266</sup>

One Health sector submitter<sup>267</sup> commented that the public health approach to gambling has been weakened by inappropriate industry input and an over-reliance on industry profits at the local and government levels. The community’s view and concern about how much gambling they want in their communities is frequently ignored by decision-makers and needs to be considered.

**2.2.3. Additional objectives and priority actions were suggested, especially technological enhancements for harm minimisation**

Thirty submitters (14 Service Providers,<sup>268</sup> six NCGM sector submitters,<sup>269</sup> six individuals,<sup>270</sup> three Health sector submitters<sup>271</sup> and one Gambling Industry (other) submitter<sup>272</sup>) suggested additional objectives and priority actions that could be included in the Strategic Framework.

***Submitters expressed a need to prioritise the use of harm minimisation technology, with MVE considered as an effective tool for harm minimisation***

Service Providers,<sup>273</sup> NCGM Sector submitters,<sup>274</sup> individuals<sup>275</sup> and one Gambling Industry (other) submitter<sup>276</sup> submitted that there should be a focus on harm minimisation technology over the next funding period, and particularly the promotion of MVE as an effective harm minimisation tool. The use of MVE and facial recognition to monitor enforcement and prevent relapse has proven to be valuable, and the Ministry should take a lead in such technology by actively encouraging new initiatives and providing strong funding support.

Three NCGM sector submitters<sup>277</sup> suggested that the Ministry establish a technology fund to which societies can apply for the start-up costs associated with installing new, voluntary, harm minimisation initiatives. They also considered that clear timeframes for implementation should be set.

One Gambling Industry (other) submitter<sup>278</sup> noted that the main barrier to reducing the problem gambling rate further is the very high relapse rate. A well-coordinated MVE order system that automatically detects attempted exclusion order breaches would help prevent people from relapsing. This submitter considered that NCGM venues and societies are supportive of a secure national MVE database, and stated that positive industry support should be acted on. Uptake of facial recognition and confidence in the system would be improved if the Ministry owned the national database of excluded persons and provided access to the data to multiple accredited facial recognition providers. The submitter also suggested setting a clear goal of having all New Zealand’s high-risk NCGM venues equipped with facial recognition by July 2022. This submitter and another

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<sup>265</sup> C04  
<sup>266</sup> C10  
<sup>267</sup> 24  
<sup>268</sup> 11,20,37,39,40,44,45,46,53,60,C05,C10,C12,C13  
<sup>269</sup> 05,16,18,50,51,C07  
<sup>270</sup> 47,49,62,C03,C09,C14  
<sup>271</sup> 13,65,C16  
<sup>272</sup> 07  
<sup>273</sup> 11,44,45,C12,C13  
<sup>274</sup> 05,16,18,50,C04  
<sup>275</sup> C03,C14  
<sup>276</sup> 07  
<sup>277</sup> 05,16,18  
<sup>278</sup> 07

NCGM section submitter<sup>279</sup> commented that the Ministry could purchase or contract with a commercial supplier of this kind of technology, and should do so.

***Actions to manage international online gambling-related harm were considered important priorities***

Another strong theme regarding priority actions was the need to address the growing problem of online gambling-related harm, particularly from international providers.

One Service Provider<sup>280</sup> stated that low levels of help-seeking behaviour for online gambling related harm indicates that further innovative initiatives are needed. Another Service Provider<sup>281</sup> suggested that harm minimisation advertising should be targeted at youth, as this is the group using online gambling most, and that this advertising should be monitored. This Service Provider advocated for gambling awareness advertisements to be placed alongside online gambling promotion advertising. Another Service Provider<sup>282</sup> noted that while youth and gaming is mentioned by the Ministry as a future priority research project, there is nothing included for intervention teams who are already working with youth under the age of 15 years.

One NCGM sector submitter<sup>283</sup> was concerned that gamblers who are excluded from NCGM venues are turning to unsupervised online gambling, and that online providers should therefore be monitored, levied and taxed.

An individual submitter<sup>284</sup> considered that online gambling is not covered under the Act, and needs to be appropriately regulated.

***Increasing the workforce capacity of Service Providers should be a priority action, especially increasing the availability of online help services***

Three Service Providers<sup>285</sup> and one individual<sup>286</sup> noted that people generally seek help via online methods as a first step. Therefore, there should be an immediate priority action to fund and develop online access and intervention tools for specialist gambling harm intervention services and provide training to the workforce in working across different modalities. In addition, digital services and promotion should be directed at vulnerable populations, including young people.<sup>287</sup> One Service Provider noted that since rural communities often still do not have reliable access to internet, toll-free helplines also still need to be available for all communities.<sup>288</sup>

***Additional priority actions included restrictions on advertising, support for vulnerable groups, and additional actions in terms of research areas***

One Service Provider<sup>289</sup> wanted an action to increase restrictions on advertising and promotion of gambling, such as there is for alcohol, and another wanted more awareness of services for whanau that are experiencing harm from gambling – a group that currently make up a low percentage of clients.<sup>290</sup>

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<sup>279</sup> 16

<sup>280</sup> 20

<sup>281</sup> 37

<sup>282</sup> C05

<sup>283</sup> 51

<sup>284</sup> C09

<sup>285</sup> 39,44,C10

<sup>286</sup> 62

<sup>287</sup> 44

<sup>288</sup> C10

<sup>289</sup> 44

<sup>290</sup> 20

Four Service Providers also wanted additional actions to support vulnerable groups which they considered are not specifically highlighted in the Strategic Framework, including youth<sup>291</sup> and Asian populations.<sup>292</sup>

A Health sector submitter<sup>293</sup> suggested additional actions in terms of research areas, including:

- Gambling grant funding distribution
- Drivers of health-depleting behaviour in the gambling industry, and
- The efficacy of structural and environmental interventions to reduce problem gambling (for example, muting machines or banning alcohol consumption while gambling).

Other suggested priority actions included:

- Greater support for low and moderate risk gamblers, such as those using Lotto<sup>294</sup>
- Requiring GPs to screen annually for addiction, abuse and mental health,<sup>295</sup> and
- Responsible Gambling training to identify those who have established certain behaviours and may need to seek treatment.<sup>296</sup>

There was a cross-sector call for culturally-specific support services, including five Service Providers,<sup>297</sup> two Health sector submitters,<sup>298</sup> one NCGM sector submitter,<sup>299</sup> and one Individual,<sup>300</sup> and recognition of problem-gambling as an issue in combination with other mental health and addiction issues.<sup>301</sup> These points, which are discussed above in the section *Priority actions intended to reduce inequality and inequity* were also reiterated.

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<sup>291</sup> 37,44,C05

<sup>292</sup> 45

<sup>293</sup> 20

<sup>294</sup> 11

<sup>295</sup> 20,40

<sup>296</sup> 51

<sup>297</sup> 39,45,46,53,C10

<sup>298</sup> 13,65

<sup>299</sup> C07

<sup>300</sup> 47

<sup>301</sup> 45,47,49,60,C16

### 3. THE DRAFT SERVICE PLAN

This part of this report outlines the commentary received from submitters on the draft Service Plan. It covers:

- Satisfaction (or otherwise) with the direction and overall content of the draft Service Plan, and
- The proposed funding allocation and activities, and opinions about the key service areas including:
  - Public health services
  - Intervention services
  - Research and evaluation, and
  - Ministry operating costs.

Five questions were asked, four of which included 'Yes/No' responses. Table 5 shows the wording of these questions and the number of submitters who responded, by response. Sometimes the narrative response suggested that support was qualified or conditional, in which case the 'Yes' response was altered to 'Qualified Support', at the request of the Ministry.

**Table 5: Questions about the draft Service Plan from the consultation document**

| Question  | Yes | No | Qualified Support | Total     |
|---|-----|----|-------------------|-----------|
| 6. Does the draft service plan adequately cover what it needs to cover, for example, does it include the right types of services and activities?  | 20  | 16 | 2                 | <b>38</b> |
| 7. Does the draft service plan provide the right mix of activities (public health, intervention and research/evaluation) including line item activities in tables 14-17?  | 21  | 24 | 3                 | <b>48</b> |
| 9. Do you think the total indicative funding appropriation (\$55.339 million over three years) proposed in the draft service plan is appropriate?   | 13  | 38 | 3                 | <b>54</b> |
| 10. Do you think that the service plan would be more effective if some funding amounts allocated in Tables 14-17 were shifted from one budget line item or service area to another? This may include proposing the Ministry stop funding some activities or should fund something not already covered in the proposals. | 20  | 10 | 1                 | <b>31</b> |

Sixty-six submitters provided narrative responses to at least some of the questions about the draft Service Plan. Responses were received from across the six sector groups, as detailed in Table 6.

**Table 6: Number of submissions, by sector, that addressed the Service Plan**

| NCGM sector | Gambling Industry (other) | Service Providers | Health sector | Local Government | Individuals |
|-------------|---------------------------|-------------------|---------------|------------------|-------------|
| 21/22       | 5/8                       | 18/21             | 11/13         | 3/6              | 7/12        |

### 3.1. The degree of support for the proposed funding allocation

The breakdown of the proposed funding allocation by service area and year, as presented in the consultation document, is shown in Table 7.

**Table 7: The proposed funding allocation by service area over three years**

| Service area  | 2019/20<br>(\$m) | 2020/21<br>(\$m) | 2021/22<br>(\$m) | Total<br>(\$m) |
|---|------------------|------------------|------------------|----------------|
| Public health services (harm prevention and minimisation)                         | 6.870            | 6.840            | 6.880            | 20.590         |
| Intervention services (treat and help problem gamblers and their families/whānau) | 8.461            | 8.361            | 8.361            | 25.183         |
| Research and evaluation   | 2.209            | 2.210            | 2.210            | 6.629          |
| Ministry operating costs  | 0.957            | 0.990            | 0.990            | 2.937          |
| <b>Total (\$m)</b>  | <b>18.497</b>    | <b>18.401</b>    | <b>18.441</b>    | <b>55.339</b>  |

Subsequent to the consultation period commencing, and in response to questions raised during public meetings about the planned use of the \$5 million underspend, the Ministry published additional information on its website to assist in the development of submissions. With the addition of the underspend to the proposed levy appropriation, the total funding allocation increased to \$60.339 million over three years. Further, the Ministry provided a breakdown for allocating the \$5 million underspend, which is reproduced below from the presentation accessed via the website.

**Table 8: Indicative detailed costings for the \$5 million underspend<sup>302</sup>**

| Service Area                                     | 2019/20<br>(\$m) | 2020/21<br>(\$m) | 2021/22<br>(\$m) | Total<br>(\$m) |
|--|------------------|------------------|------------------|----------------|
| Pilots (public health and intervention services) | 0.500            | 1.250            | 1.250            | 3.000          |
| Pilots (evaluation)                              | 0.200            | 0.100            | 0.200            | 0.500          |
| Peer Support Services                            | 0.035            | 0.235            | 0.530            | 0.800          |
| Residential care services                        | 0.100            | 0.100            | 0.500            | 0.700          |
| <b>Total</b>                                     |                  |                  |                  | <b>5.000</b>   |

#### 3.1.1. Submitters argued for and against the proposed funding appropriation

There was low support for the proposed size of the funding appropriation (as shown in Table 7). Of the 82 submissions, 28 did not address the question; and of the 54 that did address it, 38 did not support the funding appropriation. Many submitters explained their reasoning for withholding their support, but comments in support were general: “Yes, the amount is appropriate.”<sup>303</sup> Responses from submitters that withheld support follow.

<sup>302</sup> This information was accessed from <https://www.health.govt.nz/publication/strategy-prevent-and-minimise-gambling-harm-2019-20-2021-22-consultation-document>

<sup>303</sup> 25

### **3.1.2. For NCGM sector submitters, reduced presentations and uninspiring spending proposals made the proposed funding appropriation inappropriate**

NCGM sector submitters put forward several reasons why they did not consider the proposed funding appropriation to be appropriate. Eleven NCGM sector submitters considered that the reduction in the number of treatment presentations should be reflected in a reduced funding appropriation.<sup>304</sup> Six NCGM sector submitters expressed frustration at the appropriation, commenting that the proposal offered nothing new or innovative.<sup>305</sup> For example:

*You haven't fixed anything... with all the money year after year to me it's a shameful result.*<sup>306</sup>

Two NCGM sector submitters<sup>307</sup> also considered that the consultation document was not sufficiently explicit about why an increase was sought, and that the proposed increased spending needed to be justified in the final document. One NCGM submitter<sup>308</sup> commented that the budget was inappropriate for the proposed activities “*doing all the same things that have not had a material impact in the past*”, but that the appropriation was appropriate for exploring new technologies. This submitter also commented that a reduced appropriation would mean more money available for community funding.

#### ***Service Providers considered that insufficient funding made the proposed appropriation inadequate***

Three Service Providers<sup>309</sup> and an Individual submitter<sup>310</sup> considered the appropriation did not adequately account for anticipated changes in wages, which one submitter suggested should be aligned with the Alcohol or Drug Addiction workforce.

Another Service Provider<sup>311</sup> asserted that more investment was needed across public health, intervention services, and research and evaluation, especially investing in more staff, if a reduction in gambling harm is to be achieved.

#### ***There is contention over the \$5 million underspend***

A major point of contention about the size of the proposed appropriation centred on how the \$5 million underspend should be treated in the levy formula. Comments about this were included in 24 submissions, mainly from NCGM submitters.

Submitters from a Local Government,<sup>312</sup> Health,<sup>313</sup> and two from the Service Provider sectors<sup>314</sup> supported the proposed retention of the \$5 million under-spend by the Ministry.

A Gambling Industry (other) submitter<sup>315</sup> supported the retention of the underspend, on the understanding that \$3.5 million be set aside for a technology fund, to support investment in facial recognition software. A Service Provider<sup>316</sup> tacitly supported the retention of the underspend but asked who would represent Pasifika in the decision-making process about how the money is to be

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<sup>304</sup> 01,03,05,06,14,16,18,26,28,50,63

<sup>305</sup> 16,18,28,C03,C04,C07

<sup>306</sup> C03

<sup>307</sup> 14,18

<sup>308</sup> C04

<sup>309</sup> 11,37,C05

<sup>310</sup> 21

<sup>311</sup> 37

<sup>312</sup> 12

<sup>313</sup> 36

<sup>314</sup> 56,C08

<sup>315</sup> 59

<sup>316</sup> C11

spent, and a Service Provider<sup>317</sup> questioned why the research budget has been excluded from the likely beneficiaries of the allocation from the underspend.

Thirteen NCGM sector submitters<sup>318</sup> and one Gambling Industry (other) submitter<sup>319</sup> expressed concern about the retention of the \$5 million underspend and it being used at the discretion of the Ministry in addition to the budget proposed in the draft Service Plan. There was a general preference from these submitters for the underspend to partially fund the proposed Service Plan, reducing the funding appropriation. One of these submitters<sup>320</sup> suggested that if the Ministry is to retain the surplus, then it should use it to encourage the uptake of MVE technology in all high turnover venues – which was considered consistent with the aim of harm minimisation.

Three NCGM sector submitters<sup>321</sup> expressed frustration at the consultation process regarding the \$5 million surplus, and urged the Ministry to reconsider how the underspend is treated in respect of variable C and variable R. They suggested that the \$5 million underspend either be used to offset the budget, or it be included in variable R. Some submissions suggested that the current situation warrants judicial review and that accordingly, the Gambling Commission and the Minister of Health should be advised. Two NCGM sector submitters commented that that the proposed budget should be reduced to consider both the underspend and the overpayment.<sup>322</sup> It was noted by three NCGM sector submitters that excess levy payments reduced the amount of money available for community funding.<sup>323</sup>

Two NCGM sector submitters<sup>324</sup> and a Health sector submitter<sup>325</sup> were concerned that the \$5 million underspend was to be added to the new appropriation resulting in a larger budget than was fully described in the consultation document. Two submitters expressed concern about the lack of transparency around the proposed use of the underspend,<sup>326</sup> noting the lack of detail in the budget regarding the proposed residential facility and face-to-face counselling services, which was considered “*a serious breach.*”<sup>327</sup>

Two NCGM submitters<sup>328</sup> expressed dissatisfaction that the proposed residential facility and additional treatment offices were not included in the budget, which was viewed as “*grounds for judicial review*”. The absence of costings for proposed face-to-face counselling services was also noted by one of these submitters.<sup>329</sup>

NCGM sector submitters suggested various ways to use the \$5 million underspend:

- Return it to levy payers<sup>330</sup>
- Establish a Gambling Awareness programme<sup>331</sup> to further educate gamblers, reducing harm, and

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<sup>317</sup> 40

<sup>318</sup> 01,05,06,14,16,17,18,28,41,51,63,64,C04

<sup>319</sup> 43

<sup>320</sup> 06

<sup>321</sup> 18,41,64

<sup>322</sup> 14,18

<sup>323</sup> 01,16,18

<sup>324</sup> 02,41

<sup>325</sup> 24

<sup>326</sup> 10,41

<sup>327</sup> 41

<sup>328</sup> 03,41

<sup>329</sup> 41

<sup>330</sup> 50

<sup>331</sup> 51

- Fund a small-group programme that is being piloted, which is based on tikanga and Māori values, using Whānau Ora Navigators.<sup>332</sup>

### 3.1.3. Opinions about the size of the appropriation were split by sector

#### ***NCGM sector submitters wanted the appropriation reduced, but Service Providers, Health sector and Local Government submitters wanted it increased***

A smaller funding appropriation was sought exclusively by submitters from the NCGM sector,<sup>333</sup> principally due to their preference for the \$5 million surplus to be used to offset the budget, reducing the appropriation; and/or because presentations are lower than anticipated, and therefore fewer treatment services are required. Suggestions for an appropriate appropriation ranged from \$40 million to \$52 million.



The funding appropriation equates to about \$18.4 million per year; this is exceeded by the amount Lotto NZ has budgeted in 2019 just for its media advertising, media production and draw.

A larger funding appropriation was suggested by submitters from nine Service Providers,<sup>334</sup> one Health sector submitter,<sup>335</sup> one Local Government<sup>336</sup> submitter, and two individuals,<sup>337</sup> principally due to their perception that needs were greater than the draft Service Plan anticipated, but also noting that there had been no real increase for some time if the CPI or inflation were taken into consideration. No specific appropriation amounts were suggested.

A Health sector submitter<sup>338</sup> pointed out that the total appropriation is small compared to Lotto's annual advertising budget:

*... the funding appropriation equates to about \$18.4 million per year; this is exceeded by the amount Lotto NZ has budgeted in 2019 just for its media advertising, media production and draw...*

Similarly, another Service Provider<sup>339</sup> observed that the overall fund appears to be insufficient to meet the challenges and issues brought about by increased online gambling.

### 3.1.4. High-level change for the funding of gambling harm minimisation was sought by some submitters

A Health sector submitter<sup>340</sup> suggested a change in the funding model, noting that the Strategic Framework and Service Plan had an over-reliance on industry profits. A Service Provider<sup>341</sup> warned that the focus of the draft Service Plan on innovation and technology was inadequately supported within the Plan for development and implementation, potentially "*setting us up for failure*".

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<sup>332</sup> 54

<sup>333</sup> 01,02,06,14,18,28,63,64

<sup>334</sup> 11,20,37,40,45,C05,C10,C11,C13

<sup>335</sup> 27

<sup>336</sup> 12

<sup>337</sup> 21,C01

<sup>338</sup> 30

<sup>339</sup> 45

<sup>340</sup> 27

<sup>341</sup> 39

**3.2. The degree of support for the proposed Service Plan**

**3.2.1. Collaborative, innovative treatments, that were culturally tailored to priority populations, were requested**

Submissions were received from the Gambling Industry (other),<sup>342</sup> Service Providers,<sup>343</sup> Health sector,<sup>344</sup> and Local Government<sup>345</sup> that broadly supported the draft Service Plan.

The proposed peer support initiative was supported by submitters from the Gambling Industry (other),<sup>346</sup> Service Providers,<sup>347</sup> Health sector,<sup>348</sup> and an individual submitter.<sup>349</sup> The proposed residential facility was supported by Gambling Industry (other)<sup>350</sup> and Health sector submitters,<sup>351</sup> and was suggested by an individual submitter<sup>352</sup> to be suited to a marae-based programme. The proposed consumer network was supported by an individual submitter<sup>353</sup> who suggested this could be based on a Salvation Army model.

A Health sector<sup>354</sup> and a Local Government submitter<sup>355</sup> supported piloting new service models, with one suggesting that the focus should be on regions experiencing high risk of problem gambling; and that the Ministry work closely with local government, which has insights to community needs and relationships with community leaders.

Other services and activities that submitters supported were a request from a Health sector submitter for an increased focus on health literacy, service responsiveness and gambling host responsibilities;<sup>356</sup> a Service Provider<sup>357</sup> called for a 24/7 helpline and web-support services specifically for the Asian population; and a Local Government submitter<sup>358</sup> requested a review of territorial [local government] policies and venue licence conditions.

More generally, one Health sector submitter called for activities to move beyond ‘awareness’ and focus instead on activities that enable positive change;<sup>359</sup> and another health sector submitter commended the Ministry on the inclusion of recommendations from the Sapere Gambling Harm Reduction Needs Assessment report.<sup>360</sup>

**3.2.2. Accountability, prevention, and collaboration were important to submitters**

Submissions from the NCGM sector,<sup>361</sup> Health sector,<sup>362</sup> Service Providers,<sup>363</sup> and an individual<sup>364</sup> called for greater accountability regarding levy spending. An NCGM submitter<sup>365</sup> suggested that

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<sup>342</sup> 42,43,  
<sup>343</sup> 44,45,C02,C08  
<sup>344</sup> 32,33,36,57  
<sup>345</sup> 29  
<sup>346</sup> 55  
<sup>347</sup> 44  
<sup>348</sup> 36  
<sup>349</sup> 21,38  
<sup>350</sup> 55  
<sup>351</sup> 33,36  
<sup>352</sup> 21  
<sup>353</sup> 21  
<sup>354</sup> 36  
<sup>355</sup> 25  
<sup>356</sup> 36  
<sup>357</sup> 45  
<sup>358</sup> 29  
<sup>359</sup> 57  
<sup>360</sup> 32  
<sup>361</sup> 50  
<sup>362</sup> C16  
<sup>363</sup> 44,60  
<sup>364</sup> C03  
<sup>365</sup> 44

provider contracts should be reviewed so that funding could be directed to services producing good outcomes; and an individual submitter expressed the hope that money was not wasted as it had been in the past.<sup>366</sup>

Two submissions suggested or alluded to alternative approaches.

- An NCGM submitter<sup>367</sup> suggested that the already-low problem gambling statistics presented the opportunity to focus more on prevention in at risk communities. Early intervention activities included:
  - Addressing addiction triggers in gambling venues
  - Using a holistic and cross-agency approach
  - Consolidating multiple treatment services into a single specialist addiction service, and
  - Working with local bodies to develop a shared understanding of healthy gambling; and supporting venues through the use of technology and specialist support.
- More generally, a Service Provider<sup>368</sup> commented that the current approach to delivering gambling harm minimisation might be becoming obsolete, due to new modes of communication.

Two Service Providers<sup>369</sup> commented that the competitive approach to funding can be detrimental to forming relationships between services. A different Service Provider<sup>370</sup> commented that innovative population-based health services cannot be properly resourced by the existing budget without reducing access for those already using the services, and a Health sector submitter<sup>371</sup> commented that “*support to move families out of poverty would be extremely beneficial.*”

### **3.3. The degree of support for Public Health Services draft priorities**

#### **3.3.1. Additional funding and assurances that priority populations will benefit were requested**

Six Service Provider submitters,<sup>372</sup> and one each from the Health sector,<sup>373</sup> and Local Government<sup>374</sup> commented that the draft Service Plan did not adequately fund public health services, particularly workforce:<sup>375</sup>

*The cost of operating a clinical or public health service of standard, is not reflected in the FTE amount currently paid. Given the increasing push for kaimahi to process a high standard of qualifications, the amount paid per FTE does not reflect the calibre of worker.*

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<sup>366</sup> C03

<sup>367</sup> 17

<sup>368</sup> 44

<sup>369</sup> 20,65

<sup>370</sup> 44

<sup>371</sup> 13

<sup>372</sup> 11,37,39,44,60,C05

<sup>373</sup> 13

<sup>374</sup> 12

<sup>375</sup> 11

Two Local Government,<sup>376</sup> two Service Providers,<sup>377</sup> and an Individual submitter<sup>378</sup> noted the disconnect between the expected prevalence of moderate to severe harm and the actual number of clients, noting this to be an indication that “services are not adequately reaching those in need.”<sup>379</sup> Two Local Government submitters<sup>380</sup> commented that addressing the problem of persistent gambling harm amongst different population groups requires innovative intervention approaches and more accessible and targeted services that respond to the needs of particular populations.

A Health sector submitter<sup>381</sup> similarly commented on the need for a larger budget for public health to address inequity: people need to receive services in a culturally appropriate way. Two Service Providers<sup>382</sup> commented on the lack of in-language or culturally appropriate information available for Asian people. One of these submitters<sup>383</sup> called for linguistically and culturally appropriate client-centred tools suited to Asian populations; and also noted that public health budget allocations for intervention development and tools should specifically reference the need to address the cultures of priority populations.

Service Providers also requested:

- More prevention initiatives<sup>384</sup>
- More behaviour change activities<sup>385</sup>
- That additional funding budgeted for television advertising (such as gambling harm counselling services)<sup>386</sup>
- Youth-focused interventions and public health services<sup>387</sup>
- National and local multi-media campaigns designed to meet the needs of priority populations, delivering key messages about intervention services and how to access these,<sup>388</sup> and
- An incentive fund to motivate General Practitioners to screen for gambling harm.<sup>389</sup>

A NCGM submitter<sup>390</sup> called for an additional focus on teaching people how to manage their gambling spend.

A Service Provider<sup>391</sup> stated that advertising [it is not stated but this is presumed to refer to advertising of gambling venues and activities] which targets vulnerable ethnic groups must cease; and that advertising should be restricted to times and places that prevent exposure to children.<sup>392</sup> Two Service Providers<sup>393</sup> also noted that the budget for a biennial international conference was half of what was anticipated.

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<sup>376</sup> 12

<sup>377</sup> 12,20,39

<sup>378</sup> 62

<sup>379</sup> 12

<sup>380</sup> 12,29

<sup>381</sup> 13

<sup>382</sup> 44,45

<sup>383</sup> 45

<sup>384</sup> 44

<sup>385</sup> 57

<sup>386</sup> 20

<sup>387</sup> C05

<sup>388</sup> 45

<sup>389</sup> 20

<sup>390</sup> 51

<sup>391</sup> 44

<sup>392</sup> Since it seems unlikely that such advertising would be funded through the appropriation, it seems likely that the submitter intends that a public health initiative should be included to investigate, report on and make recommendations about the practices in order to influence policy change.

<sup>393</sup> 40,44

Service Providers made the following points about public health initiatives that they did not support:

- Less funding was needed for education and awareness activities<sup>394</sup>
- Funding allocated to HPA to promote face-to-face services should be reallocated to service providers for their own service promotion. Further, the Service Provider noted their intention to develop online tools for gambling harm intervention and commented that the draft Service Plan appears to direct all funds planned for this activity to the HPA,<sup>395</sup> and
- An NCGM submitter<sup>396</sup> expressed concerns at the likely cost of having leaflets produced, arguing that the industry could probably have produced the same material for less.

### 3.4. The degree of support for Intervention Services draft priorities

#### 3.4.1. A wide range of additional intervention activities were requested

Service Providers,<sup>397</sup> Health sector<sup>398</sup> and individual submitters<sup>399</sup> commented on the underfunding of intervention workforce. For example, pay was inadequate considering the qualifications required of staff delivering interventions; and more funding was needed to raise awareness of the services available, especially to promote face-to-face services. The individual submitter<sup>400</sup> requested more funding for service providers so that they can do more of the good work that they are doing. Service Providers<sup>401</sup> argued that workforce development funding should be focused on developing competencies to deliver services to prioritised populations – Asian, Māori, and Pasifika; with one Service Provider noting:<sup>402</sup>

*Inequality and inequity demand higher levels of expectations from our people [workforce]. We ask that consideration be given to those populations i.e. Māori, Pacific and Asia to have extra support and resources to ensure advances are sustained.*

Five NCGM sector submitters<sup>403</sup> and a Health sector submitter<sup>404</sup> requested that a separate fund be established for purchasing, developing and testing technological initiatives such as facial recognition and other harm minimisation technologies.

Three Service Providers<sup>405</sup> called for face-to-face support to be available in all regions, noting that the increase in online gambling might make it problematic for some people to be accessing online support services. Another Service Provider<sup>406</sup> suggested using online help services to reach people in remote communities.

One Service Provider suggested that more intensive treatment is required to gain effective outcomes and prevent relapse, and proposed that:<sup>407</sup>

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<sup>394</sup> 11

<sup>395</sup> 39

<sup>396</sup> 10

<sup>397</sup> 11,20,39,44,60,C05

<sup>398</sup> 33,37,C16

<sup>399</sup> 47

<sup>400</sup> 47

<sup>401</sup> 11,20,39,44,60,C05

<sup>402</sup> 60

<sup>403</sup> 08,18,26,28,C04

<sup>404</sup> 33

<sup>405</sup> 11,39,44

<sup>406</sup> 45

<sup>407</sup> 39

*... multiple modes of accessing specialist gambling harm intervention services and online specialist intervention tools ... be designed, developed, piloted and evaluated thoroughly during this next service plan period.*

A Health sector submitter<sup>408</sup> called for more investigation into areas identified in the Gambling Harm Needs Assessment, particularly increased screening across the health and social services sectors; and piloting new service models. The call for increased screening was reiterated in the submission from an individual.<sup>409</sup>

A Service Provider<sup>410</sup> called for a pilot programme to provide a service including both public health promotion and an intervention capacity (such as Gambling Harm Counsellors) located in the same building to provide a “one stop shop” to make it easier for people to get support.

A Health sector submitter sought the inclusion of kaiāwhina in the gambling harm minimisation workforce, arguing that:<sup>411</sup>

*As frontline workers, kaiāwhina are essential for helping consumers meet their goals ... however, in many instances there is lack of inclusion of kaiāwhina as active participants in the multi-disciplinary team. ... Given that kaiāwhina are often the primary touchpoint for consumers, being the first to recognise consumer's needs, this is an omission that hinders the best outcomes and responses to tangata whaiora.*

An NCGM submitter<sup>412</sup> suggested that auditing should be extended to ensuring that Ministry-contracted providers use their funding solely to treat gambling harm and for gambling research.

One Service Provider suggested the following intervention innovations:<sup>413</sup>

- Court diversion to residential care for gambling-related convictions, focused on Māori and Pasifika women (fraud, debt etc)
- Whole-of-government approach to criminal behaviour driven by gambling which would include residential rehabilitation programmes
- Pilot a Pasifika helpline staffed by Pasifika counsellors in first languages and include online support options
- Fund more counselling sessions before screening to better work with whānau
- Reinstate minimum number of sessions for Casino exclusions
- Development of a help website for Asians, and online e-therapy
- Develop generic e-therapy, and
- Address service gaps:
  - Asian Helpline to operate 24/7
  - Peer support pilot
  - Increased allocation for social media in more languages, and
  - Online and technological solutions for reaching the hard to reach populations.

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<sup>408</sup> 36

<sup>409</sup> 62

<sup>410</sup> 37

<sup>411</sup> C16

<sup>412</sup> 41

<sup>413</sup> 44

A Service Provider suggested a large, multi-media de-stigmatisation campaign, designed for Asian and migrant communities. The campaign would need to use first languages so that there is meaningful communication with the intended audiences:<sup>414</sup>

*Not only can shame and stigma affect social and community connectedness, but they can severely impede help-seeking, early detection, and future treatment.*

A Service Provider<sup>415</sup> sought a larger funding allocation for consumer networks. Another Service Provider<sup>416</sup> suggested intervention funding should also include kaumatua, champions, peer support workers; an afterhours call centre in South Auckland; and incentives for organisation to take on student placements.

### **3.4.2. NCGM sector submitters withheld support for a range of intervention activities**

A range of intervention activities were not supported by submitters from the NCGM sector.

Ten NCGM sector submitters<sup>417</sup> requested that the Ministry investigate and stop the funding of services that participate in advocacy activities that were considered inappropriate: against the principles of harm minimisation. The submitters gave examples such as objecting to liquor licencing applications; advocating against the proposal to incentivise NCGM venues to relocate from lower socioeconomic areas to higher socioeconomic areas; and stigmatising gambling.

One Service Provider commented:<sup>418</sup>

*Please investigate the misuse of the Ministry's funding and confirm that the Ministry has directed its contracted providers to no longer object to liquor licences on the grounds of low alcohol sales.*

It was argued by NCGM sector submitters<sup>419</sup> and Health sector submitter<sup>420</sup> that the development of additional face-to-face counselling services in small or rural areas was unnecessary, with six submitters calling for the Ministry to close facilities that do not treat at least one person per week.

The need for a residential facility was not supported by five NCMG sector submitters<sup>421</sup>, with concerns were expressed about the cost and potential returns. There was also a wariness expressed by these submitters that such a facility might also be used by people with serious comorbidities such as alcohol and drug addictions, which was considered inappropriate.

The Ministry was requested by three NCGM sector submitters<sup>422</sup> to stop funding of a grants database. It was argued that this is outside the health jurisdiction. The same three submitters also requested the Ministry to reduce funding to treatment providers, due to the decreased demand for their services.<sup>423</sup>

One NCGM sector submitter<sup>424</sup> did not support the proposed consumer network, expressing concerns that such a network would develop into an anti-gambling advocacy group. The proposed consumer network was also not supported by a submitter from Gambling Industry (other).<sup>425</sup> The

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<sup>414</sup> 45

<sup>415</sup> 11

<sup>416</sup> C05

<sup>417</sup> 03,05,16,18,26,28,41,50,63,C04

<sup>418</sup> 03

<sup>419</sup> 03,05,14,26,50

<sup>420</sup> 35

<sup>421</sup> 05,14,17,26,50

<sup>422</sup> 16,18,26

<sup>423</sup> 16,18,28

<sup>424</sup> 35

<sup>425</sup> 50

Ministry was requested by this same Gambling Industry (other) submitter to insist that service providers deliver evidence-based treatment and advocacy, and that they must be aligned with Ministry advice and key messages.<sup>426</sup>

A Service Provider<sup>427</sup> asserted that intervention services need to be based on population needs rather than mainstream organisations providing all the services, so that people receive culturally-specific services.

### 3.5. The degree of support for Research and Evaluation draft priorities

#### 3.5.1. A range of research and evaluation activities were supported by most sectors

A Health sector submitter<sup>428</sup> called for more investigation into areas identified in the Gambling Harm Needs Assessment. In particular:

- An evaluation of existing service provision, to identify measurable outcomes
- An exploration of ongoing support and relapse within provider client populations, with an emphasis on the treatment of comorbidities, and
- A review of learnings from regional models and working in a co-design approach with providers, venues and consumers.

Three Gambling Industry (other) submitters<sup>429</sup> reinforced the need for timely research and robust data to support decision making; and the need to ensure that intended research outputs provide practical solutions. One of these submitters<sup>430</sup> suggested including predictive modelling research, to potentially assist with early identification of people moving toward problem gambling; and called for more research into relapse prevention, and the convergence of gambling and gaming. Another Gambling Industry (other) submitter<sup>431</sup> suggested an emphasis on online gambling.

A Local Government submitter<sup>432</sup> suggested that local bodies be directly funded to conduct their own evaluations of the impacts of their policies and to inform policy development.

An individual submitter<sup>433</sup> suggested that the Service Plan include flexibility to enable funding of promising innovations and projects that sit outside of the Plan.

#### ***NCGM sector submitters withheld support for research and evaluation activities***

Concern was expressed by nine NCGM submitters,<sup>434</sup> a Gambling Industry (other) submitter,<sup>435</sup> and one individual submitter<sup>436</sup> that many of the proposed research projects did not appear to offer new or innovative outputs that would advance the work of minimising gambling harm. Four of these submitters<sup>437</sup> specifically disagreed with the need for secondary analysis of the National Gambling Study and the proposed meta-analysis of Health and Lifestyles survey data:<sup>438</sup>

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<sup>426</sup> 50  
<sup>427</sup> 45  
<sup>428</sup> 36  
<sup>429</sup> 42,43,50  
<sup>430</sup> 43  
<sup>431</sup> 42  
<sup>432</sup> 25  
<sup>433</sup> 21  
<sup>434</sup> 02,14,16,18,26,28,51,63,C04  
<sup>435</sup> 43  
<sup>436</sup> C03  
<sup>437</sup> 18,28,63,C04  
<sup>438</sup> 02

*The proposed research projects do not inspire confidence and do not validate a need for increased funding.*

### **3.5.2. There was cross-sector agreement about research and evaluation priorities**

Eight Service Providers,<sup>439</sup> three NCGM sector submitters,<sup>440</sup> two Gambling Industry (other) submitters,<sup>441</sup> two Health sector submitters,<sup>442</sup> a Local Government submitter,<sup>443</sup> and an individual<sup>444</sup> considered that the *Emerging Issues* research activities should be prioritised, especially research about online gambling, and particularly the convergence of gaming and gambling, which some submitters noted to be especially impacting teenagers.

Some Service Providers<sup>445</sup> prioritised the *Inequality and Inequity* research, particularly about gambling and priority population groups, seeking outputs that will alleviate inequity.

The *Prevalence and Incidence* research proposals were given the lowest priority, often noting that findings were predictable:<sup>446</sup>

*We ... do not need any new research to tell us what we already know – i.e. the rates of problem gambling are higher for Māori, Pasifika and Asian ethnicities; problem gamblers are more likely to smoke, drink and use other drugs (comorbidity exists).*

### **3.6. Ministry Operating Costs**

One Service Provider<sup>447</sup> suggested transferring resource from the Ministry operating costs to local providers, so that they can create their own solutions for their local communities.

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<sup>439</sup> 37,39,44,45,53,C02,C05,C08

<sup>440</sup> 05,50,C04

<sup>441</sup> 42,55

<sup>442</sup> 36,57

<sup>443</sup> 25

<sup>444</sup> C09

<sup>445</sup> C02,C05,C08

<sup>446</sup> 16

<sup>447</sup> C10

## 4. THE LEVY FORMULA AND ALTERNATE LEVY WEIGHTINGS

This part of the report outlines the commentary received from submitters on the levy formula and the draft levy rates. It covers submitters' views on:

- The levy formula and whether it provides a reasonable way to reflect relative harm
- Player expenditure forecasts for each gambling sector
- Preferred weightings for expenditure and presentations, and
- The estimated draft levy rates for each sector.

Five questions were asked about the levy, two of which included 'Yes/No' responses. Table 9 shows the tally of responses by question.

**Table 9: Yes/No responses to questions concerning the levy rates and formula**

| Question   | Yes | No |
|--|-----|----|
| 11. Are the player expenditure forecasts for each gambling sector (D) realistic?   | 10  | 12 |
| 12. Are there realistic pairs of expenditure/presentation weightings (W1 and W2) other than those discussed in this consultation document? | 7   | 5  |

The Levy section of the consultation document was addressed at least in part by 47 submitters from across the six sector groupings, as illustrated in Table 10.

**Table 10: Number of submissions, by sector, that addressed questions about the levy**

| NCGM sector | Gambling industry (other) | Service Providers | Health sector | Local Government | Individuals |
|-------------|---------------------------|-------------------|---------------|------------------|-------------|
| 20/22       | 4/8                       | 14/21             | 2/13          | 4/6              | 3/12        |

### 4.1. The degree of support for player expenditure forecasts

Ten submitters<sup>448</sup> (six Service Providers, three individuals, and one Gambling Industry (other) submitter) commented on whether the player expenditure forecasts were realistic.

#### 4.1.1. Forecasts were considered unrealistic, because they do not reflect the full scope of harmful products or the impact of that harm to individual gamblers

Almost all submitters (six Service Providers and three individuals<sup>449</sup>) thought that the player expenditure forecasts were unrealistic. These submitters considered that the player expenditure forecasts do not:

<sup>448</sup> 11,20,42,C01,C02,C03,C05,C09,C11,C13

<sup>449</sup> 11,20,C01,C02,C03,C05,C09,C11,C13

- Take into account that individual bet amounts are increasing (rather than the number of people gambling); that is, the overall amount of money being gambled is increasing but the number of players is not (two Service Providers<sup>450</sup> and two individuals<sup>451</sup>)
- Take into consideration (but should) online gambling, particularly international online operators (two Service Providers<sup>452</sup> and an individual<sup>453</sup>), and
- Provide “*an accurate picture of the harm associated with each product*” as the reporting data collected does not allow for the product to be scaled with respect to how significant the level of harm or priority is for the gambler (e.g. few gambling harm treatment clients identify Lotto as a significant source of harm, but there should be more recognition of Lotto as a widespread and growing influence, even if individual amounts are relatively low (one Service Provider<sup>454</sup>)).

### ***The Lotto SOI forecast was considered a better way to determine expenditure***

The Gambling Industry (other) submitter<sup>455</sup> did not explicitly consider that the player expenditure forecasts were unrealistic. It stated that the consultation document did not describe the method used by the DIA to develop the forecasts and that it was therefore unable to comment on the reasonableness of the approach. Instead, the submitter noted that the forecasts were significantly higher than the corresponding values from Lotto’s 2019-2022 Statement of Intent (SOI). Further, the submitter noted that the SOI forecasts were intended to reflect the best forecasts at the time, based on historical data, analysis of consumption trends and proposed future game changes. The submitter considered that it is important to determine an appropriate expenditure forecast, given that it directly impacts the levy rate. The submitter suggested that the Ministry adopted Lotto’s SOI forecast.

## **4.2. The degree of support for the various weighting options**

NCGM sector submitters,<sup>456</sup> Service Providers,<sup>457</sup> Local Government submitters,<sup>458</sup> Health sector submitters,<sup>459</sup> Gambling Industry (other) submitters,<sup>460</sup> - amounting to 36 submitters, commented on the weighting of expenditure and presentations in the levy formula, most of whom represent gambling operators.

Twenty-five submitters expressed a preference for one of the pairs of weightings outlined in the consultation document.

- Seventeen submitters<sup>461</sup> (15 NCGM sector submitters, one Gambling Industry (other) submitter and one Service Provider) preferred the 30/70 weighting
- Five submitters<sup>462</sup> (four Gambling Industry (other) and one Local Government) preferred the 10/90 weighting

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<sup>450</sup> C02,C13

<sup>451</sup> C01,C03

<sup>452</sup> C05,C13

<sup>453</sup> C09

<sup>454</sup> 11

<sup>455</sup> 42

<sup>456</sup> 01,02,03,05,06,08,10,14,16,18,26,28,34,41,50,51,63,64,C04,

<sup>457</sup> 20,39,40,C10

<sup>458</sup> 12,25

<sup>459</sup> 33

<sup>460</sup> 42,43,55,61

<sup>461</sup> 01,02,03,06,08,10,14,16,18,28,34,40,50,51,63,64,C04

<sup>462</sup> 12,42,43,55,61

- One Local Government submitter<sup>463</sup> and one Service Provider<sup>464</sup> expressed a preference for a weighting on presentation but had no preference between the 20/80 or the 30/70 weighting options, and
- One Health sector submitter<sup>465</sup> preferred the 20/80 weighting (i.e., the weighting that the Ministry indicated may be appropriate).

No submitters expressed a preference for the 5/95 weighting.

Three submitters suggested alternative weightings: two NCGM submitters<sup>466</sup> suggested a weighting of 100/0 (that is, 100 percent expenditure and no presentations data); one NCGM submitter<sup>467</sup> suggested an alternative weighting of 50/50.

Two Service Provider submitters<sup>468</sup> made other general comments about the levy weightings needing to reflect harm but did not express a preference for a specific weighting.

#### **4.2.1. The NCGM Sector and some Gambling Industry (other) submitters preferred the 30/70 weighting**

Most submitters who commented on the weightings (17/25 submitters<sup>469</sup>; 15 NCGM operators, one Service Provider, and one other Gambling Industry (other) submitter) preferred the 30/70 option.

Submitters presented numerous reasons why they preferred a 30/70 weighting. Their reasons can be broadly categorised as either being a good fit with the intentions of the Act, or of 30/70 being a fairer, more equitable weighting.

##### ***The 30/70 weighting was considered a good fit to the intentions of the Gambling Act***

Nine NCGM sector submitters<sup>470</sup> noted that the 30/70 weighting was consistent with the definition of harm in the Gambling Act 2003. They noted that focusing on pathological gamblers was inconsistent with the broader definition of harm and does little to encourage early intervention and/or prevent escalation. This also ignored the fact that many problem gamblers have other pre-existing addictions and disorders.

Five NCGM sector submitters<sup>471</sup> commented that expenditure data is more accurate than presentation data, and therefore should have more weight accorded to it. Expenditure is an objective measure based on accurate data from all forms of gambling, while presentations are highly subjective and may only represent a small sub-section of gamblers.<sup>472</sup>

##### ***The 30/70 weighting was considered fairer than other suggested weightings***

Ten NCGM sector submitters<sup>473</sup> rejected a higher weighting on presentations because this punishes the proactive harm minimisation practice of actively encouraging people to seek help from treatment providers. They submitted that the 30/70 levy is less likely to see operators penalised for making proactive referrals to treatment providers, and it protects against adverse incentives.

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<sup>463</sup> 25

<sup>464</sup> 39

<sup>465</sup> 33

<sup>466</sup> 26,41

<sup>467</sup> 05

<sup>468</sup> 20,C10

<sup>469</sup> 01,02,03,06,08,10,14,16,18,28,34,40,50,51,63,64,C04

<sup>470</sup> 03,08,10,16,18,28,34,51,63

<sup>471</sup> 01,06,34,50,63

<sup>472</sup> 01,06,34,50,63

<sup>473</sup> 01,03,08,10,16,18,28,34,51,63

Seven NCGM sector submitters<sup>474</sup> commented that a 30/70 weighting acknowledges that not all levy payments are spent on interventions, but that they also fund research and evaluation and public health measures. One of these submitters<sup>475</sup> also noted that the cost of general research and evaluation should be borne equally by all four of the major gambling operators, not mainly funded by the NCGM sector based on the number of people who report to the various treatment providers. One submitter<sup>476</sup> went onto say that the Lotteries Commission and the New Zealand Racing Board should pay a larger share of the online gambling research given that they have online gambling products and the NCGM sector does not.

Five NCGM sector submitters<sup>477</sup> considered the 30/70 weighting to be more reflective of a user pays model. The funding distribution was considered to provide high-quality services for the small number of acute problem gamblers, and to benefit the much larger number of people who have low or moderate gambling risk. This focus was considered appropriate due to the greater public benefit. Low and moderate-risk gamblers were considered to be captured by the expenditure data, as they regularly spend money on products, however they tend to not be captured by presentation data. All five submitters commented that adopting a weighting which has a higher expenditure ratio means that the bulk of people who benefit from the Strategy are the same people meeting the cost of the Strategy.

Four NCGM operators<sup>478</sup> noted that help-seeking behaviours (identified through increases in presentations) do not necessarily indicate that more people in general are suffering harm from that type of gambling. For example, in the NCGM sector, there has been an intense television and radio campaign encouraging NCGM gamblers to seek help, as well as improved training at NCGM venues, including a more proactive approach to referring players to treatment providers and more prominent and helpful problem gambling signage. This has resulted in more NCGM players presenting to treatment providers, although the total amount of players suffering from harm has not changed. One NCGM noted:<sup>479</sup>

*[Many] people who are suffering from low or moderate gambling harm from lottery products would never make the formal step of telephoning the gambling helpline and/or making an appointment to see a counsellor. ... The presentation data therefore only tends to reflect the people who have a very serious level of gambling harm and are in crisis.*

Three NCGM operators<sup>480</sup> commented that a weighting focused more on expenditure (rather than presentations) is appropriate given a changing gambling environment, for example, although the expenditure for NCGMs is increasing, the number of presentations is decreasing, and NCGM spending as a proportion of the overall expenditure is decreasing. One NCGM sector submitter<sup>481</sup> also noted the rise in harm minimisation trends that exist in the NCGM sector.

Two NCGM sector submitters<sup>482</sup> commented that a 30/70 weighting would result in the NCGM sector paying a slightly reduced share of the total Strategy cost, and the New Zealand Lotteries Commission paying a slightly higher share. This was described as “fair and appropriate”,<sup>483</sup> as it

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<sup>474</sup> 01,08,10,16,18,28,63

<sup>475</sup> 01

<sup>476</sup> 10

<sup>477</sup> 16,18,28,34,63

<sup>478</sup> 16,28,63,C04

<sup>479</sup> 01

<sup>480</sup> 08,34,50

<sup>481</sup> 08

<sup>482</sup> 02,06

<sup>483</sup> 06

would reduce the share borne by the community gambling sector (no further explanation was offered for this view).

**4.2.2. Gambling Industry (other) submitters preferred the 10/90 weighting**

Four Gambling Industry (other) submitters (two casino operators<sup>484</sup> Lotto NZ<sup>485</sup> and the New Zealand Racing Board<sup>486</sup>) and one Local Government submitter<sup>487</sup> favoured a 10/90 weighting. Several reasons were given for supporting the 10/90 weighting.

***The 10/90 weighting was considered to accurately reflect contributors to gambling-related harm and more fairly apportion costs based on gambling activities that contribute to harm***

In contrast to comments made by NCGM sector submitters in relation to the 30/70 weighting, ‘presentations’ were considered to be a relatively strong indicator of harm by three Gambling Industry (other) submitters<sup>488</sup> and one Local Government submitter.<sup>489</sup> One Gambling Industry (other) submitter stated:<sup>490</sup>

*Since presentations are the best available longitudinal quantitative proxy for harm, attributing a 90% weighting to presentations is the only plausible way of ensuring a balanced and appropriate apportioning of the costs.*

Three Gambling Industry (other) submitters<sup>491</sup> considered that the 10/90 weighting more fairly apportions costs to those gambling activities that cause harm rather than where the money is spent and whether gambling activities result in less harm. The New Zealand Racing Board commented that the 10/90 weighting ensures that NCGMs, the form of gambling with “the highest number and percentage of presentations”, contributes the greatest amount.<sup>492</sup>

One Gambling Industry (other) submitter stated that:<sup>493</sup>

*Each sector has a responsibility for funding the problem gambling strategy and its broad components and ... apportioning the costs of the levy should be linked directly to the harm associated with each sector's gambling products.*

The New Zealand Racing Board also commented that a higher weighting on expenditure unfairly penalises the New Zealand Racing Board and the Lotteries Commission, both of which are responsible for less than half the share of presentations attributed to NCGMs.<sup>494</sup>

***The 10/90 weighting was considered to reflect and support harm reduction activities***

Two Gambling Industry (other) submitters<sup>495</sup> commented that the 10/90 weighting better reflects the harm reduction activities of responsible operators who try to identify and help problem gamblers and it does not disincentivise this practice (or impact adversely on help-seeking behaviours). They noted that a higher weighting toward presentations reflects the goal of reducing harm from gambling, rather than addressing the amount spent by gamblers.

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<sup>484</sup> 55,61  
<sup>485</sup> 42  
<sup>486</sup> 43  
<sup>487</sup> 12  
<sup>488</sup> 42,43,55  
<sup>489</sup> 12  
<sup>490</sup> 55  
<sup>491</sup> 43,55,61  
<sup>492</sup> 43  
<sup>493</sup> 26  
<sup>494</sup> 43  
<sup>495</sup> 43,61

While those who supported the 30/70 weighting suggested that a higher weighting on presentations could create incentives against actively encouraging help-seeking behaviour, one Gambling Industry (other) submitter<sup>496</sup> (which preferred a 10/90 weighting) explained that a higher weighting on presentations provides an incentive for operators to ensure that prevention and minimisation programmes are effective.

#### ***Lowering the weighting on presentations could exacerbate under-/over-recovery***

One Gambling Industry (other) submitter<sup>497</sup> was concerned that lowering the weighting on presentations would exacerbate the disparities in over and under-recovery, which it said showed that it had significantly overpaid in contrast to NCGMs and casinos.

#### ***The consultation document provided insufficient reason to move away from the established weighting***

Another Gambling Industry (other) submitter<sup>498</sup> said that presentations are a better proxy of the financial costs associated with the Strategic Direction, because many of the activities in the Strategic Direction provide more assistance to those with severe problems. Rather than reducing the weighting of presentations data, this submitter suggested a better solution would be to improve the quality of the data. Overall, this submitter did not consider that the consultation document had provided robust evidence to justify a move away from the existing weightings.

#### **4.2.3. A Health sector submitter preferred the 20/80 weighting**

Only one Health sector submitter<sup>499</sup> expressed a preference for the 20/80 weighting. The reason for supporting this weighting was that the levy for NCGMs should remain over 80 percent, and due to the increase in Lotto products being purchased, it would be sensible to have a higher percentage there too. It was also noted that this weighting increases the percentage for the New Zealand Racing Board.

While not explicitly preferring this option, one Service Provider<sup>500</sup> noted that the 10/90 weighting is based mostly on help-seeking presentations, and does not adequately cover the broad range of gambling related harm associated across the different sectors.

One Local Government submitter<sup>501</sup> did not express a preference between the 30/70 and 20/80 weightings.

#### **4.2.4. Alternative weighting options were suggested**

Submitters were asked whether there were any other realistic pairs of expenditure/presentation weightings (W1 and W2) other than those discussed in the consultation document (Question 12).

Three submitters (two NCGM sector submitters and one Service Provider)<sup>502</sup> provided suggestions for alternative weightings:

- A 100/0 weighting: two NCGM sector submitters<sup>503</sup> thought that higher presentation numbers are positive, rather than negative, and that each gambling sector should be challenged to increase their presentation numbers, with the Ministry then advising

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<sup>496</sup> 43

<sup>497</sup> 43

<sup>498</sup> 42

<sup>499</sup> 33

<sup>500</sup> 39

<sup>501</sup> 25

<sup>502</sup> 05,26,41

<sup>503</sup> 26,41

operators who show improvement that they will be rewarded with future regulatory concessions. Therefore, presentation numbers should not be included in the formula.

- A 50/50 weighting: one Service Provider<sup>504</sup> thought that an expenditure weighting of closer to 50/50 would see all four gambling providers paying “*a more equal share for the research into online gambling and the convergence between video games and gambling.*” They explained that a low expenditure weighting results in the community gaming sector paying for over half the cost of the research, while a higher weighting on expenditure results in credit being given when venue staff ban high-spending problem gamblers and refer the gamblers to the treatment providers. The submitter considered that increasing the weighting on expenditure is appropriate, as the numbers are conclusive, while presentation numbers are more subjective. Presentation numbers rely on problem gamblers being honest about all their forms of gambling, including online gambling. Presentation numbers also rely on treatment providers being able to interpret and allocate the presentation information consistently, despite geographical spread and limited data input training.

#### 4.2.5. Other comments about weightings were made

Two submitters made more general comments about the pairs of weightings:

- One Service Provider<sup>505</sup> stated that it preferred the weighting which produces the most amount of funding for frontline services. It noted that the presentations calculation is merely a calculation, and does nothing to quantify the level of gambling harm seen in communities.
- A Gambling Industry (other) submitter<sup>506</sup> stated that the weightings were difficult to analyse without further research.

One Service Provider<sup>507</sup> commented that the formula equated presentations to problem gambling services with harm from gambling, which was not considered a true public health approach. Most people harmed by gambling do not present for treatment. This includes problem gamblers, gamblers who are moderate- or low-risk but still experiencing some type of harm, and others affected by the gambling of someone close to them, such as friends or whānau.

### 4.3. The degree of support for the levy rates

Fifteen submitters (seven NCGM sector submitters, four Service Providers, two Gambling Industry (other) submitters, one Local Government submitter and one Health sector submitter)<sup>508</sup> commented on the various estimated levy rates for each of the levy-paying gambling sectors.

Thirteen of these submitters (six NCGM sector submitters, four Service Providers, one Gambling Industry (other) submitters, one Local, Government submitter and one Health sector submitter)<sup>509</sup> commented on the gambling levy in relation to specific gambling sectors. Some of these submitters made more than one comment in relation to differential levy rates.

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<sup>504</sup> 05

<sup>505</sup> C10

<sup>506</sup> 20

<sup>507</sup> 40

<sup>508</sup> 01,02,06,08,14,31,33,41,42,44,55,56,C04,C10,C11

<sup>509</sup> 02,06,08,14,31,33,41,44,55,56,C04,C10,C11

Two submitters<sup>510</sup> (one Health sector, one Service Provider) merely stated that levy rates should reflect the level of harm associated with each type of gambling activity, without offering further comment.

#### **4.3.1. The use of presentation data in the levy formula is contested by NCGM sector and Service Provider submitters**

##### ***Presentation data was inaccurate and too unreliable for inclusion in the levy rate calculation***

Four NCGM sector submitters<sup>511</sup> commented that the NCGM sector's levy share should not be based predominantly on the presentation numbers, as presentation numbers can be inconsistent, and vary based on factors such as:

- How the treatment provider asks questions
- The honesty of the gambler
- Bias against NCGM by the treatment providers
- Help-seeking advertising, and
- Diligence of staff.

A Service Provider<sup>512</sup> also commented that presentations are not an accurate representation of gambling harm, as they often underestimate the number of people that are seeking or need clinical services. This submitter considered that dropping the levy is not a good response to a reduction in presentations. The submitter suggested redirecting funding to Māori specific clinical and public health services, given that Māori are over-represented in gambling harm statistics, and having broader conversations around collaboration between public health and clinical services to help fill gaps in meeting client needs.

#### **4.3.2. There is some support for increased complexity in levy setting for the NCGM sector**

Submitters from the NCGM sector, Local Government, Service Provider sectors considered that NCGM levy rates should be specific in some way.

##### ***NCGM clubs are responsible for less harm than the commercial NCGM sector***

One NCGM sector submitter<sup>513</sup> commented that the club NCGM sector is responsible for less harm than the commercial NCGM sector. Therefore, this submitter considers that the club sector should have its own separate category, and only be responsible for meeting the costs of the presentations that come from the club sector.

##### ***Improved harm minimisation practices should be reflected in a reduced levy***

Another NCGM sector submitter<sup>514</sup> submitted that there have been several positive changes from a harm minimisation perspective in the sector over the last three years, and that this should be reflected in a reduced levy.

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<sup>510</sup> 33,C11

<sup>511</sup> 02,06,14,C04

<sup>512</sup> 56

<sup>513</sup> 14

<sup>514</sup> 08

### ***Public benefit from community grants should be recognised***

A third NCGM sector submitter<sup>515</sup> suggested that some gambling modes should pay a lower levy because of the public good [form community grant] that they consider offsets the harm associated with gambling.

### ***Problem gambling from NCGM is relatively quick and easy to treat (compared with other gambling types), which should be reflected in a reduced levy***

A fourth NCGM sector submitter<sup>516</sup> commented that evidence suggests that although NCGM problem gambling is a serious issue, once it is identified and help is sought, it can be effectively treated, whereas problem gambling from other forms may be more complex and expensive to treat. Therefore, the levy for NCGM operators should be lower, as treatment costs are comparatively less.

### ***A differential rate should be applied to NCGMs in high and low socioeconomic areas***

A Local Government submitter<sup>517</sup> recommended that a differential between NCGMs within higher and lower socioeconomic areas be included within the problem gambling levy. This submitter did not comment further.

### ***NCGM gambling causes more harm than other sectors, which should be taken into account***

Finally, in contrast to the comments from NCGM providers, a Service Provider<sup>518</sup> submitted that NCGMs create more harm than other forms of gambling, and this should be taken into consideration, as opposed to the expenditure/player presentation to problem gambling services. This submitter did not see the point in research and evaluation focused on prevalence and incidence of problem gambling if it cannot be used as a rationale for increasing the levy.

#### **4.3.3. A Gambling Industry (other) submitter commented that the levy does not reflect casino host responsibility initiatives**

One Gambling Industry (other) submitter<sup>519</sup> explained that the levy does not reflect the casino's host responsibility initiatives. The submitter suggested it has the most sophisticated host responsibility programme within the sector in New Zealand (and arguably in the world), including dedicated Host Responsibility staff on site 24/7, Customer Service Ambassadors to interact with customers on the casino floor, introduction of a predictive modelling technology which analyses player data to help identify customers most at risk from gambling harm, and introduction of a Voluntary Pre-commitment Programme to allow customers to set both the time and amount they wish to spend over a certain period. This submitter considered that the levy should be linked directly to the harm associated with each sector's gambling products.

#### **4.3.4. Additional considerations were proposed for setting levy rates**

One Service Provider<sup>520</sup> and one Gambling Industry (other) submitter<sup>521</sup> suggested changes that could be made to the levy rates. These changes included:

- Making allowances in the levy rates calculation for further services (Service Provider),<sup>522</sup> and

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<sup>515</sup> 41  
<sup>516</sup> 08  
<sup>517</sup> 31  
<sup>518</sup> C11  
<sup>519</sup> 55  
<sup>520</sup> 44  
<sup>521</sup> 42  
<sup>522</sup> 44

- Changing the weighting to reflect the relative impact of products on the demand for problem gambling services (Gambling Industry (other)).<sup>523</sup>

The Service Provider<sup>524</sup> suggested that the levy rates calculation allow more for:

- Wage increases (to pay in a competitive market, and particularly for Māori, Pacific and Asian)
- Introduction of facial recognition investment
- Increased health promotion expenditure, and
- Provision of a pool to pilot new solutions such as technologically based solutions in reaching more people geographically and through preferred communication methods.

A Gambling Industry (other) submitter<sup>525</sup> commented that the even weighting across products is problematic and does not reflect the relative impact of this submitter's products on the demand for problem gambling services. For example, in most cases the impact of Lotto's products is relatively minor, but use is included in the questionnaire and given the same weighting as other products. This submitter recommended that the questionnaire could be amended such that individuals are required to state the primary product they consume, in addition to other products. This would allow a greater weighting to be applied to the primary product, which this submitter considers would lead to a more equitable outcome.

#### **4.3.5. Research and evaluation costs should be borne equally by all four gambling sectors**

Two NCGM sector submitters<sup>526</sup> suggested that the cost of general research and evaluation should be borne equally by all four major gambling operators, not mainly funded by the NCGM Sector based on the number of people who report to treatment providers.

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<sup>523</sup> 42

<sup>524</sup> 44

<sup>525</sup> 42

<sup>526</sup> 01,06

## 5. POLICY IN RELATION TO NCGM VENUES AND THE LEVY FORMULA

Three questions were asked about the proposal to relocate NCGM venues from lower socioeconomic areas to higher socioeconomic areas, two of which included a 'Yes/No' response. Table 11 shows the wording of this question and the number of submitters who responded, by response. Sometimes the narrative response suggested that support was qualified or conditional, in which case the 'Yes' response was altered to 'Qualified Support', at the request of the Ministry.

Table 11: Yes/No responses to questions concerning incentivising NCGM venues to relocate

| Question  | Yes | No | Qualified Support | Total |
|---|-----|----|-------------------|-------|
| A. Do you think operators of class 4 NCGM venues should be incentivised to move from lower socioeconomic areas to higher socioeconomic areas? | 18  | 8  | 25                | 51    |
| D. Does the current formula provide a reasonable way to reflect the relative harm caused by each gambling sector?                             | 9   | 17 | 0                 | 26    |

Sixty-five submitters addressed, at least in part, the questions about incentivised moves for NCGMs in lower socioeconomic areas. The breakdown by submitter type is shown below in Table 12.

Table 12: Number of submissions, by Sector, that commented on the proposed NCGM incentivised moves

| NCGM sector | Gambling Industry (other) | Service Providers | Health sector | Local Government | Individuals |
|-------------|---------------------------|-------------------|---------------|------------------|-------------|
| 21/22       | 5/8                       | 16/21             | 11/13         | 6/6              | 8/12        |

### 5.1. The degree of support for incentivised relocation of NCGM venues

#### 5.1.1. There was broad support for allowing NCGM venues to relocate, however, incentivisation was not generally supported

The Ministry asked stakeholders their views on the location of NCGMs including questions about whether NCGM operators should be incentivised to move from lower socioeconomic areas to higher socioeconomic areas, what barriers exist to doing this, and how operators should be incentivised to move.

Service Providers, Local Government, Health sector submitters, NCGMs, and individuals did not support the idea to incentivise NCGM venues to leave, because of various concerns about the proposed policy.



The proposal to incentivise the relocation of NCGM venues was seen as contrary to the public health aims of reducing harm overall

Three Service Providers,<sup>527</sup> three Health sector submitters,<sup>528</sup> one Local Government submitter<sup>529</sup> and one NCGM<sup>530</sup> commented that this approach does not reflect the reality of gambling behaviours and the fact that individuals are highly mobile and can (and will) travel easily from one area without NCGMs to another area in order to gamble. They may also spend more time in the other area to compensate for the time taken to travel. The approach may increase their risk of gambling harm, because venue operators in other areas do not know them and may not identify them as ‘at-risk’. This approach also does nothing to stop harm occurring in existing venues.

Four Service Providers,<sup>531</sup> four Health sector submitters,<sup>532</sup> one individual<sup>533</sup> and one NCGM<sup>534</sup> submitted that this approach is contrary to the public health aims of the Gambling Act 2003. They considered this to be particularly in relation to preventing and reducing gambling-related harm, and will potentially increase harms by introducing opportunities to use NCGMs to a new population which is currently less exposed to harm from gambling. That is, it merely moves the problem somewhere else while creating more harm in another area, when the goal should be to reduce harm overall. Also, the proposed approach was considered contrary to the Strategy’s objectives.

Another concern was the economic implications and business practices. A Service Provider,<sup>535</sup> Local Government submitter,<sup>536</sup> individual<sup>537</sup> and Health sector submitter<sup>538</sup> considered that operators are unlikely to be supportive of the approach if relocating to another venue means a reduction in gambling activity and a flow-on in terms of reduction in profit. If it were profitable to operate in higher socioeconomic areas they would be already, and therefore would be unlikely to move without incentives. Two Service Providers<sup>539</sup> submitted that businesses may face considerable push-back from wealthier communities concerned about the introduction of NCGMs. Incentivisation was also suggested by two submitters (one Service Provider and one from the Health sector) to provide an opportunity for failing businesses to stay open or for businesses to minimise costs already associated with moving premises.<sup>540</sup>

Along the same lines, two Health sector submitters<sup>541</sup> and a Service Provider<sup>542</sup> commented that the approach would not reduce overall access to NCGMs and therefore would not reduce harm or alleviate inequality.

One Health sector submitter<sup>543</sup> commented that incentivisation is likely to be costly. This raised concerns about where the funding to support incentivisation would come from, especially if there was to be no increase in the overall appropriation. This submitter was particularly concerned that budget for incentives would take away funding for other important harm reduction activities, which was not supported.

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<sup>527</sup> 39,40,C08  
<sup>528</sup> 24,32,36  
<sup>529</sup> 23  
<sup>530</sup> 01  
<sup>531</sup> 40,45,C11,C13  
<sup>532</sup> 24,27,30,33  
<sup>533</sup> 04  
<sup>534</sup> 34  
<sup>535</sup> C11  
<sup>536</sup> 12  
<sup>537</sup> 21  
<sup>538</sup> 27  
<sup>539</sup> 40,C11  
<sup>540</sup> 24,37  
<sup>541</sup> 24,36  
<sup>542</sup> 45  
<sup>543</sup> 27

Submitters from the Health sector,<sup>544</sup> Local Government,<sup>545</sup> and an individual submitter<sup>546</sup> were concerned about the adverse impact that an incentivised approach would have on local government responsibilities and gambling policies. These submitters considered that a sinking lid approach was ethical and effective in reducing access to and the number and location of NCGM venues, and therefore the best approach to harm minimisation overall.<sup>547</sup> Incentivising relocation would make it harder for Local Governments to implement a sinking lid in their NCGM policies, and it ignores their responsibilities under the Act and the community’s participation in decision-making about NCGMs.<sup>548</sup>

One NCGM sector submitter<sup>549</sup> and one Service Provider<sup>550</sup> expressed concern that removing NCGMs from lower socioeconomic areas communities would result in lost re-investment opportunities (in the form of grants, etc.) for those communities and redistribution of funds into wealthier areas.

An individual<sup>551</sup> and one NCGM sector submitter<sup>552</sup> preferred that efforts be focused on making the gambling environment safer through improved in situ interventions to reduce harm at the point of play.

One Local Government submitter<sup>553</sup> suggested that further research be completed to determine what incentives might be attractive.

A small number of alternatives to incentivising relocation were proposed, including:

- An in-principle approach to reducing NCGM numbers overall, as well as density reduction<sup>554</sup>
- Forcing NCGM operators to leave lower socioeconomic areas,<sup>555</sup> and
- Paying operators to leave or giving them a deadline for exit.<sup>556</sup>

**5.2. Structural barriers to relocating NCGM venues were identified**

Thirty submitters discussed barriers that exist to moving NCGMs from lower socioeconomic areas (14 NCGM submitters,<sup>557</sup> five Local Government,<sup>558</sup> four Service Providers,<sup>559</sup> three Health sector,<sup>560</sup> two Gambling Industry (other)<sup>561</sup> and two individuals<sup>562</sup>).

The main barriers identified by submitters related to Council policy and the need for NCGM operators to obtain consent in order to legally relocate. Thirteen NCGM sector<sup>563</sup> and two Gambling Industry (other) submitters<sup>564</sup> noted the difficulties created by Council policies which undermine

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<sup>544</sup> 24,27,32,33  
<sup>545</sup> 29  
<sup>546</sup> 62  
<sup>547</sup> 24,27,29,32,33,62  
<sup>548</sup> 24  
<sup>549</sup> 41  
<sup>550</sup> C05  
<sup>551</sup> 04  
<sup>552</sup> 41  
<sup>553</sup> 12  
<sup>554</sup> 13,30,40,C08,C13  
<sup>555</sup> C10  
<sup>556</sup> 11,21  
<sup>557</sup> 01,05,06,14,16,17,18,26,28,34,41,50,63,C04  
<sup>558</sup> 12,23,25,29,52  
<sup>559</sup> 11,C05,C10,C12  
<sup>560</sup> 13,33,58  
<sup>561</sup> 35,43  
<sup>562</sup> C01,C03  
<sup>563</sup> 01,05,06,16,17,18,26,28,34,41,50,63,64  
<sup>564</sup> 35,43

consideration of relocation (that is, most Councils either do not allow relocation in any circumstances or have very restricted circumstances under which relocation can be considered, most of which are outside of operators' control). Two Local Government submitters,<sup>565</sup> and one submitter from the Health sector,<sup>566</sup> one NCGM sector,<sup>567</sup> one Service Provider,<sup>568</sup> and one individual<sup>569</sup> also identified Council policy restrictions on relocations as a barrier.

The practical impacts of the time and effort required to complete the consent process, and the fact that there is no guarantee of a decision that will allow a venue to relocate or a club to merge and relocate (with an on-licence under the Sale and Supply of Liquor Act) makes it difficult to commit to venue changes. This was considered a barrier by five NCGM sector<sup>570</sup> and two Gambling Industry (other)<sup>571</sup> submitters. Consent-related business risks (that is, preparing to move venues but not getting consent or a liquor licence) were also identified by one Local Government submitter.<sup>572</sup> Another Local Government submitter<sup>573</sup> identified the further uncertainty with the process of the possibility of applying for a new licence but permission being subject to having fewer machines.

The role of the Waikiwi Tavern judgment raised concerns for an NCGM submitter and a Local Government submitter,<sup>574</sup> who noted that this judgment means that no one is relocating, or that there is now confusion about which authority has decision-making powers in relation to relocation.<sup>575</sup>

Another barrier related to the Gambling Act 2003 requirement that NCGMs be located in certain types of venues. Eight NCGM submitters<sup>576</sup> considered that this restriction provides insufficient venue choice options, should relocation be favoured by an operator. If NCGMs could be in other venue types, this barrier would be reduced.

Individual and Local Government submitters focussed on the commercial realities which could act as a barrier. Submitters noted that NCGM venues tend to operate where there is demand for services.<sup>577</sup> Some of these commercial realities included the willingness of businesses to take on NCGMs in higher socioeconomic areas where there might be a lower demand or turnover, resulting in lower commission for the operator and lower returns to the community.<sup>578</sup> Another money-related barrier identified by two Service Providers,<sup>579</sup> two Health sector submitters,<sup>580</sup> and one individual submitter<sup>581</sup> was the concern about the impact on community funding if venues relocate away from high deprivation communities and revenue drops.

There was also concern that communities that participate in decision-making about the location of NCGM venues might not be willing to have these venues in their areas, and that they would work against an NCGM operator trying to establish a venue.<sup>582</sup>

Other barriers included:

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<sup>565</sup> 25,29,  
<sup>566</sup> 33  
<sup>567</sup> C04  
<sup>568</sup> C05  
<sup>569</sup> C03,C05  
<sup>570</sup> 14,16,18,28,34,41,63  
<sup>571</sup> 35,43  
<sup>572</sup> 23  
<sup>573</sup> 29  
<sup>574</sup> 26,52  
<sup>575</sup> 52  
<sup>576</sup> 01,05,14,16,18,28,41,63  
<sup>577</sup> 12,23,25,C03,C10  
<sup>578</sup> 34,35  
<sup>579</sup> 11,C12  
<sup>580</sup> 13,58  
<sup>581</sup> C01  
<sup>582</sup> 17,37,40,58,C11

- Strong advocacy from some groups that do not support relocation of NCGMs<sup>583</sup>
- Councils lack the power to enforce relocation and the Gambling Act 2003 makes no provision to reduce the number of NCGMs in lower socioeconomic areas through relocation<sup>584</sup>
- Community concern about the loss of community facilities in some areas<sup>585</sup>
- Compliance with the authorised purpose return,<sup>586</sup> and
- Even where council policies support relocation to reduce NCGMs in lower socioeconomic areas, no NCGM operators have applied to relocate.<sup>587</sup>

### 5.3. Incentives to support relocation were suggested

Thirty-eight submitters suggested incentives to encourage NCGM operators to move (20 NCGM submitters<sup>588</sup> six Service Providers,<sup>589</sup> four Local Government,<sup>590</sup> three Health sector,<sup>591</sup> three individuals<sup>592</sup> and two Gambling Industry (other)<sup>593</sup>). These focused on increasing financial gain for operators, amending council policies to make it easier for NCGM operators to relocate, and reducing treatment provider advocacy against relocation.

Financial incentives proposed by NCGM, Gambling Industry (other) and Local Government submitters included allowing:

- Seven NCGM operators to increase the number of machines at a new venue and/or allowing them to offer larger bet sizes and/or prize money (including proposing alignment with Queensland's gaming machine standards for venues operating in higher socioeconomic areas)<sup>594</sup>
- Three submitters suggested general or non-specified financial support (such as supporting relocation with no financial loss or rental subsidies)<sup>595</sup>
- The development of more competitive NCGM products which will increase the resale value of machines and businesses<sup>596</sup>
- Licences to be sold at market rates or to be on-sold if the rest of the business is not or cannot be sold<sup>597</sup>
- Rental of premises as a stand-alone gambling venue similar to the TAB<sup>598</sup>
- Operators to sell their licences to other approved operators resulting in a clustering of larger gambling machines in a smaller number of venues<sup>599</sup>

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<sup>583</sup> 34,43

<sup>584</sup> 25,52

<sup>585</sup> C03

<sup>586</sup> 41

<sup>587</sup> 25

<sup>588</sup> 01,02,03,05,06,10,14,16,17,18,19,26,28,34,41,50,51,63,C04,C07

<sup>589</sup> 11,40,C08,C11,C12,C13

<sup>590</sup> 12,23,25,52

<sup>591</sup> 13,33,C06

<sup>592</sup> 04,62,C03

<sup>593</sup> 07,35

<sup>594</sup> 03,07,10,19,26,35,C04

<sup>595</sup> 23,25,35

<sup>596</sup> 07

<sup>597</sup> 34

<sup>598</sup> 05,41

<sup>599</sup> 19

- Replacing the current universal authorised purpose return regulation with a licence condition imposed on each society,<sup>600</sup> and
- For a reduction in the gambling levy rate for those who relocate for harm minimisation purposes.<sup>601</sup>

Financial incentives suggested by non-NCGM submitters focused on reduced council rates payment or just simply paying for operators to move.<sup>602</sup>

Two Local Government submitters<sup>603</sup> noted that relocation is already permitted within their policy framework. However, other specific changes to council policies were suggested to further incentivise a move away from lower socioeconomic areas. These suggestions included:

- Nine NCGM sector submitters,<sup>604</sup> two individuals,<sup>605</sup> and one Gambling Industry (other) submitter,<sup>606</sup> suggested telling Councils to allow relocation
- Seven NCGM sector submitters suggested removing requirements to gain a Council relocation consent or licence entirely (such as not having to reapply for a new Class 4 licence following a club merge) if moving to a higher socioeconomic area<sup>607</sup>
- Seven NCGM sector submitters suggested providing for prompt and certain methods for venues to relocate, including providing certainty that a licence will be approved before a current lease is terminated/unconditional arrangements on new premises are made<sup>608</sup>
- An NCGM sector submitter suggested amending the application process to follow the liquor licensing process<sup>609</sup>
- An individual submitter suggested creating entertainment areas.<sup>610</sup>

Eight NCGM submitters<sup>611</sup> proposed policies that would allow NCGM operators the freedom to move wherever they felt appropriate (noting that this a freedom granted to other businesses). These policies would also recognise that relocation should be a “right” if an operator is moving to a higher socioeconomic area from a lower socioeconomic area. Other NCGM submitters required that Council policies provide commercial clarity about NCGM location,<sup>612</sup> or requested greater national consistency in Council gambling policy.<sup>613</sup>

Some NCGM submitters considered that an amendment to Ministry contracts restricting treatment providers’ advocacy against relocation applications or for Council’s sinking lid policies would also be an incentive. (This links to the suggestion that operators be able to have more NCGMs per venue or to move premises without having to complete a licence process). This included active advocacy from providers to move venues to higher socioeconomic areas.<sup>614</sup>

Other incentives proposed by Local Government and NCGM submitters included:

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<sup>600</sup> 41

<sup>601</sup> 12

<sup>602</sup> 33,C12,C14

<sup>603</sup> 23,52

<sup>604</sup> 01,02,03,10,14,17,26,41,C07

<sup>605</sup> 04,C03,

<sup>606</sup> 35

<sup>607</sup> 02,03,05,06,26,50,51

<sup>608</sup> 02,03,05,06,26,50,51

<sup>609</sup> 17

<sup>610</sup> C03

<sup>611</sup> 14,16,17,18,28,34,50,63

<sup>612</sup> 02,03

<sup>613</sup> 17,C07

<sup>614</sup> 02,05,06,26

- Balancing fewer overall sites; an increase in the number of machines per venue site; and increased scrutiny of vendors and operators to ensure harm minimisation practices are upheld<sup>615</sup>
- A rule change to stop other operators coming into a recently vacated premises and establishing another venue,<sup>616</sup> and
- Other unspecified regulatory changes.<sup>617</sup>

Three Service Providers,<sup>618</sup> a Health sector submitter,<sup>619</sup> and an individual submitter<sup>620</sup> did not support any incentivisation, as they did not support the proposal to relocate any NCGM venues.

## 5.4. The degree of support for the levy formula policy

The levy proposed in the consultation document is based on and will be set using the current formula set out in the Act. However, the Ministry and DIA were also interested in stakeholders' views of what could change in the future.

Twenty-five submitters commented on sub-question D (13 NCGM, six Service Providers, three Gambling Industry, two Local Government, one individual).<sup>621</sup> Twenty-three submitters provided suggestions to improve the levy formula, and two Service Providers<sup>622</sup> stated that they did not really understand the formula, and therefore assumed that it provided a reasonable way to reflect the relative harm.

### 5.4.1. Suggestions were made for improving the levy formula

#### *International online gambling providers should contribute to the levy*

Thirteen submitters<sup>623</sup> (ten NCGM Sector, two Gambling Industry and one individual) commented that the levy formula should include a contribution from international online gambling providers. International online gambling providers are not currently included in the calculations, and do not pay a levy contribution, although the availability and use of international online gambling platforms is increasing.

Nine NCGM operators<sup>624</sup> submitted that the international online gambling sector needs to be included in the problem gambling levy, and be required to contribute an appropriate share, thereby reducing the cost for NCGM providers. One of these operators<sup>625</sup> went further, submitting that the New Zealand Racing Board and Lotteries Commission have significant online gambling offerings, and SkyCity Casino has its own "free to play" online casino and has indicated a desire to partner with offshore online casinos. The NCGM sector has no online offering, and therefore if money is going to be spend on studies into online gambling, a weighting should be chosen which results in those providers making a larger contribution.

One Gambling Industry (other) submitter<sup>626</sup> called for an amendment to the formula to include a contribution by international online gambling providers, arguing that they and other providers that

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<sup>615</sup> 19

<sup>616</sup> 23

<sup>617</sup> 13,23,C11,C13

<sup>618</sup> 11,40,C08

<sup>619</sup> C06

<sup>620</sup> 62

<sup>621</sup> 02,03,05,11,12,14,16,18,20,28,34,39,41,42,43,50,51,52,60,63,64,C04,C05,C08,C09

<sup>622</sup> C05,C08

<sup>623</sup> 03,14,16,28,34,42,43,50,51,63,64,C04,C09

<sup>624</sup> 03,14,16,28,34,51,63,64,C04

<sup>625</sup> 14

<sup>626</sup> 43

are subject to the problem gambling levy are forced to meet the costs associated with presentations resulting from international online gambling.

One individual<sup>627</sup> also submitted that the levy should include a contribution by international online gambling providers, without further comment.

### ***Under- and over-recovery of the levy should be included in the formula***

Thirteen submitters (11 NCGM Sector<sup>628</sup> and two Gambling Industry(other)<sup>629</sup>) were concerned with the way that the Ministry had interpreted the levy recovery.

The eleven NCGM submitters considered that the variable R in the formula should automatically include a reduction in the future levy payable if there has been an underspend by the Ministry in the previous period.<sup>630</sup> They commented that the Ministry gives gambling providers credit for the over-recovery, but not for the further underspend, and that the intention of the Act was to capture the full surplus, and have this reduce future levy payments. One submitter went so far as to say that failing to include the \$5 million underspend in the formula could be raised as potential grounds for judicial review.<sup>631</sup>

One NCGM submitter<sup>632</sup> questioned the levy calculation, which was considered ambiguous. The submitter asked how variable R would be calculated if there was an overspend rather than an underspend. Another NCGM submitter<sup>633</sup> expressed concern at the Ministry's intention to credit gambling providers for the over-payment but not for the underspend.

Two Gambling Industry (other) submitters<sup>634</sup> also commented that any underspend by the Ministry should be automatically included in the formula for the next period.

### ***The levy should be apportioned based on harm associated with different modes of gambling***

A Service Provider<sup>635</sup> considered that the "addictive potential" of products should be acknowledged and incorporated into the formula. Currently, the formula does not accurately depict the harm associated with each product. This submitter considered that the issue may lie with the reporting data collected, which does not allow for the product to be scaled with regards to how significant its level of harm/priority is for the problem gambler.

A Local Government submitter<sup>636</sup> commented that the levy should be apportioned to each gambling sector based on the prevalence and degree of harm associated with that mode of gambling, rather than the problem gambling service presentations. There is need for additional elements in the formula to better reflect the actual level of harm, such as consideration of the expected prevalence of modern and problem gambling as identified by the National Gambling Study.

### ***Expenditure should be recognised as the most accurate measure of harm***

Two submitters (one Gambling Industry<sup>637</sup> one Service Provider<sup>638</sup>) submitted that the way which expenditure is defined is problematic and should be revised. Harm can be caused by both losing money and winning games. The current approach only incorporates the former. A better approach

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<sup>627</sup> C09

<sup>628</sup> 02,03,05,16,18,28,41,43,50,63,64

<sup>629</sup> 42,43

<sup>630</sup> 02,03,05,16,18,28,41,43,50,63,64

<sup>631</sup> 18

<sup>632</sup> 41

<sup>633</sup> 05

<sup>634</sup> 42,43

<sup>635</sup> 11

<sup>636</sup> 12

<sup>637</sup> 42

<sup>638</sup> 20

would be to account for the impact of both losing money and winning games in gambling harm, and the costs of the services needed to support it. Player expenditure should be defined as “turnover” in the formula.

#### **5.4.2. Service Providers identified other considerations which needed to be included when developing the formula**

##### ***Other important industry data***

One Service Provider<sup>639</sup> commented that the industry holds other important data which is not included in the formula (but should be), such as exclusion numbers, which would help to more accurately calculate fair allocations.

##### ***More consideration given to the role of Service Providers***

One Service Provider<sup>640</sup> suggested that a formula be designed to consider Service Providers achieving despite limited workforce capacity. It also commented that the Ministry could consider something similar to the decile 1 and 2 school system, and fund workforce increase and community leaders who carry out extensive behind the scene work. This submitter went on to say that the levy formula must fit within the principles of equality, fairness and equity for restoring mana, operators, Ministry operating costs and valuing providers’ work.

#### **5.4.3. A Local Government submitter commented that the financial burden of administering the Act needs to be reduced**

A Local Government submitter<sup>641</sup> commented that councils are absorbing costs in meeting the statutory obligations, including:

- Adopting policies
- Conducting special consultative procedures
- Administering the relocation of gambling venues, and
- Restarting the process every 3 years.

The submitter also stressed that the next iteration of the Strategy “must” include a commitment to provide councils with the funding necessary to reduce the financial burden of administering the Gambling Act on ratepayers.

#### **5.4.4. Some submitters did not understand the formula**

Two Service Providers,<sup>642</sup> in answering this question, simply stated that they did not understand the formula, and would trust that the Ministry was doing the best by all those involved.

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<sup>639</sup> 39

<sup>640</sup> 60

<sup>641</sup> 52

<sup>642</sup> C05,C08

**6. OTHER ISSUES RAISED BY SUBMITTERS**

Part 6 of this report outlines issues raised by submitters that did not directly relate to the draft Strategic Plan, the draft Service Plan, the levy or the policy related to NCGMs; however, they are pertinent to the policy or legislative settings for preventing and minimising gambling harm.

- Thirty-one submissions included details about their role in the gambling industry.<sup>643</sup>
- Fourteen submissions expressed concerns that the PGSI might be replaced.<sup>644</sup>
- Eight submitters included elements of personal experience in their submissions.<sup>645</sup>
- Six submissions described other behaviours that they considered to be gambling comorbidities.<sup>646</sup>
- Five submissions critiqued the needs assessment completed by the Sapere Research Group.<sup>647</sup>
- Two submissions included details of the history of the gambling industry in New Zealand.<sup>648</sup>
- Two submissions expressed concerns about the Gambling Act.<sup>649</sup>
- Two submissions objected to an implication in the consultation document that certain priorities were new when they had been in process for several years.<sup>650</sup>
- One submitter commented that the National Advisory Group needs to be more appropriately utilised.<sup>651</sup>
- One submitter noted inconsistencies in the consultation document concerning the previous budget.<sup>652</sup>
- One submitter registered the concern that academic research institutes are no longer accepting industry funding for research, making the industry increasingly reliant upon the Ministry for research.<sup>653</sup>
- One submission requested that the population category of 'Asian' also include 'South Asian'.<sup>654</sup>
- One submitter suggested that a short video be made to explain the levy formula and the impacts of the weightings.<sup>655</sup>
- One submitter suggested that the consultation document clearly define the meaning of 'community', including prison populations and private training establishments.<sup>656</sup>

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<sup>643</sup> 07,08,09,10,14,17,18,19,23,24,27,28,29,30,32,33,34,35,36,43,44,46,50,51,53,55,58,59,60,63,64

<sup>644</sup> 01,02,03,05,06,16,18,28,44,50,61,63,64,C04

<sup>645</sup> 04,29,47,48,49,60,C01,C02

<sup>646</sup> 03,11,36,41,43,64

<sup>647</sup> 05,36,44,50,64

<sup>648</sup> 44,55

<sup>649</sup> 44,56

<sup>650</sup> 17,64

<sup>651</sup> 21

<sup>652</sup> 39

<sup>653</sup> 42

<sup>654</sup> 45

<sup>655</sup> 45

<sup>656</sup> 45

- One submitter expressed concern that levy consultations and decisions have been undertaken without critical analysis of previous Service Plans.<sup>657</sup>
- One submission requested that a word search be conducted of the Strategy document to replace ‘problem gambling’ with ‘Harmful gambling’. ‘problem gambling service’ replaced with ‘minimising gambling harm service’; and ‘problem gambler’ be replaced with ‘people experiencing gambling harm’.<sup>658</sup>
- One submission questioned the legality of gaming machines.<sup>659</sup>
- One submission pointed out inconsistencies within the consultation document regarding the numbers of people experiencing harm from gambling.<sup>660</sup>
- One submitter suggested that casinos be required to “report on their financials”.<sup>661</sup>
- One submission urged the Ministry to extend the consultation process to gambling machine venues in order to capture the point of view of those who attend such venues.<sup>662</sup>
- One submission reflected on the ethical dilemma of NCGMs generating funding for community projects, juxtaposed with the harm from problem gambling.<sup>663</sup>

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<sup>657</sup> 55

<sup>658</sup> 57

<sup>659</sup> 58

<sup>660</sup> 61

<sup>661</sup> C01

<sup>662</sup> C07

<sup>663</sup> C11

## 7. THEMATIC ANALYSIS BY SECTOR

Part 7 explores the way different sectors addressed the common themes throughout the submissions.

### 7.1. Use of presentation rates in calculating the levy

The reliance on presentations was an important theme, which had cross-sector comment. However, the way that it was addressed varied by sector. For example, Service Providers tended to focus on the accuracy (or otherwise) of presentations as a measure of harm, while NCGM sector submitters and Gambling Industry (other) submitters focused on the impact that presentations should have on the levy formula.

#### 7.1.1. Service Provider submitters did not support reliance on presentations

The reliance on presentations to treatment services as a measure of harm considerably understates the harm to individuals and families, and does not equate to a true public health approach.<sup>664</sup> It was noted that the presentations calculation does not quantify the level of gambling harm occurring in communities because not everyone presents, and gambling harm extends beyond the individual gambler.

#### 7.1.2. NCGM sector submitters considered there should be less emphasis on presentations

Eleven NCGM sector submitters considered that there have been reduced rates of treatment presentations, and this should be reflected in a reduced funding appropriation.<sup>665</sup>

Most NCGM sector submitters<sup>666</sup> considered that a higher weighting on presentations punishes NCGM societies that engage in proactive harm minimisation practices, and that operators should not be penalised for making proactive referrals. Two NCGM sector submitters<sup>667</sup> went so far as to suggest a 100/0 weighting in the formula (that is, not taking presentations into account at all). Another argument for a lower weighting on presentations was that presentations data is not as accurate as expenditure data.<sup>668</sup>

Four NCGM sector submitters<sup>669</sup> did not consider that their levy share should be based predominantly on presentation numbers, as these can be inconsistent.

#### 7.1.3. Gambling Industry (other) submitters supported a higher presentations weighting

Three Gambling Industry (other) submitters<sup>670</sup> considered that presentations are a relatively strong indicator of harm, and wanted a higher weighting on presentations. One submitter<sup>671</sup> commented that a higher weighting on presentations ensures that NCGMs (the form of gambling which it considered to have the highest presentation numbers) contributes the greatest amount.

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<sup>664</sup> 39,44,56

<sup>665</sup> 01,03,05,06,14,16,18,26,28,50,63

<sup>666</sup> 01,03,08,10,16,18,28,34,51,63

<sup>667</sup> 26,41

<sup>668</sup> 01,06,16,18,28,34,40,50,63,C04

<sup>669</sup> 02,06,14,C04

<sup>670</sup> 42,43,55

<sup>671</sup> 43

Gambling Industry (other) submitters<sup>672</sup> also considered that higher weighting on presentations reflects the goal of reducing harm, rather than reducing spending overall.

#### **7.1.4. Local Government submitters supported a higher presentations weighting**

One Local Government submitter<sup>673</sup> considered that presentations are a relatively strong indicator of harm, and wanted a higher weighting on presentations.

### **7.2. Player expenditure forecasts were considered unrealistic**

Service Providers, Gambling Industry (other) and Individual submitters all considered that the player expenditure forecasts were unrealistic.

#### **7.2.1. Service Provider submitters**

Service Providers<sup>674</sup> considered that player expenditure forecasts were not realistic because they do not take into account individual bet amounts or online gambling, and so do not provide an accurate picture of the harm associated with each product.

#### **7.2.2. Individuals**

Three individual submitters<sup>675</sup> did not think that player expenditure forecasts were realistic, largely for the same reasons as Service Provider submitters.

#### **7.2.3. Gambling Industry (other) submitters**

One Gambling Industry (other) submitter<sup>676</sup> stated that the consultation document did not describe the method used by the DIA to develop the forecasts, and noted that they are significantly higher than the corresponding values from Lotto's Statement of Intent. It was suggested that the Ministry adopt Lotto's forecasting.

### **7.3. Culturally specific services are required for Māori**

Service Providers, Health sector and an individual submitter all considered that culturally specific services were required for Māori.

#### **7.3.1. Service Provider submitters**

Five Service Provider submitters<sup>677</sup> focused on the need for culturally-specific services for Māori. They considered that Māori and Pasifika populations are experiencing harm from gambling in greater numbers than other populations (particularly by NCGMs). Service Providers considered it essential that all treatment providers and public health services should be able to work in a culturally appropriate way with Māori. Service providers also focused on media and the marketing of services, the effectiveness of peer support programmes, and the importance of a collective approach to harm minimisation, for example within a community or whānau.

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<sup>672</sup> 43,61

<sup>673</sup> 12

<sup>674</sup> 11,C02,C05,C13

<sup>675</sup> C01,C03,C09

<sup>676</sup> 42

<sup>677</sup> 44,54,C05,C08,C10

### **7.3.2. Health sector submitters**

One Health sector submitter<sup>678</sup> focused on the importance of the kaiāwhina workforce, and considered that further investment is needed given the immense opportunity to deliver whānau, family and community-based support at the right time.

### **7.3.3. Individual**

An individual submitter also focused on peer support specific to Māori clients, particularly whānau helping whānau.<sup>679</sup>

## **7.4. Culturally specific services are required for Pasifika**

Service Providers, Health sector and an individual submitter all considered that culturally specific services were required for Pasifika, particularly language-specific helplines.

### **7.4.1. Service Provider submitters**

Three Service Providers<sup>680</sup> focused on the Pasifika community, and considered that one of the main problems was the lack of cultural competency in working with high priority populations. A major concern was the lack of Pasifika-specific helplines, and a pilot programme to address this was suggested.

### **7.4.2. Health sector submitters**

Two Health sector submitters<sup>681</sup> also commented on the need for Pacific-specific services, particularly a helpline.

### **7.4.3. Individual**

One individual<sup>682</sup> stated that the best way to deal with the issue was to provide materials that are more communicative for the intended audience. For Pasifika people, this could be done using dramas to deliver specific messages.

## **7.5. Culturally specific services are required for Asian populations**

### **7.5.1. Service Provider submitters stressed that gambling is perceived very differently in Asian cultures compared to western or Pacific cultures**

Three Service Providers<sup>683</sup> stressed that the Asian population views gambling differently, and cultural competency and workforce development concerning knowledge and sensitivity of how to work with Asian clients is essential. In contrast to Māori and Pasifika populations, the main concern is casino gambling. The need for a culturally-specific, anonymous helpline was emphasised. Service Providers catering specifically to Asian clients<sup>684</sup> also considered international online gambling to be an important issue.

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<sup>678</sup> C16

<sup>679</sup> 38

<sup>680</sup> 52,60,C11

<sup>681</sup> 13,65

<sup>682</sup> C15

<sup>683</sup> 44,45,46

<sup>684</sup> 44,45,46

### **7.5.2. Individuals**

Two individuals<sup>685</sup> considered that web-based services in Asian languages which enable clients to seek correct information and self-help tools whenever needed were particularly important to develop.

## **7.6. Increasing online gambling was a cross-sector concern**

The rise of online gambling (including on sites hosted in other jurisdictions and with respect to Lotto's online offerings) was a repeated theme throughout the submissions, particularly with reference to inclusion in the levy formula. Submitters from all sectors considered that international online gambling providers should be included in the levy formula because they are contributing to gambling harm, and this should be reflected in the levy payments.

Many of the comments involving international online gambling also related to advertising and the impact of online gambling on young people, and these themes are discussed separately in the sections below.

### **7.6.1. Service Provider submitters focused on an increasing treatment need**

Service Providers catering specifically to Asian clients<sup>686</sup> considered international online gambling to be an important issue, because Asian clients often feel isolated, and turn to online gambling as an emotional escape. Low levels of help-seeking behaviour for online gambling related harm was considered to indicate that further innovative initiatives are required,<sup>687</sup> particularly to alert young people to the treatment services available.<sup>688</sup>

Service Providers also considered that the overall funding appropriation appears to be insufficient to meet the challenges and issues brought about by increased online gambling,<sup>689</sup> and that player expenditure forecasts should take into consideration online gambling, and particularly international online operators.<sup>690</sup>

### **7.6.2. Local Government submitters noted this an emerging concern**

Two Local Government submitters<sup>691</sup> noted that although the gambling environment looks much the same as it did three years ago, an emerging concern is the potential rise in international online gambling, and associated gambling-related harm.

### **7.6.3. NCGM sector submitters were concerned that providers are not contributing to the levy**

One NCGM sector submitter<sup>692</sup> stated that it was pleased to see that research into online gambling had been included as a priority, and another stressed the importance of a robust evidence base.<sup>693</sup> There was a concern that gamblers who are excluded from NCGM venues are turning to

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<sup>685</sup> 47,48

<sup>686</sup> 44,45,46

<sup>687</sup> 20

<sup>688</sup> 37

<sup>689</sup> 45

<sup>690</sup> C05,C13

<sup>691</sup> 12,29

<sup>692</sup> 50

<sup>693</sup> 17

unsupervised online gambling,<sup>694</sup> and therefore online providers should be monitored, levied and taxed.

One submitter<sup>695</sup> considered that the Lotteries Commission and New Zealand Racing Board should pay a larger levy share to fund online gambling research given that they have online gambling products and the NCGM sector does not.

#### **7.6.4. Gambling Industry (other) submitters encouraged more research**

A Gambling Industry (other) submitter<sup>696</sup> considered that there should be an emphasis on online gambling in research and evaluation.

#### **7.6.5. Health Sector submitters encouraged more research**

A Health sector submitter<sup>697</sup> stressed the importance of a robust evidence base with respect to online gambling.

#### **7.6.6. Individuals were concerned about the lack of regulation**

One individual<sup>698</sup> noted that online gambling is not covered under the Act, and expressed a concern that online gambling needs to be appropriately regulated. Additionally, the player expenditure forecasts should take into consideration online gambling, and particularly international online operators.

### **7.7. Young people and gambling**

Addressing gambling harm for young people, particularly in relation to international online gambling, was a concern for Service Providers.

#### **7.7.1. Service Provider submitters want a greater focus on youth in the Strategy**

While youth and gambling is noted by the Ministry as a future priority research project, there is nothing included for intervention teams who are currently working with youth under 15 years of age.<sup>699</sup> Youth should be specifically highlighted in the Strategic Framework, with additional actions to support them as a vulnerable group, including youth-focused interventions.<sup>700</sup> Harm minimisation advertising should be targeted at youth, because this is the group using online gambling the most.<sup>701</sup> Gambling advertising should be restricted to times and places that prevent exposure to children.<sup>702</sup>

### **7.8. Advertising of gambling services and of support services: each need attention**

Another theme was advertising. There were two strands to this theme: advertising of gambling products; and advertising of support services.

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<sup>694</sup> 51

<sup>695</sup> 10

<sup>696</sup> 42

<sup>697</sup> 36

<sup>698</sup> C09

<sup>699</sup> C05

<sup>700</sup> 37,44,C05

<sup>701</sup> 37

<sup>702</sup> 44

### **7.8.1. Service Provider submitters want to restrict the promotion of gambling**

Service Providers considered that there should be action to increase restrictions on advertising and promotion of gambling.<sup>703</sup> In particular, Lotto NZ should not be permitted to advertise during primetime and when children are likely to be exposed to promotions, and the Racing Board should not be allowed to promote sports odds in mainstream media.<sup>704</sup> Advertising which targets vulnerable groups must cease, and advertising in general should be restricted to times and places that prevent exposure to children.

Harm minimisation advertising should be targeted at youth, particularly for online gambling, and the advertising should be monitored for effectiveness.<sup>705</sup> Gambling awareness advertisements should be placed alongside gambling promotion advertising<sup>706</sup> and through mass media.<sup>707</sup>

A Service Provider considered that a better understanding is required of how gambling advertising exposure impacts different population groups, particularly youth.<sup>708</sup>

### **7.8.2. NCGM sector submitters noted the relationship between advertising and problem gambling**

An NCGM sector submitter acknowledged the relationship between advertising of gambling services and problem gambling, noting the rise in Lotto spending: *“it seems that advertising is exacerbating the problem”*.<sup>709</sup>

### **7.8.3. Local Government submitters sought more information**

A Local Government submitter expressed its interest in developing a better understanding of the impact of gambling advertising exposure, especially the propensity to gamble. It was considered that such an understanding would usually inform strategies to reduce gambling harm.<sup>710</sup>

### **7.8.4. Health sector submitters sought more information**

A Health sector submitter identified the need to develop a better understanding of how gambling industry advertising impacts population groups, increasing their propensity to gamble.<sup>711</sup>

### **7.8.5. Individual submitters made practical suggestions to reach people in need of help**

Individual submitters suggested that advertising of treatment services could be inserted during pauses in place on machines,<sup>712</sup> and that treatment services could advertise through Chinese media platforms and in places where Asian people often frequent, such as Asian supermarkets.<sup>713</sup>

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<sup>703</sup> 44

<sup>704</sup> 44

<sup>705</sup> 37

<sup>706</sup> 20

<sup>707</sup> 20

<sup>708</sup> 45

<sup>709</sup> 50

<sup>710</sup> 20

<sup>711</sup> 57

<sup>712</sup> 04

<sup>713</sup> 47

## **7.9. Peer support was backed, but there were reservations about residential services**

Submitters from across the sectors expressed approval for the peer support proposal, but the residential facility proposal was questioned.

### **7.9.1. Service Provider submitters were supportive of both proposals**

Four Service Provider submitters expressed support for peer support programmes,<sup>714</sup> particularly for vulnerable groups, such as Asian populations.<sup>715</sup> It was stated that peer support should be included in intervention funding.<sup>716</sup>

Service Providers also expressed support for making available residential care services for the most vulnerable clients.<sup>717</sup>

### **7.9.2. NCGM sector submitters were more supportive of peer support than residential services**

Two NCGM sector submitters considered that peer support elements are important,<sup>718</sup> and that comparable programmes work well in the alcohol and drug context, and similar positive results could be achieved for gambling. They suggested that it be provided on a voluntary, or minimal cost basis to keep costs low.<sup>719</sup>

Two NCGM sector submitters were concerned that the proposed residential facility has not been included in the budget.<sup>720</sup> Five NCGM sector submitters did not support the need for a residential facility, and expressed concern about the cost and potential returns.<sup>721</sup>

### **7.9.3. Individuals were generally supportive of peer support**

Individuals<sup>722</sup> considered that support elements are important, because the most effective harm minimisation programmes involve support by people who have experienced similar issues, for example whānau helping whānau. However, there are challenges such as limited workforce, privacy and additional training requirements.<sup>723</sup> The peer support role could potentially be merged with the consumer advisor role.<sup>724</sup>

### **7.9.4. Health sector submitters were generally supportive**

Health sector submitters expressed support for peer support programmes<sup>725</sup> and the proposed residential facility.<sup>726</sup>

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<sup>714</sup> 44,54,55

<sup>715</sup> 44

<sup>716</sup> C05

<sup>717</sup> 15,54,C02

<sup>718</sup> 05,26

<sup>719</sup> 05,14

<sup>720</sup> 03,41

<sup>721</sup> 05,14,17,26,50

<sup>722</sup> 21,38

<sup>723</sup> 04

<sup>724</sup> 21

<sup>725</sup> 36

<sup>726</sup> 33,36

### **7.9.5. Gambling Industry (other) submitters were generally supportive**

Two Gambling Industry (other) submitters<sup>727</sup> expressed support for new intervention services such as residential care for gambling harm.

## **7.10. Venue relocation and incentivisation**

Submitters from all sectors commented on the proposal to incentivise NCGM operators to relocate from low socioeconomic areas to high socioeconomic areas, and discussed the barriers that exist to moving NCGMs from lower socioeconomic areas.

### **7.10.1. Service Provider submitters did not support incentivisation**

Service Provider submitters did not support the idea of incentivising NCGM venues to relocate from low socioeconomic to high socioeconomic areas. Three Service Providers commented that the approach does not reflect the reality of gambling behaviours (that is, that people will travel to the nearest NCGM venue, and possibly even stay longer to reflect the travel time),<sup>728</sup> is contrary to the public health aims of the Gambling Act 2003<sup>729</sup> and is not reflective of the goal to reduce harm overall.<sup>730</sup> Other concerns were the economic implications for NCGM venues<sup>731</sup> and potential loss of re-investment opportunities for community organisations that rely on community grants.<sup>732</sup>

Two Service Providers<sup>733</sup> noted commercial realities as a barrier to incentivisation, and four suggested unspecified regulatory changes as a way of forcing relocation.<sup>734</sup> One Service Provider suggested that any incentivisation should be directed to activities that reduce gambling harm.<sup>735</sup> Three Service Providers<sup>736</sup> did not support any incentivisation, as they did not support the proposal to relocate NCGM venues in the first place.

### **7.10.2. NCGM sector submitters highlighted structural barriers to relocating**

Some NCGM sector submitters did not support the idea of incentivising NCGM venues to relocate. The reasons for this were consistent with those articulated by Service Providers. One NCGM sector submitter<sup>737</sup> considered the idea “*nothing short of ridiculous*”. Another considered that the approach did not reflect the realities of gambling behaviour,<sup>738</sup> and another<sup>739</sup> commented that the approach would be contrary to the public health aims of the Gambling Act 2003 (particularly in relation to preventing and reducing gambling related harm). There was some concern that removing NCGMs from lower socioeconomic areas communities would result in lost re-investment opportunities (in the form of grants, etc.) for those communities and redistribution of funds into wealthier areas.<sup>740</sup>

The main barrier to NCGM venue relocation discussed by NCGM sector submitters was local authority policy restrictions,<sup>741</sup> followed by the practical impacts of the time and effort required to

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<sup>727</sup> 42,55

<sup>728</sup> 39,40,C08

<sup>729</sup> 40,45,C11,C13

<sup>730</sup> 45

<sup>731</sup> C11

<sup>732</sup> C05

<sup>733</sup> C10,C12

<sup>734</sup> 11,C08,C10,C13

<sup>735</sup> 37

<sup>736</sup> 11,40,C08

<sup>737</sup> 19

<sup>738</sup> 01

<sup>739</sup> 34

<sup>740</sup> 41

<sup>741</sup> 01,05,06,16,17,18,26,28,34,41,50,63,64

complete the consent process.<sup>742</sup> Another barrier discussed was the Gambling Act 2003 requirement that NCGMs be located in certain types of venues.<sup>743</sup> Eight NCGM submitters were also concerned that there would be strong advocacy against relocation, potentially impacting on the viability of their businesses should they look to relocate.<sup>744</sup>

Some NCGM sector submitters suggested incentives, for example:

- Financial incentives, such as allowing larger bet sizes,<sup>745</sup> selling licenses at market rate,<sup>746</sup> rental of premises as a stand-alone gambling venue similar to the TAB,<sup>747</sup> allowing operators to sell their licenses to other approved operators,<sup>748</sup> and replacing the current universal authorised purpose return regulation with a licence condition imposed on each society<sup>749</sup>
- Specific changes to Council policies including amending the application process to follow liquor licensing processes,<sup>750</sup> removing requirements to gain a Council relocation consent,<sup>751</sup> and providing prompt and certain methods for venues to relocate,<sup>752</sup> and
- Policies that would allow NCGM operators the freedom to move wherever they felt appropriate.<sup>753</sup>

**7.10.3. Health sector submitters opposed incentivisation**

Health sector submitters opposed the incentivisation approach for similar reasons to NCGM venues, including that it is not reflective of gambling behaviours,<sup>754</sup> is contrary to the public health aims of the Act,<sup>755</sup> fails to reduce harm overall,<sup>756</sup> and has adverse economic implications.<sup>757</sup>

One Health sector submitter<sup>758</sup> suggested that relocation could be achieved through unspecified regulatory changes, and another did not support any incentivisation, as they did not support the proposal to relocate any NCGM venues.<sup>759</sup>

**7.10.4. Local Government submitters acknowledged structural barriers and did not support incentivisation**

Local Government submitters did not support the proposal. One considered that a sinking lid approach was the best approach to harm minimisation.<sup>760</sup> One Local Government submitter<sup>761</sup> suggested that further research be completed to determine what incentives might be attractive.

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<sup>742</sup> 14,16,18,28,34,41,63  
<sup>743</sup> 01,05,14,16,18,28,41,63  
<sup>744</sup> 17,34  
<sup>745</sup> 03,10,19,26,C04  
<sup>746</sup> 34  
<sup>747</sup> 05,41  
<sup>748</sup> 19  
<sup>749</sup> 41  
<sup>750</sup> 17  
<sup>751</sup> 02,03,05,06,26,50,51  
<sup>752</sup> 02,03,05,06,26,50,51  
<sup>753</sup> 14,16,17,18,28,34,50,63  
<sup>754</sup> 24,32,36  
<sup>755</sup> 24,27,30,33  
<sup>756</sup> 24,36  
<sup>757</sup> 24,27,32,33  
<sup>758</sup> 13  
<sup>759</sup> C06  
<sup>760</sup> 29  
<sup>761</sup> 12

Local Government submitters identified barriers to relocation such as local authority policy restrictions,<sup>762</sup> consent-related business risks,<sup>763</sup> the role of the Waikiwi Tavern judgment,<sup>764</sup> and commercial realities.<sup>765</sup>

Two Local Government submitters noted that their present policies enabled NCGM venues to relocate from low socioeconomic areas, but both noted that no venues had moved.<sup>766</sup>

#### **7.10.5. Gambling Industry (other) submitters noted structural barriers**

Gambling Industry (other)<sup>767</sup> submitters noted barriers to NCGM venue relocation, including Council policy restrictions, and the practical impacts of completing the consent process.

#### **7.10.6. Individuals did not support relocation or incentivisation**

An individual submitter considered that a sinking lid approach was the best approach to harm minimisation,<sup>768</sup> and another preferred that efforts be focused on making the gambling environment safer through improved in situ interventions to reduce harm at the point of play.<sup>769</sup>

An individual<sup>770</sup> noted commercial realities as a barrier to incentivisation.

One individual suggested an alternative to incentivisation.<sup>771</sup>

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<sup>762</sup> 25,29

<sup>763</sup> 23

<sup>764</sup> 52

<sup>765</sup> 12,23,25

<sup>766</sup> 12,52

<sup>767</sup> 35,43

<sup>768</sup> 62

<sup>769</sup> 04

<sup>770</sup> C03

<sup>771</sup> 21

## APPENDIX A – LIST OF SUBMITTERS

**Table 13: List of submitters, sorted by submitter unique ID**

|    |  |     |                                   |
|----|--|-----|-----------------------------------|
| 1  | Akarana Community Trust                        | 40  | Auckland University of Technology |
| 2  | Trillian Trust                                 | 41  | One Foundation                    |
| 3  | Rano Community Trust                           | 42  | Lotto NZ                          |
| 4  | Personal                                       | 43  | New Zealand Racing Board          |
| 5  | First Light Community Foundation               | 44  | Problem Gambling Foundation       |
| 6  | Trust House Foundation                         | 45  | Asian Family Services             |
| 7  | COMS Systems Limited                           | 46  | ASHA                              |
| 8  | Dragon Community Trust Limited                 | 47  | Personal                          |
| 9  | Te Oranga Kaumātua Kuia and Hāpai Te Hauora    | 48  | Personal)                         |
| 10 | CERT   | 49  | Personal                          |
| 11 | Addiction Advice Limited/Nelson-               | 50  | New Zealand Community Trust       |
| 12 | Marlborough Problem Gambling Services          | 51  | Pelorus Trust                     |
| 13 | Christchurch City Council                      | 52  | Hamilton City Council             |
| 14 | K'aute Pasifika Trust                          | 53  | Mapu Maia                         |
| 15 | Clubs New Zealand                              | 54  | Tautoko Māori                     |
| 16 | Salvation Army OASIS Wellington                | 55  | SKYCITY Entertainment Group       |
| 17 | Four Winds Foundation                          | 56  | Hapai Te Hauora Tapui             |
| 18 | The Lion Foundation                            | 57  | Health Promotion Agency           |
| 19 | Gaming Machine Association of New Zealand      | 58  | Feed Families Not Pokies Inc      |
| 20 | Hennessy's Irish Bar                           | 59  | Torutek Limited                   |
| 21 | ABACUS Counselling, Training & Supervision Ltd | 60  | Taeaomanino Trust                 |
| 22 | Personal                                       | 61  | Christchurch Casinos Limited      |
| 23 | BlueSync Limited                               | 62  | Personal                          |
| 24 | Wellington City Council                        | 63  | Milestone Foundation Limited      |
| 25 | Waikato DHB                                    | 64  | Pub Charity Limited               |
| 26 | Whakatāne District Council                     | 65  | Alliance Health Plus              |
| 27 | BlueSky Community Trust Ltd                    | 66  | Careerforce                       |
| 28 | Auckland Regional Public Health Service        | C01 | Personal                          |
| 29 | Grassroots Trust Limited                       | C02 | Personal                          |
| 30 | Manawatu District Council                      | C03 | Personal                          |
| 31 | Canterbury DHB                                 | C04 | Personal                          |
| 32 | Whanganui District Council                     | C05 | Personal                          |
| 33 | Nelson Marlborough DHB                         | C06 | Personal                          |
| 34 | Southern DHB                                   | C07 | Personal                          |
| 35 | Hospitality New Zealand                        | C08 | Personal                          |
| 36 | Advance Gaming                                 | C09 | Personal                          |
| 37 | Whanganui DHB                                  | C10 | Personal                          |
| 38 | Ngā Tai o Te Awa                               | C11 | Personal                          |
| 39 | Personal                                       | C12 | Personal                          |
|    | The Salvation Army Oasis                       | C13 | Personal                          |
|    |  | C14 | Personal                          |
|    |  | C15 | Personal                          |
|    |  | C16 | Personal                          |

**Table 14: List of submitters, sorted alphabetically**

|   |     |      |   |
|---|-----|------|---|
| ABACUS Counselling, Training & Supervision Ltd                        | 20  | 29   | Manawatu District Council                                       |
| Addiction Advice Limited/Nelson-Marlborough Problem Gambling Services | 11  | 53   | Mapu Maia   |
| Advance Gaming  | 35  | C13  | Personal  |
| Akarana Community Trust   | 1   | 49   | Personal  |
| Alliance Health Plus  | 65  | 4    | Personal  |
| ASHA  | 46  | 63   | Milestone Foundation Limited                                    |
| Asian Family Services   | 45  | 32   | Nelson Marlborough DHB  |
| Auckland Regional Public Health Service                               | 27  | C11  | Personal  |
| Auckland University of Technology                                     | 40  | 50   | New Zealand Community Trust                                     |
| Personal  | C02 | 43   | New Zealand Racing Board  |
| BlueSky Community Trust Ltd   | 26  | 37   | Ngā Tai o Te Awa  |
| BlueSync Limited  | 22  | 41   | One Foundation  |
| Personal  | 62  | C15  | Personal  |
| Canterbury DHB  | C09 | C05  | Personal  |
| Careerforce   | 66  | C03  | Personal  |
| Personal  | C12 | 51   | Pelorus Trust   |
| CERT  | 10  | 44   | Problem Gambling Foundation                                     |
| Personal  | C07 | 64   | Pub Charity Limited   |
| Christchurch Casinos Limited  | 61  | C08  | Personal  |
| Christchurch City Council   | 12  | 3    | Rano Community Trust  |
| Personal  | C01 | 38   | Personal  |
| Clubs New Zealand   | 14  | CC14 | Personal  |
| COMS Systems Limited  | 7   | 15   | Salvation Army OASIS Wellington                                 |
| Personal  | 48  | C16  | Sarah Jeffares  |
| Personal  | 21  | 55   | SKYCITY Entertainment Group                                     |
| Dragon Community Trust Limited  | 8   | 33   | Southern DHB  |
| Feed Families Not Pokies Inc  | 58  | 60   | Taeaomanino Trust   |
| First Light Community Foundation                                      | 5   | 54   | Tautoko Māori<br>Te Oranga Kaumātua Kuia and Hāpai Te<br>Hauora |
| Four Winds Foundation   | 16  | 9    | Hauora  |
| Gaming Machine Association of New Zealand                             | 18  | 17   | The Lion Foundation   |
| Grassroots Trust Limited  | 28  | 39   | The Salvation Army Oasis  |
| Hamilton City Council   | 52  | 59   | Torutek Limited   |
| Hapai Te Hauora Tapui   | 56  | 2    | Trillian Trust  |
| Health Promotion Agency   | 57  | 6    | Trust House Foundation  |
| Hennessy's Irish Bar  | 19  | 24   | Waikato DHB   |
| Personal  | C10 | 23   | Wellington City Council   |
| Hospitality New Zealand   | 34  | 25   | Whakatāne District Council                                      |
| Personal  | C06 | 36   | Whanganui DHB   |
| Personal  | C04 | 31   | Whanganui District Council                                      |
| K'aute Pasifika Trust   | 13  |      |   |
| Personal  | 47  |      |   |
| Lotto NZ  | 42  |      |   |

## **APPENDIX B – CONSULTATION QUESTIONS**

### **Strategic direction**

1. Do you support the strategic direction outlined in the proposed strategy?
2. Does the draft strategic plan adequately reflect changes in the gambling environment?
3. Are there any objectives or priority actions that you feel are more important or less important than the others?
4. Do you think the inclusion of the priority actions to reduce inequality and inequity in Objectives 9 and 10 will help reduce gambling harm for the groups identified?
5. Are there other actions to prevent and minimise gambling harm that should be included as priority actions?

### **Service plan and funding**

6. Does the draft service plan adequately cover what it needs to cover, for example, does it include the right types of services and activities?
7. Does the draft service plan provide the right mix of activities (public health, intervention and research/evaluation) including line item activities in tables 14-17?
8. Which research and evaluation areas/items listed in the proposed strategy in Section 3.7 and Appendix 1 do you consider to be a high priority or a low priority? Please explain why.
9. Do you think the total indicative funding appropriation (\$55.339 million over three years) proposed in the draft service plan is appropriate?
10. Do you think that the service plan would be more effective if some funding amounts allocated in Tables 14–17 were shifted from one budget line item or service area to another? This may include proposing the Ministry stop funding some activities or should fund something not already covered in the proposals.

### **Levy formula and levy rates**

11. Are the player expenditure forecasts for each gambling sector (D) realistic?
12. Are there realistic pairs of expenditure/presentation weightings (W1 and W2) other than those discussed in this consultation document?
13. Which pair of weighting options for W1 and W2 do you prefer, if any, and why? Please keep in mind that the levy weighting options only affect the proportion of levy to be paid by each gambling sector and do not affect the total amount of the levy.
14. Do you have any comment on the estimated levy rates for each sector, keeping in mind that the levy formula itself is set out in legislation and is not under consideration in this consultation?

### **Policy in relation to electronic gaming machines (NCGMs) and the levy formula**

- A. Do you think operators of class 4 NCGM venues should be incentivised to move from lower socioeconomic areas to higher socioeconomic areas?
- B. What barriers, if any, do you think currently exist to moving class 4 gambling venues out of lower socioeconomic areas?

- C. If barriers do exist, how do you think venues can be incentivised to move?
- D. Does the current formula provide a reasonable way to reflect the relative harm caused by each gambling sector? If no, what sort of formula would better reflect the relative harm caused by each sector? Please explain what changes should be made and indicate if there are any additional elements that you think should be included in the formula and/or whether any of the current elements should be removed from the formula.

**Anything else?**

- 15. Is there anything else you would like to tell us about the draft strategy or preventing and minimising gambling harm more generally?

