

Strategy to Prevent and Minimise Gambling Harm

2022/23 to 2024/25

Proposal document

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1 Introduction

The Gambling Act 2003 sets out requirements for an 'integrated problem gambling strategy focused on public health'. The Ministry of Health is responsible for developing and refreshing this strategy at three-yearly intervals, and for implementing it. The Act specifies a two-stage consultation process to develop the strategy and the levy rates.

Earlier this year, the Ministry produced a draft *Strategy to Prevent and Minimise Gambling Harm for 2022/23 to 2024/25 consultation document*, including draft levy rates; held 10 online hui; and invited submissions. It engaged Allen + Clarke, an independent consultancy firm, to analyse the written and hui submissions and provide a report analysing these (the submissions analysis report).

This proposals document sets out the Ministry's response, the Ministry having considered:

- the submissions on the consultation document, including those received at the online hui
- the Allen + Clarke independent report analysing these submissions¹
- the 2021 *Gambling Harm Needs Assessment*² and available research.

The Ministry acknowledges that the multiple stories reflected in the submissions received represent a range of differing perspectives about gambling and gambling harm minimisation. The analysis revealed several common themes, varying according to the point of view of the submitter. Themes included the following.

- Submissions across the board supported the overall strategy goal and related objectives to promote equity and wellbeing by preventing and reducing gambling related harm.
- Submissions from individuals with personal experience of gambling harm focused on the need to reduce the potential for harm and to improve access to services and support, so people who gamble and affected others can get the right help and support when they need it.
- Submissions from the non-casino gaming machines (NCGM) sector and the gambling industry (other) sector presented the views of legitimate businesses operating in the entertainment space.
- Submissions from service providers and the health and local government sectors, and some individual submissions, reflected their views to help people whose gambling is causing harm.

¹ Allen + Clarke. 2021. *Draft Strategy to prevent and minimise Gambling Harm 2022/23 to 2024/25, Submissions Analysis*. Wellington: Allen + Clarke.

² Malatest International. 2021. *Gambling Harm Needs Assessment 2021*. Wellington: Malatest International. The Gambling Act requires the Ministry to obtain a needs assessment as part of the strategy development.

At times, these points of view came close together or even intersected, but they were often shaped by very different aims and objectives. For example, the perspective of a small business that hosts a gambling venue had relatively little in common with the perspective of someone whose gambling had resulted in them seeking help, or of an affected family member – although all of these submitters agreed on the need to reduce gambling harms.

The Ministry acknowledges that all these perspectives are real and valid, and the goals and outcomes of the strategy matter to all submitters. We have tried to ensure that this document reflects that acknowledgement. For example, the commentary on levy weightings for expenditure and presentations takes into consideration that there opposing points of view had different concepts of ‘fairness’.

Many submissions sought greater involvement in the design and delivery of services by affected stakeholders, to address persistent health inequities and risks. Proposals ranged from co-commissioning approaches through to co-design to improve the range and quality of services, to ensuring that these services are age- and culturally appropriate and meet the varied needs of at-risk and priority populations.

We also observed that, as in previous consultations, several submitters sought changes to the broader legal and policy framework to address gambling harm; for example, in regard to the prevalence and location of electronic gaming machines (pokies) and regulation of online gambling.

Unregulated online gambling continues to be a significant issue. The risks have grown over the last few levy periods, since about 2009, as internet access and smart devices have become more commonplace. Many submissions expressed concerns about the ease of access to online gambling, including the growth of gambling elements being used in online games and gambling on offshore sites. Submissions expressed concerns about the targeting of young people, and exposure to gambling advertising through a range of media.

We acknowledge the need to act on these concerns. The strategy includes an objective for the Department of Internal Affairs to identify improvements to the legislative and regulatory framework to reduce gambling-related harm, including through the ongoing Online Gambling Review. The recently released *Kia Manawanui Aotearoa*³ is a whole-of-government action plan for mental health that includes a commitment to review the Gambling Act 2003, with particular reference to preventing and minimising harm from online gambling and electronic gaming machines.

In the meantime, the strategy will continue to provide for services to respond to harm from any form of gambling, as well as research and evaluation to improve our understanding of gambling behaviour, the associated harms and the effectiveness of particular interventions.

³ Ministry of Health. 2021. *Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing*. Wellington: Ministry of Health.

The Ministry is grateful for the passion and compassion evident in submissions from people who shared their personal experiences of gambling harm, using these experiences to constructively contribute to our consultation. While it is impossible for this proposals document to reflect every individual's point of view, the Ministry hopes that submitters can see themselves in these proposed responses.

Structure of this document

The structure of this proposals document is based on the structure of the *Strategy to Prevent and Minimise Gambling Harm 2022/23 to 2024/25: Consultation Document*. Changes have been made where the Ministry considers they are warranted. The Ministry has published the submissions analysis report noted above on its website.

This *Strategy to Prevent and Minimise Gambling Harm 2022/23 to 2024/25 proposals document* (proposals document) is divided into the following sections:

- A strategic overview (**Section 2**). This section provides relevant background and context about the gambling environment, the nature of gambling in New Zealand, gambling related harms and the public health approach to gambling harm.
- A strategic plan 2022/23 to 2024/25 (**Section 3**). This section outlines the proposed framework which sets out the Ministry's approach to the prevention and minimisation of gambling harm, high-level objectives and priorities for action. It forms the strategic context for the proposed three-year service plan.
- A three-year service plan 2022/23 to 2024/25 (**Section 4**). The proposed service plan sets out the Ministry's service priorities to prevent and minimise gambling harm, and the costs of these services, for the three years from 1 July 2022 to 30 June 2025.
- Draft levy rates for 2022/23 to 2024/25 (**Section 5**). This section describes the calculation of levy rates and the levy weighting options for the four gambling industry sectors: non-casino gaming machine (NCGM) operators, casinos, TAB New Zealand (TAB NZ) and New Zealand Lotteries Commission (Lotto New Zealand). It also describes the impact of each weighting option each levy paying sector.

Next steps

The Ministry has submitted this document to the responsible Ministers (the Minister of Health and the Minister of Internal Affairs) and to the Gambling Commission, as required by Section 318(2) of the Act.

The Gambling Commission will undertake its own analysis of the proposed strategy and will convene a meeting to consult invited stakeholders on the strategy and the levy rates. It will subsequently provide advice to the responsible Ministers.

After considering the Gambling Commission's advice, the responsible Ministers will take a paper to Cabinet seeking its endorsement of Ministers' decisions on the shape of the strategy and the levy. While that is likely to happen in March 2022, the Government will not make the new strategy public nor promulgate the levy regulations until around late May 2022, when the 2022 Budget has been tabled in Parliament.

The new strategy and new problem gambling levy regulations should take effect on 1 July 2022.

2 Strategic overview

This section provides the context and background about gambling activities and gambling harm that informs the strategy and services to address gambling harm.

Participation in gambling

Most New Zealanders gamble at least occasionally. Estimates suggest that in 2020,⁴ 69.3 percent of respondents (about 2.8 million New Zealanders aged 16 years and older) had participated in some form of gambling in the past 12 months.

The most popular forms of gambling in 2020 were New Zealand Lotteries Commission products (59.1 percent), followed by informal gambling eg playing card with friends (35 percent), sports, dog- or horse-race betting provided by TAB NZ (10.9 percent), gaming machines at a pub or club (9.6 percent), gaming machines at casinos (4.0 percent), table games at casinos (2.5 percent) and online gambling on overseas websites (2.6 percent).

The Gambling Act 2003 (the Act) defines 'gambling' and regulates various forms of gambling activities. It identifies four types of gambling that contribute significantly to gambling harm and are subject to the problem gambling levy:

- non-casino gaming machines (NCGMs or 'pokies'), operated by clubs, societies and some TAB New Zealand (TAB NZ) venues
- the mixture of table games and gaming machines provided by casinos
- sports and race betting provided by TAB NZ on their mobile app, website, at raceways and through TAB NZ venues (some TAB NZ venues also operate NCGMs)
- a range of lottery products provided by the New Zealand Lotteries Commission (Lotto New Zealand), including: the national lottery, Keno, Instant Kiwi (scratch) tickets and MyLotto online games on their mobile app and website.

Gambling outlets

Traditionally gambling has required participation at a venue or retail outlet, but this is changing as gambling providers make use of internet access and develop internet-based products, as summarised below. This increase in internet use is consistent with the trend for more goods and services being purchased online.

⁴ Te Hiringa Hauora and Kupe. 2020. Health and Lifestyles Survey Gambling Harm. Retrieved from: <https://kupe.hpa.org.nz/#!/gambling/gambling-harm>.

DIA reports that, as at 30 June 2021, there were 1,059 licensed NCGMs (or 'pokies') venues active, operating 14,704 machines. This reflects a trend of venues and machines decreasing since venues peaked at more than 2,200 in the late 1990s and machines peaked at 25,221 in June 2003. Despite the decline in venue and machine numbers, total NCGM expenditure continues to increase.

Lotto New Zealand's 2019/20 annual report states that there were 1,230,000 registered MyLotto account holders compared with 845,000 in the previous year. This increase was attributed to the closure of the retail network during COVID-19 alert level 4 restrictions. Analysis from 2020 Health and Lifestyles Survey (HLS) shows 23.5 percent bought one of Instant Kiwi, Lotto, Strike, Powerball, Keno or Bullseye online, or by using the My Lotto mobile app in the last 12 months. This is a significant increase from 9 percent in 2018.

In the 12 months to 28 February 2021, TAB NZ reports there were 205,000 active TAB NZ customers and 560 retail TAB outlets. Of these outlets, 44 hosted gaming machines in the previous 12 months.⁵ Analysis from HLS 2020 shows 4.4 percent of New Zealand adults placed a bet with TAB NZ racing or sports event bets online, or by using the TAB mobile app in the last 12 months.

There are six casinos in New Zealand: one each in Auckland, Hamilton, Christchurch, and Dunedin, and two in Queenstown. Analysis from 2020 HLS shows 4.0 percent of New Zealanders had played gaming machines at casinos and 2.5 percent had played table games at casinos in the previous 12 months. The casinos operate 3,056 gaming machines, 239 table games and 240 fully automated gambling machines. The Act prohibits any more casinos opening in Aotearoa New Zealand.

Online gambling

As shown above, an increasing number of people in New Zealand purchased Lotto New Zealand products or placed bets on TAB NZ products online in 2020. According to analysis from the 2020 Health and Lifestyles Survey (HLS), over 1,093,000 (26.7 percent) New Zealand adults (aged 16 years and over) took part in online gambling in 2020. The most common form was purchasing tickets via the MyLotto app (23.5 percent), followed by betting online with TAB NZ (4.4 percent), and then online gambling on overseas websites (2.6 percent). Online gambling increased during the COVID-19 lockdown period, and some people gambled a lot more in that time than pre-lockdown.

⁵ Correspondence with TABNZ.

There are concerns about the growing opportunities for online gambling, including those offered by overseas-based gambling operators, and their potential to increase harmful gambling behaviour. Submissions on the strategy from service providers and health groups expressed concerns about the ubiquitous nature of online gambling and gaming convergence, particularly in terms of the potential impact on vulnerable groups including Māori, Pacific and young people/rangatahi. People using overseas gamble websites are much more likely to be at risk of experiencing harm.⁶

DIA is currently conducting a review into online gambling in New Zealand. A discussion document was released in July 2019 seeking New Zealanders' views on a future regulatory framework for online gambling. The review is ongoing at the time of drafting this document.

Observation of patterns of online gambling in overseas jurisdictions has led to stakeholders expressing concerns that New Zealanders' participation in online gambling may dramatically increase. An increase in online gambling overseas is attributed to the growth in online providers and products facilitated by rapid changes in technology, increasing ease of access to the internet, and the widespread prevalence of digital devices.

Gaming convergence

'Gaming convergence' is the merging of gambling and gaming elements in a single product. The two main examples are where:

- gambling takes on the visual and aural cues associated with gaming; for example, in New Zealand, virtual reality-enabled Instant Kiwi tickets (such forms of gambling are also an example of continuous gambling,⁷ which research shows poses an increased risk of harm)⁸
- video games include elements of what appears to be gambling (but do not currently meet the definition of gambling under the Act); for example, opening loot boxes and spinning wheels to unlock 'power ups'.

Gaming convergence, when coupled with associated increased levels of advertising and internet-based payment systems that make it easier to spend money on gambling products, represents a new level of exposure to high-risk gambling products in New Zealand and the associated probability of related gambling harm.

⁶ <https://www.hpa.org.nz/research-library/research-publications/online-gambling-in-new-zealand->

⁷ Continuous gambling refers to gambling where a person can immediately 'reinvest' their winnings in further gambling for example gaming machines (in or out of a casino), casino table games, 'scratchies' (Instant Kiwi), and sports/race betting. Non-continuous gambling is where there is a delay of many hours or days between placing a stake or buying a ticket and receiving the result of a win or loss (eg, traditional lottery draws and raffles).

⁸ Abbott M. 2006. Do EGMs and problem gambling go together like a horse and carriage? *Gambling Research: Journal of the National Association for Gambling Studies (Australia)* 18(1): 7–38.

However, while these games look and feel like gambling, they do not meet the current definition under the Act (because there is no opportunity to stake, win or lose real money). This is of concern because there is evidence that video gaming problems may be associated with problematic gambling behaviour.⁹

Gambling expenditure

DIA data shows that total gambling expenditure (player losses) on the four main forms of gambling is continuing a trend of increasing each year, except for 2019/20 which was a notable exception most likely due to the restrictions resulting from the COVID-19 pandemic lockdowns).

Total gambling expenditure in 2019/20 was \$2,251 billion for NCGMs, Lotto New Zealand, TAB NZ and casinos combined. This is lower than any of the three previous years, likely as a result of the COVID-19 alert level restrictions, which required public venues to close for seven to eight weeks.

Expenditure on NCGMs increase annually from a low of \$806 million in 2013/14, to a high of \$924 million in 2018/19. For 2019/20, total expenditure fell to \$802 million, which can be primarily attributed to the significant loss of gaming machine profits (GMP) due to the COVID-19 alert level restrictions. Despite this decrease, recorded GMP expenditure for 2020/21 was \$987 million, the highest since records began in 2007.

Expenditure on Lotto New Zealand products in 2019/20 increased significantly to \$631 million; over \$100 million more than the 2018/19 year, making it Lotto New Zealand's largest turnover ever as more New Zealanders moved to online gambling during lockdown. Note that annual expenditure on Lotto products is volatile, depending on the number and size of Powerball jackpots.

In contrast, annual expenditure on TAB NZ products remained fairly steady, around the \$300 to \$350 million range. For 2019/20, the total was \$315 million, which represented about a 5 percent decrease on the previous year.

Annual expenditure on casinos in 2019/20 was \$504 million, a significant decrease compared with previous years. Again, a key contributing factor to this was the COVID-19 lockdown period, which forced venues to close and later impose social distancing restrictions, as well as continuing restrictions on international travel.

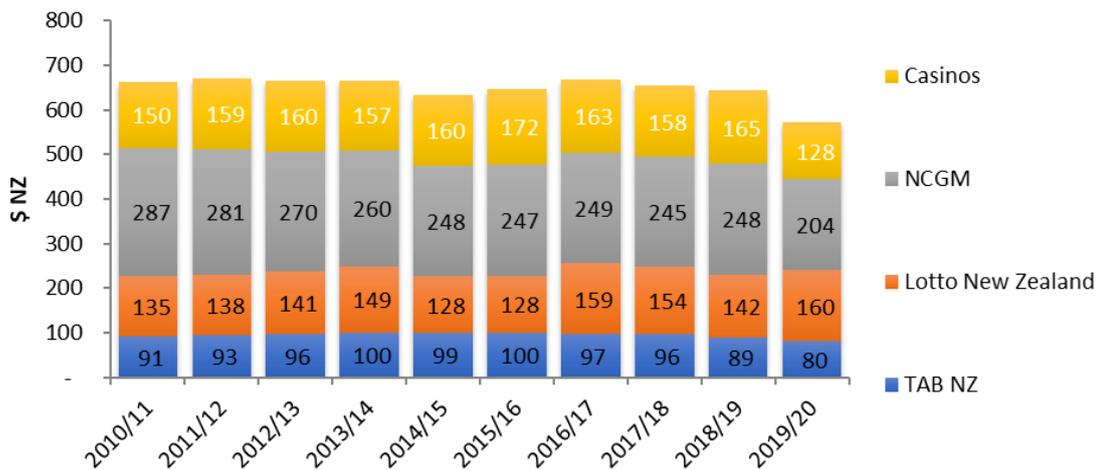
Figure 1 below shows the average per-capita gambling expenditure for each of the four main forms of gambling. Note that actual expenditure levels are higher than the figure suggests, since the levels in the figure apply to all people in New Zealand, including the one-third of the population who report that they do not gamble at all.

⁹ Malatest International, *Gambling Harm Needs Assessment 2021*.

Gambling expenditure trends show an increase in real terms across all four gambling sectors. Adjusting for inflation by type of gambling shows that spending levels have remained relatively unchanged in recent years. As noted above, the 2019/20 year was an exception. COVID-19 meant a decrease in gambling spend, except for Lotto which increased.¹⁰

Most casino gambling expenditure also derives from gaming machines. Comparing the gambling participation and expenditure information confirms that most of the money spent on gambling in New Zealand comes from the relatively limited number of people who play non-casino or casino gaming machines, or both. This has been the case for more than a decade.

Figure 1: Inflation-adjusted expenditure (2020) per capita (adults aged over 18 years), by type of gambling, 2010/11–2019/20



The nature of gambling harm

The Act defines harm as:

- harm or distress of any kind arising from, or caused or exacerbated by, a person’s gambling; and
- includes personal, social, or economic harm suffered:
 - by the person; or
 - by the person’s spouse, civil union partner, de facto partner, family, whānau, or wider community; or
 - in the workplace; or
 - by society at large.

¹⁰ See the Gambling expenditure webpage of the Department of Internal Affairs website at: www.dia.govt.nz/gambling-statistics-expenditure (accessed 12 March 2021).

Harm may include damage to relationships, emotional and psychological distress, disruptions to work or study, loss of income, the financial impacts of gambling and potentially fraud and related crimes. Gambling harm also includes the negative impact on the gambling person's family, whānau and community. Gambling may also cause financial stress and anxiety and contribute to child neglect and family violence.

Measuring harm

We can measure gambling harm at both the individual and population level.

The Problem Gambling Severity Index

The HLS and other population surveys utilise the internationally validated Problem Gambling Severity Index (PGSI).¹¹ The PGSI differentiates between different types of harm and frequency of harm occurring, as reported by survey respondents. The PGSI is commonly used, including by clinical intervention services funded by the Ministry of Health (Ministry), to screen and categorise three levels of harm: severe or high risk (problem gambling), moderate risk and low risk.

While the proportion of the New Zealand population who are at risk of gambling harm as measured by the PGSI is currently at the lowest level since the early 1990s, the level of harm in the overall population has remained relatively stable since 2012 (at about 5 percent). This plateau effect has also been observed overseas.¹²

However, while gambling harm rates have not significantly changed, the adult population has grown. This means that the actual number of people who are experiencing gambling-related harm has increased.¹³

Analysis from 2020 HLS show estimates as measured by the PGSI suggest that, in Aotearoa New Zealand in 2020, there were 65,000 people aged 16 years or older who were at either moderate risk or high risk of harm from gambling ('problem gamblers'). A further 119,000 were at low risk but would experience gambling-related harm during their lifetimes. About 183,000 adults reported second-hand gambling harm in their wider families or households.¹⁴

¹¹ Ferris JA, Wynne HJ. 2001. *The Canadian Problem Gambling Index*. Ottawa, ON: Canadian Centre on Substance Abuse, pp. 1–59.

¹² Abbott M. 2017. Gambling and gambling harm in New Zealand: a 28-year case study. *International Journal of Mental Health and Addiction* 15(1221).

¹³ Te Hiringa Hauora and Kupe. 2020. *Health and Lifestyles Survey Gambling Harm*. Retrieved from <https://kupe.hpa.org.nz/#!/gambling/gambling-harm>.

¹⁴ Te Hiringa Hauora. 2021. *Results from the Health and Lifestyles Survey 2020*.

The burden-of-harm impact on health-related quality of life

Another measure of gambling harm is known as the burden-of-harm impact on health-related quality of life. Research shows that the total burden of harms that people who gamble experience, in terms of the decrease to health-related quality of life years, is greater than the harm they experience from common health conditions, such as diabetes and arthritis, and approaches the levels seen with anxiety and depressive disorders.

Importantly, the cumulative effects of harm attributable to people who gamble who participate in low-risk gambling is very significant, with one study finding nearly 50 percent of all gambling harm being experienced by these people.¹⁵ This is because many more people experience low levels of harm or burden of disease than people who experience high levels.

Research shows that one in five New Zealand adults (22 percent) is affected at some time in their lives by their own gambling or others' gambling.¹⁶

Forms of gambling associated with gambling harm

Some features and/or modes of gambling are particularly associated with harm. Evidence shows that harm is far more likely to be associated with continuous forms of gambling (those in which a gambler can immediately 'reinvest' their winnings in further gambling) than other modes of gambling.

The common forms of 'continuous' gambling are gaming machines (in or out of a casino), casino table games, 'scratchies' (Instant Kiwi) and sports/race betting. Non-continuous forms include traditional lottery draws and raffles, as there is a delay of many hours or days between placing a stake or buying a ticket and receiving the result of a win or loss.

Non-casino gaming machines

Most of the money spent on gambling in New Zealand comes from the relatively limited number of people¹⁷ who play non-casino or casino gaming machines or both. Most people accessing gambling-harm intervention services cite pub or club pokies as the primary problem gambling mode.

¹⁵ The 2017 study *Measuring the Burden of Gambling Harm in New Zealand* estimated that, in 2012, there were 161,928 years of life lost to incapacity as a result of harms from gambling. *Measuring the Burden of Gambling Harm in New Zealand*. Wellington: Ministry of Health. URL: www.health.govt.nz/publication/measuring-burden-gambling-harm-new-zealand (accessed 18 July 2021).

¹⁶ Thimasarn-Anwar T, Squire H, Trowland H, et al. 2017. *Gambling Report: Results from the 2016 Health and Lifestyles Survey*. Wellington: Te Hīringa Hauora. URL: www.hpa.org.nz/research-library/research-publications/new-zealanders-participation-in-gambling-results-from-the-2016-health-and-lifestyles-survey (accessed 18 July 2021).

¹⁷ That is, 11 percent of New Zealand adults, according to results from the 2020 HLS.

The most harmful form of gambling in New Zealand is NCGMs at pubs/clubs (defined in the Act as class 4 gambling). At-risk and problem gamblers accounted for over half of total (estimated) electronic gaming machine (EGM) expenditure in 2015 (moderate-risk and problem gamblers 28 percent; low-risk gamblers 24 percent).¹⁸ Similarly, analysis from HLS 2020 shows 50.3 percent of those who played EGMs in pubs or clubs at least once a month experienced some level of gambling harm.¹⁹

Who is bearing the burden of gambling harm?

While many New Zealanders who gamble do so without experiencing harm, a significant minority either experience harm from their own gambling or their gambling negatively impacts the lives of others. Harm may include damage to relationships, emotional and psychological distress, disruptions to work or study, loss of income, the financial impacts of gambling (including stress and anxiety) and potentially fraud and related crimes, which can also impact negatively on the gambler's family, whānau and community. Gambling may also contribute to child neglect and family violence.²⁰

Research shows that Māori and Pacific peoples, some Asian communities and young people / rangatahi disproportionately experience gambling harm.

Analysis from HLS 2020 shows that:

- Māori were 3.13 times more likely to be moderate-risk or problem gamblers than non-Māori and non-Pacific. In the Māori adult population, approximately 3.7 percent were moderate-risk / problem gamblers, and 5.7 percent were low-risk gamblers.
- Pacific peoples were 2.56 times more likely to be moderate-risk or problem gamblers than non-Māori and non-Pacific peoples. An estimated 3.0 percent of Pacific adults were moderate-risk / problem gamblers, and 4.4 percent were low-risk gamblers.

Māori and Pacific peoples are more likely to be affected by gambling harm than any other group. Māori and Pacific peoples are also more likely to have other risk factors for gambling harm, such as having low incomes and living in low socioeconomic communities where some forms of gambling, particularly NCGMs are more accessible.

After adjusting for deprivation level, the HLS 2020 found Māori were over 3.39 times more likely to report either gambling-related arguments or money problems related to gambling compared with non-Māori and non-Pacific. For Pacific people, they were 2.67 times more likely to report these harms than non-Pacific and non-Māori.

¹⁸ Abbott M, Bellringer M, Garrett N. 2018. New Zealand National Gambling Study: Wave 4 (2015). Report number 6. Auckland: Auckland University of Technology, Gambling and Addictions Research Centre. <https://www.health.govt.nz/publication/new-zealand-national-gambling-study-wave-4-2015>.

¹⁹ Te Hiringa Hauora. 2021. *Results from the Health and Lifestyles Survey 2020*.

²⁰ Government Inquiry into Mental Health and Addiction. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction*. Wellington: Government Inquiry into Mental Health and Addiction. URL: www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf (accessed 15 July 2021).

Past HLS survey results show the proportion of Asian peoples who gamble is relatively low when compared with Māori, Pacific peoples and European/Other; however, those who do gamble are more likely to experience harm compared with European/Other.

Approximately 1.0 percent of Asian adults in 2020 were moderate-risk / problem gamblers, and 3.2 percent were low-risk gamblers. The HLS 2016 also indicate that awareness of what to do to help a friend or family member who gambles too much is lower for Asian peoples.

Research shows that young people / rangatahi are likely to be experiencing gambling harms.

According to HLS 2020 results, about 45.7 percent of youth aged 16–24 had gambled in the past year. While this is expectedly lower than the total population average, young people make up approximately 14 percent (9,000 people) of the total proportion of moderate and high-risk gamblers (1.6 percent of all adults or 65,000 people). In comparison, the 2018 HLS showed 27 percent of those who had gambled in the past year were 15–24 years of age.

Research has identified specific harms from some kinds of gambling to children and young people. Preliminary findings from research examining video games and Pacific youth gambling suggest that there are some parallels between problem gaming and problem gambling behaviour.²¹ This research found that 28 percent of Pacific survey respondents spend more than \$20 per month on loot boxes,²² and Pacific young people in the study drew parallels between problem gaming and problem gambling.

This aligns with a Norwegian longitudinal study, which found that people who bet on gaming enhancements, such as 'skins', when they were children and continued gambling online when they became adults had higher rates of at-risk and problem gambling as adults than people who did not bet on gaming enhancements when they were children.²³

Recent research into young people's views about their own gambling found that about one in three New Zealand secondary school students had participated in gambling at some point in their lives. Boys were more likely than girls to have gambled, and both children. Of this subgroup who gambled, 13 percent wanted to cut down on their gambling and 11 percent were worried about their own gambling. These concerns were not evenly distributed across the population: worry about their gambling and wanting to cut down on gambling were both higher for students in low decile schools (decile 1–3) than in high decile schools (decile 8–10, at 20 percent vs 8 percent and 23 percent vs 8 percent respectively).²⁴

²¹ PGF Group. 2020. *Report to Stakeholders 2020*. Te Pūrongo Ā-tau. Auckland: PGF Group. <https://www.pgf.nz/downloads/assets/13448/1/pgf0033>.

²² In video gaming, a loot box is a virtual container that holds a random item that can be used in some games.

²³ Mold H, Holmay B, Merkesdal AG, et al. 2019. Are video games a gateway to gambling? A longitudinal study based on a representative Norwegian sample. *Journal of Gambling Studies* 35: 545–57. <https://link.springer.com/article/10.1007/s10899-018-9781-z#Abs1>.

²⁴ Archer D, King-Finlay T, Kuresa B, et al. 2021. *Youth19 Gambling Brief*. The Youth19 Researchers and The Adolescent Health Research Group, Auckland and Wellington. <https://www.youth19.ac.nz/publications/gambling>

This is worth noting when set against the study finding that students in lower-decile schools were less likely to report having ever gambled than those in higher-decile schools. This suggests that, while youth gambling may be less common in more deprived areas, it causes more concern, and potentially more harm, to those students with greater levels of disadvantage.

There are growing concerns about the accessibility of online gambling and gaming convergence and the impacts of these on the wellbeing of children and young people / rangatahi. People interviewed for the Ministry-commissioned 2021 needs assessment highlighted increasing numbers of parents asking for support for young people who were 'addicted' to gaming.

There is also some anecdotal concern that increasing unregulated online gambling may be particularly harmful for disabled people. Almost one in four New Zealanders identify as disabled, and these proportions are larger in the groups that we know are vulnerable to harm from gambling, that is, Māori, Pacific peoples and people with low incomes.²⁵ Disabled people on average have lower incomes, which may exacerbate their experience of gambling harm.

We have limited information about gambling among the disabled community in New Zealand, but American research has found that one-quarter of recipients of disability benefits were experiencing harm from gambling.²⁶ Additionally, recent small-scale Australian research found people with intellectual disabilities are engaging with gambling in the same ways as the general public.²⁷

Women, who are commonly the primary caregivers within their family or whānau, are also particularly vulnerable to the economic strain caused by problem gambling. Recent research has shown that socio-cultural positioning of women as the primary caregivers for families contributes to gambling harm by placing unrealistic expectations on the women while simultaneously constraining their ability to prioritise their own wellbeing and access rest, relaxation and support. Gambling venues in local communities appear to offer women respite, distraction, comfort, time out and/or connection, while placing them at increased risk of experiencing problems and harm.²⁸

²⁵ 2013 New Zealand Disability Survey. Statistics New Zealand. <https://www.stats.govt.nz/information-releases/disability-survey-2013>.

²⁶ Morasco BJ, vom Eigen KA, Petry NM. 2006. Severity of gambling is associated with physical and emotional health in urban primary care patients. *General Hospital Psychiatry* 28: 94–100. doi: 10.1016/j.genhosppsych.2005.09.004.

²⁷ Pitt H, Thomas SL, Watson J, Shuttleworth R, et al. 2021. How do people with intellectual disability engage with and understand gambling? A qualitative study of adults in Victoria, Australia. *Front Public Health* 8: 536520, 12 January. doi: 10.3389/fpubh.2020.536520.

²⁸ Palmer du Preez K, Mauchline L, Paavonen A, et al. 2019. *A Mixed Methods Analysis of Gambling Harm for Women in New Zealand*. Auckland: Auckland University of Technology, Gambling and Addictions Research Centre. Available from the Ministry of Health website at: www.health.govt.nz/publication/mixed-methods-analysis-gambling-harm-women-new-zealand (accessed 18 July 2021).

A report from the 2016 Pacific Island Families Study found that risk factors for gambling among mothers studied included alcohol consumption, being a victim of verbal abuse and increased deprivation levels.²⁹

Gambling harm and other health problems

Harmful gambling typically presents with other health issues and has been consistently associated with a range of co-existing health issues, such as higher levels of smoking, hazardous alcohol consumption and other drug use, as well as higher levels of depression and poorer self-rated health. Coexisting health issues (comorbidity) is an indication that a person may require holistic health services.³⁰

Some 21 percent of clients screened by Ministry-funded health services for co-existing problematic alcohol or drug use in 2019/20, reported feeling the need to cut down their use of prescription or other drugs and 34 percent reported having risky levels of alcohol use.

Harm to family and affected others

Gambling harm can be experienced not only by people who gamble but also by their friends, families, whānau and communities. Australian research³¹ suggests that between five to ten other people are adversely affected by a person who has severe problematic gambling behaviour.

In New Zealand, we know that harmful gambling behaviour is strongly correlated with family, whānau or partner violence, with half of problem gamblers reporting having experienced family or whānau violence.³² There is also evidence that children and young adults are exposed to considerable gambling messaging, for example, through advertising, which can normalise harmful gambling behaviours.³³

²⁹ Bellringer M, Kolandai-Matchett K, Taylor S, et al. 2016. *Pacific Islands Families Study 2014: Mother and youth gambling*. Auckland: Auckland University of Technology, Gambling and Addictions Research Centre. Available from the Ministry of Health website at: www.health.govt.nz/publication/pacific-islands-families-study-2014-mother-and-youth-gambling-report (accessed 18 July 2021).

³⁰ Bellringer ME, Janicot S, Ikeda T, et al. 2020. *New Zealand National Gambling Study: Correspondence between changes in gambling and gambling risk levels and health, quality of life, and health and social inequities*. NGS Series Report Number 9. Auckland: Auckland University of Technology (AUT), Gambling and Addictions Research Centre.

³¹ Productivity Commission. 1999. *Australia's Gambling Industries, Final report, Summary, Report No. 10*. Canberra: AusInfo. URL: www.pc.gov.au/inquiries/completed/gambling/report/summary.pdf (accessed 18 July 2021).

³² Auckland University of Technology. 2017. *Problem Gambling and Family Violence in Help-seeking Populations: Co-occurrence, impact and coping*. Wellington: Ministry of Health.

³³ Signal L, Smith M, Barr M, et al. 2017. Kids'Cam: an objective methodology to study the world in which children live. *American Journal of Preventive Medicine* 53(3): e89–e95. [https://www.ajpmonline.org/article/S0749-3797\(17\)30163-0/fulltext](https://www.ajpmonline.org/article/S0749-3797(17)30163-0/fulltext).

It is also useful to consider the broader impacts on society from the large amount of expenditure that is currently being put into gambling. New Zealanders lose around \$2.4 billion per annum on gambling, with almost \$1 billion of that on EGMs alone. In all, 40 percent of players' losses on NCGMs must be returned to the community in the form of grants. Recent research in Aotearoa New Zealand estimated that, if the current levels of household expenditure on EGMs were switched to retail spending, this could create an additional 1,127 full-time equivalent jobs worth approximately \$50 million in wages and salaries.³⁴ The tax impacts on this would be nearly \$60 million in increased GST collected and \$7 million in income tax on workers. This research assumed that all spending switch to retail and not to other forms of gambling. Even if it is assumed that only half of the spending was switched, it would appear this could have a significant economic impact.

It is also clear that spending on gambling, especially NCGMs, is not spread evenly across our communities. This is at least partly due to access. More than 60 percent of NCGMs venues (the source of the highest risk of harmful gambling activity) are located in the most socioeconomically deprived areas (that is, the poorest areas of the country).³⁵ People in these areas spend up to three times as much on NCGMs as people in the least deprived area.³⁶ While it is possible that people may gamble outside their neighbourhoods, there are significant associations between gambling behaviour and neighbourhood access to gambling venues. In particular, problem gambling has been found to be significantly associated with living closer to a gambling venue.³⁷

³⁴ NZIER. 2020. *The Retail Employment and Tax Costs of Class 4 Gambling in New Zealand: NZIER report to the Problem Gambling Association*. Wellington: New Zealand Institute of Economic Research (NZIER). URL:

https://img.scoop.co.nz/media/pdfs/2008/Final_Report_Diverting_gambling_losses_22_June.pdf (accessed 18 July 2021).

³⁵ Based on NZDep 2013 census area units: University of Otago Wellington. Socioeconomic Deprivation Indexes: NZDep and NZiDep, Department of Public Health. URL:

www.otago.ac.nz/wellington/departments/publichealth/research/hirp/otago020194.html (accessed 17 November 2018).

³⁶ Ward AD, McIvor JT, Bracewell P. 2020. The geographic distribution of gaming machine proceeds in New Zealand. *Kōtuitui: New Zealand Journal of Social Sciences Online* 15 (1): 54–74. DOI:

<https://doi.org/10.1080/1177083X.2019.1640752> (accessed 18 July 2021).

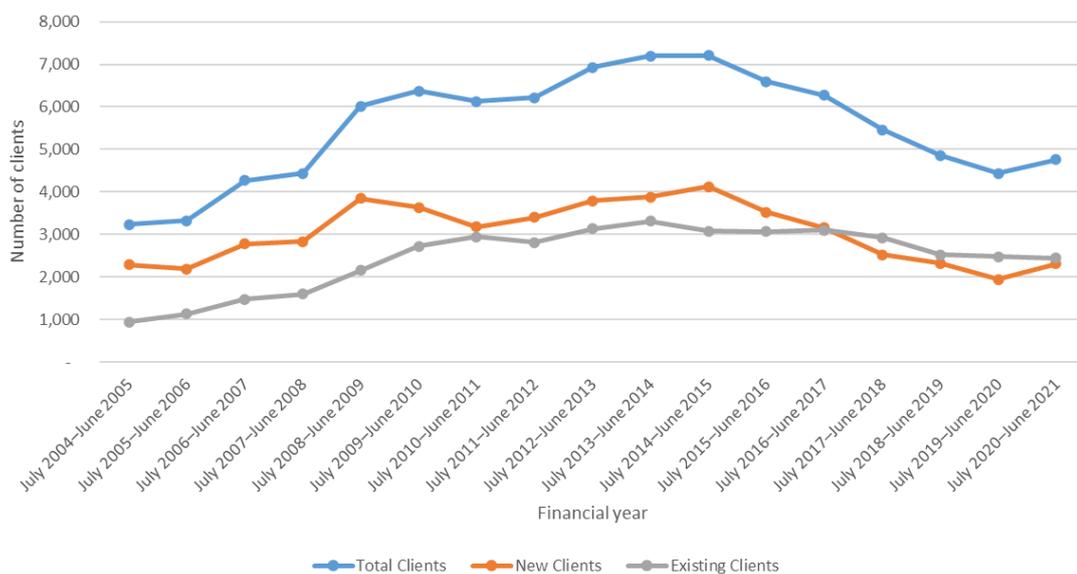
³⁷ Ministry of Health. 2008. *Raising the Odds? Gambling behaviour and neighbourhood access to gambling venues in New Zealand*. Wellington: Ministry of Health.

Service delivery 2019/20 to 2021/22

Every year, people seek help from services funded by the Ministry for harms due to their own or someone else’s gambling. In the 2020/21 year, over 6,605 people received treatment from Ministry-funded services for harms due to their own gambling.³⁸ This is a small proportion of the 45,000 to 92,000 people that the analysis of 2020 HLS estimated were experiencing moderate to significant harms from their own gambling. In addition, between 144,000 and 230,000 New Zealand adults experienced at least one form of household-level gambling harm in the previous 12 months. In the 20/21 year, around 4,341 families or whānau and others received treatment from Ministry-funded services for issues related to someone else’s gambling.

As Figure 2 below shows, there has been a general decrease in people accessing Ministry-funded services (excluding clients who only received brief interventions). Exclude brief intervention data makes this decreases more obvious when we, and results from a range of factors that need to be addressed to improve service uptake. The Ministry’s suggestions for ways to address this issue are discussed in this proposals document.

Figure 2: Clients accessing Ministry-funded services (excluding brief interventions)



³⁸ Ministry of Health, Intervention client data website: www.health.govt.nz/our-work/mental-health-and-addictions/gambling/service-user-data/intervention-client-data.

Services environment

The COVID-19 pandemic and resulting public health restrictions, such as social distancing requirements, had a significant impact on the gambling-harm services environment. Face-to-face service provision decreased dramatically, leading to a rapid increase in virtual service provision (over the telephone or through online meetings). While this shift highlighted the adaptability of health service providers, it also exacerbated the negative impacts of the restrictions on people who do not have ready access to digital software.

In addition to COVID-19, there were a number of developments in the gambling-harm services environment over the 2019/20 to 2021/22 period.

- Funding for the national Multi-venue Exclusion (MVE) Administration Service continued, and a national framework and standardised process were developed. MVE is now available across the country. An electronic gambling exclusions database was also procured and is being trialled to facilitate the exclusion application process and collect the exclusion data.
- Two new ways of working (service pilots) were introduced in the Waikato region: a PMGH service for Māori and one for Pacific peoples. Both services are based in Hamilton and are within organisations that are existing Whānau Ora providers (Te Kōhao Health and K'aute Pasifika Trust respectively).
- A gambling harm lived experience advisory group was established to inform the Ministry's gambling harm work programme.
- As of 10 May 2021, 40 percent of territorial authorities had sinking-lid policies in place for NCGMs, and a further 48 percent had caps on the number of venues and/or machines in their area. This shows an uptake in sinking lid policies compared with July 2019.
- As of 10 May 2021, a total of 27 of the 67 territorial authorities had reviewed their NCGM and TAB venue policies since 1 July 2019.

Public health provision in the 2019/20 to 2021/22 period

Public health service providers continued to encourage the adoption of healthy gambling policies, and many providers led their community's participation in territorial authority reviews of NCGM venue policy. They also worked alongside other agencies and community groups to develop community action initiatives to increase community resiliency against gambling harm and engaged with their local gambling venues to support gambling harm minimisation practices and promote their services.

National and regional health service providers delivered a wide range of health promotion activities. These included raising awareness of the signs of gambling harm by delivering numerous presentations and workshops to organisations and groups, attending hundreds of community events and through online media communications, social media and resources.

Te Hiringa Hauora’s health promotion programme focuses on encouraging positive behaviour change among at-risk people who gamble and raising awareness about the signs of harmful gambling and risky gambling behaviours. Developments led by Te Hiringa Hauora have included an increased focus on equity through a number of initiatives such as the rebranding of the national gambling campaign Choice Not Chance to Safer Gambling Aotearoa; development of South Auckland pilot campaigns and a new national campaign primarily focusing on Māori and Pacific communities. A review of the Gamble Host Responsibility project also led to a number of improvements, including Te Hiringa Hauora working to develop an online version of the host responsibility training and ethnic-specific resources.

During 2020, many planned promotional activities, including some Gambling Harm Awareness Week (GHAW) activities, did not proceed due to the COVID-19 restrictions. Notable successes have included a relationship established with Kiwibank, resulting in gambling harm screening and referral training delivered to some of their debt recovery units; the development of a TXT2X (text to exclude) toolkit to promote the use of MVEs; and many community groups and venues supporting the Pause the Pokies campaign during GHAW.

Service access

Analysis of Ministry gambling service administrative data to 2020/21 shows that the number of people who gamble seeking treatment continues to decline in Aotearoa New Zealand, despite the increase in real numbers of people experiencing gambling harm. In the 2020/21 year, 6,605 ‘Gambler’ clients and 4,341 ‘Family / Affected Other’ clients received gambling harm treatment services from a Ministry-funded provider. This decline is largely attributable to fewer new clients presenting to services, a factor exacerbated by the COVID-19 restrictions. There has been a slight uptick in clients in the 2020/21 year after a low in 2019/20. The number of existing clients receiving interventions has remained relatively static over the same period. The numbers of people seeking interventions has been relatively stable for several years.

It is important to note that these statistics are population prevalence rates, and although they are static, the actual number of people impacted by gambling harm is increasing in line with population growth. The needs assessment and outcomes monitoring reports show that only a minority of potential clients for gambling support services (that is, people whose reported harm results in a moderate to high PGSI score) actually access or present at these services. Low service use is also observed for other forms of addiction treatment.

The positive impact of the majority of PMGH gambling-harm services being located within Whānau Ora providers (Māori and Pacific) was highlighted during the COVID-19 lockdown period. Incorporating these services into the Whānau Ora framework during this time meant PMGH clients, their families and whānau and their wider communities were integrated into an organisation-wide support system that delivered health and social support, care packages and access to other services and support as required. However, improving intervention and service use rates remains a challenge. Further work is required to address systematic barriers to access based on ethnicity or socioeconomic status.

3 The strategic plan

The strategic environment

The Gambling Act

The Gambling Act 2003 (the Act) recognises that gambling harm is a significant issue and requires the development and implementation of an 'integrated problem gambling strategy focused on public health'. The Act specifies that this strategy must be informed by a needs assessment and include measures to promote public health, services to treat and assist people who experience gambling harm and their families and whānau, independent scientific research and evaluation.

The Ministry of Health role

The Ministry is responsible for an integrated strategy to prevent and minimise gambling harm (the strategy). Section 317 states the strategy must include:

- a. measures to promote public health by preventing and minimising the harm from gambling;
- b. services to treat and assist problem gamblers and their families/whānau;
- c. independent scientific research associated with gambling, including (for example) longitudinal research on the social and economic impacts of gambling, particularly the impacts of gambling on different cultural groups; and
- d. evaluation.

The Ministry of Health (the Ministry) is responsible for developing the strategy to Prevent and Minimise Gambling Harm (the strategy) and implementing services mandated by the strategy. The annual and three-year funding requirements to deliver the strategy are outlined in the draft service plan, alongside the proposed services and investments. These cost estimates are used to inform the development of the problem gambling levy on the gambling industry.

The Ministry receives funding through Vote Health to develop and implement the strategy. The Crown then recovers the cost of this appropriation through a 'problem gambling levy' set on four types of gambling: non-casino gaming machines (NCGM), casinos, the TAB New Zealand (TABNZ) and New Zealand Lotteries Commission (Lotto New Zealand).

Department of Internal Affairs

The Department of Internal Affairs (DIA) is the main gambling regulator and policy advisor to the Government on gambling regulatory issues. DIA administers the Act and its regulations. DIA's role includes key regulatory aspects of gambling harm prevention and minimisation, including:

- issuing licences for gambling activities
- regulating gambling operators to ensure that they comply with the legislative requirements, for example DIA conducts inspections of gambling venues to assess whether the harm minimisation provisions are being implemented
- working with the gambling industry sector to encourage best practice, and
- publishing gambling data, for example on expenditure.

DIA also issues licences for gambling activities, ensures compliance with the legislation, works with the gambling sector to encourage best practice and publishes statistical and other information concerning gambling. It is also responsible for limiting the opportunities for crime and dishonesty associated with gambling and ensuring gambling proceeds benefit the community.

Te Hiringa Hauora – Health Promotion Agency

Te Hiringa Hauora – Health Promotion Agency (Te Hiringa Hauora) does not have a statutory role in gambling prevention and harm minimisation under the Act, but its mandate is to promote health and wellbeing and encourage healthy lifestyles. Te Hiringa Hauora is funded under the current strategy to deliver an education and awareness work programme to prevent and minimise gambling harm. Te Hiringa Hauora work closely with the Ministry in this area, which is complementary to many other activities in both agencies.

The proposed strategic framework, which is described in more detail in **section 3** and shown in Figure 4 describes a set of complementary action areas, led by the Ministry of Health, DIA and Te Hiringa Hauora, according to each agency's core mandate. The figure shows priority action areas that are delivered jointly. This collaborative and coordinated approach is essential to the effective prevention and minimisation of gambling harm.

Territorial authorities

Under the Gambling Act 2003 and the Racing Industry Act 2020, territorial authorities are required to develop, review and apply policies on non-casino gaming machines venues and TAB venues in their area.³⁹

³⁹ Gambling Act 2003, sections 98 to 103 and Racing Industry Act 2002, sections 96–97.

Gambling Commission

The Gambling Commission also hears casino licensing applications (which include harm minimisation plans)⁴⁰ and appeals on licensing and enforcement decisions made by the Secretary of Internal Affairs in relation to gaming machines and other non-casino gambling activities.

Gambling Harm Needs Assessment 2021

In 2020, the Ministry commissioned an independent needs assessment to inform the development of the strategy, based on interviews with a cross-section of key stakeholders, a service provider survey and a literature review. The key findings were:

- Most people gamble for leisure and recreation. All forms of gambling remain widely accessible and access to online gambling for money has increased.
- Venue based gambling expenditure decreased during COVID-19 lockdowns but returned to pre-COVID levels shortly after the lockdowns lifted. Although gambling participation has decreased for the general population, harmful gambling prevalence has not declined.
- Harms and risks from gambling remain widespread and are more prevalent among Māori, Pacific peoples and young people/rangatahi than among other groups. Harmful gambling impacts all aspects of wellbeing for individuals and their whānau. Evidence suggests that the costs, in terms of individual, family and community harms associated with gambling, outweigh the benefits, such as employment and availability of community funding.
- The enablers and barriers to help seeking have not changed significantly since the last needs assessment.

The Gambling Harm Needs Assessment 2021 (the needs assessment) also considered progress towards the strategic objectives of the current strategy.⁴¹ It recommended the Ministry could do better by enhancing several areas including a stronger focus on equity, service integration, workforce development, health promotion and research. The needs assessment findings have informed our proposed strategic plan and draft service plan.

More information about the needs assessment can be found in the full report.

⁴⁰ The Gambling Commission approves the casino operator's *Host Responsibility Programme* (HRP), which the operator must comply with as part of their licence conditions. Casino operators report to the Gambling Commission annually about the implementation of their HRP. The Department of Internal Affairs may also provide input into the HRP when it is periodically reviewed by the Gambling Commission.

⁴¹ Malatest International *Gambling Harm Needs Assessment 2021*.
<https://www.health.govt.nz/system/files/documents/publications/gambling-harm-needs-assessment-2021.pdf>.

Focusing on public health

The Act sets out requirements for an 'integrated problem gambling strategy focused on public health'. Submissions strongly supported strengthening the public health measures in the strategy stressing the importance of harm prevention and early intervention and engaging with lived experience, Māori and priority populations to ensure public health activities will effectively reach those who need help and support.

Public health is about protecting against community health risks and threats, preventing illness, and promoting health across the whole population or population groups. Public health is distinguishable from other health areas in that it aims to keep people well and focuses on groups of people rather than individuals. Three core concepts integral to public health are:

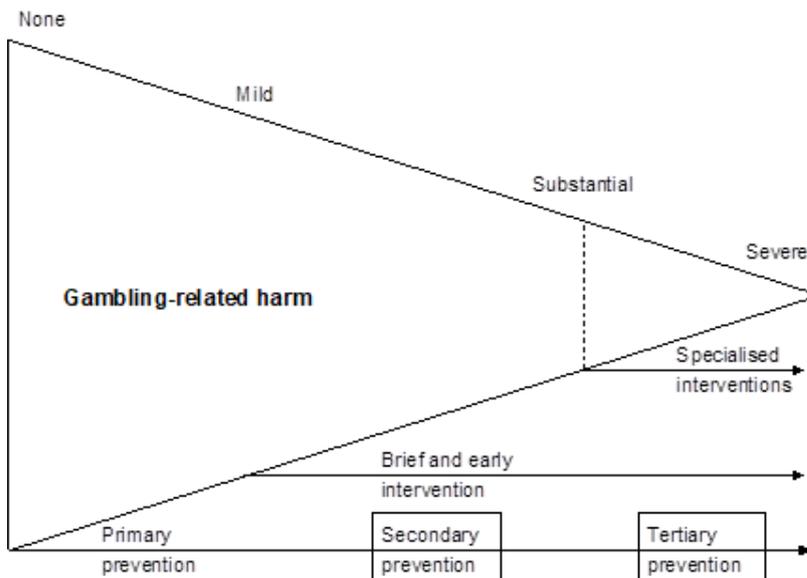
- the inclusion of both promotion and prevention activities. In the context of gambling, this includes raising awareness of the signs of harmful gambling, encouraging at-risk people to check whether their gambling is under control before harm escalates in severity, and motivating those who are at risk to engage in self-help changes or get help early.
- the collective nature of the promotional and preventative activities
- the health of the whole population as the goal.

Associated with this is the concept of health equity and inequality, discussed below.

We use a continuum-of-harm approach to public health that aligns a spectrum of gambling behaviour with a harm reduction framework, as first developed by Korn and Shaffer (1999).⁴² This approach recognises that people experience varying levels of harm from gambling and a continuum of approaches, from prevention to intensive clinical treatment, is required. Figure 3 below shows the continuum of behaviours, risks and responses, from health promotion to harm reduction and intensive treatment.

⁴² Korn DA, Shaffer HJ. 1999. Gambling and the health of the public: adopting a public health perspective. *Journal of Gambling Studies* 15: 289–365. DOI: doi.org/10.1023/A:1023005115932 (accessed 15 July 2021).

Figure 3: Continuum of gambling behaviour and responses



Gambling harm as an equity issue

The needs assessment highlighted the importance of positioning gambling harm prevention and minimisation as an equity issue, and this emphasis was supported by a broad cross-section of submissions.

Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes. An equity issue refers to something that predominantly affects one or some groups more than others. In the case of gambling harm, Māori and Pacific peoples, and to some extent young people, are shouldering a burden of harm that greatly outweighs that being experienced by other groups.

These strongly patterned outcomes have a systemic cause: for example, we know that the most harmful form of gambling – non-casino gaming machines (NCGM)– are not distributed randomly across our communities but concentrated in areas defined by lower socioeconomic status and high deprivation measures, which are also more likely to be areas where Māori and Pacific people live. We also know the services and supports that are in place to prevent and minimise gambling harm are under-utilised, and one likely reason for this is that they are not considered acceptable and culturally appropriate⁴³ by all potential service users.

⁴³ See preference to use cultural safety rather than cultural competence (also made in submission from GPS) <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1082-3>.

Equity issues require tailoring services to address inequities, which may include targeted actions based on engaging with, listening to, and partnering with the people who are most affected. In addition, issues where Māori are disadvantaged or harmed need to be considered carefully and implemented well, drawing on the strength of the special relationship that the Crown has with Māori under Te Tiriti o Waitangi (Te Tiriti).

Box 1: The Ministry of Health’s position on inequalities and inequity in health

Our definition of equity is:

“In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.”

This definition of equity was signed off by the Director-General of Health, Dr Ashley Bloomfield, in March 2019.⁴⁴

We usually refer to the differences in health experience that occur between population groups as ‘health inequalities’. A health inequality is an inequality that we can attribute to social, cultural and economic factors rather than biomedical ones.

Inequalities and inequity in health occur between groups because of a range of well-recognised socioeconomic, cultural and biological factors, the most common of which are sex, age, social deprivation, ethnicity and education.

Inequities are not random; they are typically due to structural factors present in society and the local community that cannot be explained by biomedical differences between population groups. This means their causes are often complex and multifaceted and are outside the scope of the health system to address on its own.

⁴⁴ See the Achieving equity webpage of the Ministry’s website at: www.hauora.co.nz/new-action-plan-to-boost-maori-health-and-wellbeing/#:~:text=Whakamaua%3A%20Māori%20Health%20Action%20Plan%202020-2025%20is%20the,the%20Ministry’s%20new%20Te%20Tiriti%20o%20Waitangi%20Framework www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity.

The proposed strategic framework

This draft strategy comprises a six-year strategic framework, and a three-year service plan and levy rates, and is refreshed every three years. Together, the strategic framework and service plan set out our proposed approach and the range of activities we plan to undertake to prevent and minimise gambling harm in the period 2022/23 to 2024/25.

Submissions on the draft strategy

Three out of five submissions to the consultation document indicated support for the general direction of the strategy, including some with qualifications such as also wanting bolder changes and action to address offshore online gambling.

There were divergent views on the specific priorities and preferred direction of change, based primarily on differing industry and health service perspectives, with the strongest support from health, service providers, local government or individual submissions. Submissions from the non-casino gaming machine (NCGM) sector opposed any additional spending unless the activities funded would make the strategy more effective. Some submissions felt bolder changes were needed to make a real impact on reducing gambling harm.

There was broad support for:

- strengthening the focus on equity, public health and priority populations including young people/rangatahi
- improving the range and diversity of services to address equity and gambling harm
- placing people at the centre, using lived experience and collaboration to engage with groups most affected
- enhancing the public health approach to education, including new investments to address stigma, and strengthening the gambling harm workforce.

Considerations for updating the strategic framework

This section describes the revised strategic framework to guide the strategy and service plan going forward. The proposed framework takes into account the submissions on the consultation document, needs assessment findings, an analysis of outcomes, and the most current research and of other evidence available, including emerging issues, to ensure they remained fit for purpose.

The revised strategic framework needs to be read in the context of strategic changes in the health environments, and the Ministry's broader framework for implementing Te Tiriti o Waitangi. This section also addresses alignment with the previous strategic framework.

Changes in the strategic environment for preventing and minimising gambling harm

The strategy is being refreshed at a time when the entire health system in New Zealand is undergoing major transformation of both mental health and addiction and the wider health and disability services system. These transformations are driven by common themes and principles, that as indicated below will also form the foundations for the strategy going forward, for example to provide for services that are more equitable, accessible, cohesive, and people-centred.

Set out below is a summary of the key strategic changes in the health environment within which gambling, and gambling harm prevention and minimisation, is situated.

- *Health and Disability Sector changes (Pae Ora – Health Futures Bill)*

The health and disability system is being transformed to create a more equitable, accessible, cohesive, and people-centred system that will improve the health and wellbeing of all New Zealanders, in response to the Health and Disability System Review/Hauora Manaaki Ki Aotearoa Whānui.

The Pae Ora Health Futures Bill, due to be enacted in 2022, describes the high-level purpose of building towards pae ora and a series of health system principles. It also outlines key roles including that of the Minister of Health, Health New Zealand, to replace DHBs, the Māori Health Authority to drive improvement in hauora Māori, and the Iwi-Māori Partnership Boards, to enable Māori to exercise tino rangatiratanga and mana motuhake for planning and decisions about local health services.⁴⁵

- *WAI 2575 – the Health Services and Outcomes Inquiry*

The Waitangi Tribunal is currently hearing WAI 2575 – the Health Services and Outcomes Inquiry. This inquiry will hear all claims concerning grievances relating to health services and outcomes and which are of national significance. There are currently over 200 claims seeking to participate in the inquiry and there is currently no cut-off date for the filing of claims. The stage one inquiry was a discrete and targeted inquiry into the legislative and policy framework of the primary healthcare system. As part of stage two, the Tribunal has commissioned a number of reports including on Māori mental health on issues of alcohol, tobacco and substance abuse for Māori. This may have potential implications for the Ministry's approach to this strategy in the future.

⁴⁵ Reference transformation website.

- *Kia Manawanui Aotearoa – Long-term pathway to mental wellbeing* (Kia Manawanui)

Kia Manawanui is a whole of government action plan for transformation of the mental health and addiction sector over the long-term. Building on the foundations introduced in the \$1.9 billion package for mental wellbeing in Budget 2019, *Kia Manawanui* sets out the sequenced actions to implement further changes required to support the mental wellbeing of New Zealanders. This includes continued expansion of access to mental wellbeing support, ensuring our work is grounded in Te Tiriti o Waitangi and equity, and providing environments that support diverse population groups and communities which have for too long experienced inequitable outcomes.

Importantly this plan includes an action to review the Gambling Act 2003, with specific reference to preventing and minimising harm from online gambling and electronic gaming machines.

- *Whakamaua: Māori Health Action Plan 2020–2025* (Whakamaua)⁴⁶

Whakamaua sits alongside *Kia Manawanui* and sets out objectives for the health and disability sector to work towards over the five years to the end of 2025, to accelerate and spread the delivery of kaupapa Māori and whānau-centred services: to shift cultural and social norms; to reduce health inequities and health loss for Māori and to strengthen system accountability settings.

- The Department of Internal Affairs' new strategic focus on gambling

In 2020, DIA announced its strategic focus on gambling would be 'Delivering community wellbeing through reducing gambling-related harms'.⁴⁷ Work to achieve this purpose would be driven through five focus areas: being an effective Treaty partner; forming an enabled workforce; achieving regulatory excellence; being evidence based and informed; and demonstrating system leadership.

Appendix 1 summarises other strategic documents we have aligned with this strategy, such as *Ola Manuia Pacific Health and Wellbeing Action Plan 2020–2025*.

⁴⁶ Ministry of Health. 2020. *Whakamaua: Māori Health Action Plan 2020–2025*. Wellington: Ministry of Health. *Whakamaua* articulates the importance of ensuring equity of outcomes for Māori, and the ability of iwi, hapū, whānau and Māori communities to exercise their authority to improve their health and wellbeing. Additional details are provided in Appendix 1.

⁴⁷ See the Gambling webpage on the Department of Internal Affairs website at: www.dia.govt.nz/Gambling.

Te Tiriti o Waitangi in the health and disability system

The proposed new strategic framework positions gambling harm explicitly as an equity issue. *Whakamaua* describes the principles of Te Tiriti for the context of health services, drawing on *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Hauora)*.^{48,49} We have referred to these principles to inform the strategic framework.

- Tino rangatiratanga' underpins the principles identified in Te Tiriti. It is often translated as 'self-determination' or 'sovereignty'. It means that Māori are guaranteed self-determination and mana motuhake (the right to be Māori and to live on Māori terms in accordance with Māori philosophies, values and practices) in the design, delivery and monitoring of health and disability services.
- 'Partnership' is recognised as a relationship between the Crown and Māori, in which the two parties act with respect towards one another, work together and are flexible about different structures where organisations are not meeting the needs of one another. Partnership requires the Crown and Māori to work collaboratively in the governance, design, delivering and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the health and disability system for Māori.
- 'Active protection' requires the Crown to act, to the greatest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that the Crown, its agents and its partners in Te Tiriti are well informed on the extent and nature of both Māori health outcomes and efforts to achieve Māori health equity.
- 'Options' require the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally responsive and safe way that recognises and supports the expression of hauora Māori models of care.
- 'Equity' requires the Crown to commit to achieving equitable health outcomes for Māori. Equity recognises that different people with different levels of advantage require different approaches and resources to achieve equitable health outcomes.

Research and evidence

Research and evidence inform all aspects of the strategic framework. Relevant research has been described in the preceding sections and as such is not highlighted separately in this section. Research priorities are described in **Section 4: The Service Plan**.

⁴⁸ Waitangi Tribunal. 2019. *Hauora: Report on stage one of the Health Services and Outcomes Kaupapa Inquiry*. Wai 2575: Waitangi Report 2019. Lower Hutt: Legislation Direct. URL: https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf (accessed 15 July 2021).

⁴⁹ <https://www.health.govt.nz/our-work/populations/maori-health/te-tiriti-o-waitangi>.

Key continuities with *Strategy to Prevent and Minimise Gambling harm 2019/20 to 2021/22*

It is important we do not lose any of the existing momentum to prevent and minimise gambling harm. The proposed strategic framework re-frames the current strategy, incorporates both responses to submissions on the consultation document and environmental changes and lessons learnt over recent years. There is still a close relationship to the current strategic framework, because the prevention and minimisation of gambling-related harm is a long-term activity. The current strategy had already initiated changes to align with some of the elements foreshadowed in *He Ara Oranga, the Report of the Inquiry into Mental Health and Addiction Services*, such as developing culturally responsive services and incorporating the voice of lived experience. All 11 strategic objectives from past strategies have been incorporated into the four new draft objectives, as shown in **Appendix 3**.

Some submissions called for “bolder changes” in the strategy. Any changes to services need to be balanced against the duty to provide continuity for long term activities such as health education, prevention and early intervention, required to meet the needs of new cohorts of people coming through, as well as for people having different needs at different times in their lives.

Service and research contracts initiated under the current strategy will continue, but, as opportunities occur, these will be gradually aligned to the new strategic framework that will apply from 1 July 2022, for example, through the contract renewal or tender processes.

Elements of the new framework

Taken together, in the context of the Ministry’s existing approach to Te Tiriti, the elements described below reflect our commitment to equity and to the public health approach to gambling harm prevention and minimisation, by:

- positioning gambling harm prevention and minimisation explicitly as an equity issue, by creating a new set of objectives based on *Whakamaua*
- aligning with *Kia Manawanui* and *Whakamaua* through outcomes and principles derived from those strategies
- situating harm prevention and minimisation activities within the broader context of public health promotion and the regulation of gambling
- more clearly aligning goals, objectives and actions
- responding to new research and evidence and changes in the gambling harm prevention and minimisation environment
- demonstrating how the work of the three government agencies that work in this space – the Ministry, DIA, and Te Hiringa Hauora – complement each other.

The gambling industry also has an important role to play, particularly through the host responsibility programme developed with Te Hiringa Hauora and DIA.

Descriptions of the elements of the new strategic framework are described below, followed by a stylised pictorial representation.

Pae ora – population outcome

A population outcome is an outcome for the whole population that considers both population characteristics and system performance. As it is people centred and system-focused, it cannot be achieved by any one service, Government agency, or other actor alone.

The population outcome proposed for the strategy is ***pae ora – healthy futures for Māori and all New Zealanders***, which is drawn from *Kia Manawanui*.⁵⁰

While the concept was developed originally as a vision for Māori wellbeing, *Kia Manawanui* applies this to Māori and all New Zealanders. This acknowledges pae ora provides a platform to ensure Māori and all people in Aotearoa New Zealand can live with good health and wellbeing. Adopting this outcome establishes that the wellbeing of Māori and all New Zealanders includes being free from gambling-related harm.

Pae ora is a holistic concept and includes three interconnected elements: mauri ora – healthy individuals, whānau ora – healthy families, and wai ora – healthy environments. It addresses the way people live, grow and develop as individuals and members of families, whānau, communities and their wider environments. It acknowledges the interrelated aspects of mental wellbeing and encourages us to think beyond narrow definitions of health and services. It also acknowledges the fundamental roles of individuals, whānau, iwi, hapū and communities and provides a way to think about collective action.

Strategic goal

The draft strategic goal proposed is ***'To promote equity and wellbeing by preventing and reducing gambling-related harm'***.

We have selected this goal for the following reasons.

- It supports the pae ora outcome in *Kia Manawanui* and *Whakamaua*.
- It enables us to adapt the *Whakamaua* objectives to the prevention and minimisation of gambling harm.

⁵⁰ Pae ora is also the driving outcome for *He Korowai Oranga: Māori Health Strategy* (He Korowai Oranga)⁵⁰ and *Whakamaua*, which both precede *Kia Manawanui*.

- It prioritises equity and wellbeing, which are also core aspects of the public health approach.
- It is system wide and therefore recognises the roles and efforts of other agencies, such as DIA, Te Hiringa Hauora, local government, non-governmental organisations (NGOs), communities and other groups.
- It aligns with DIA’s strategic direction (announced in 2020), that is, ‘Delivering community wellbeing through reducing gambling-related harms’.

This draft strategic goal has been designed to encapsulate what the strategy, as a sector-specific guide for service delivery, can contribute to pae ora via the four short-term objectives in *Whakamaua*. It therefore relates to things that the Ministry, in conjunction with others, particularly DIA and service providers, can achieve, in both the health and disability system and the gambling regulatory system more broadly.

Principles

We have adopted the following principles, which are part of the mental wellbeing framework articulated in *Kia Manawanui*⁵¹ and *Whakamaua*, which provide common values to guide the actions of organisations to enhance mental wellbeing.

- Upholding Te Tiriti

It is the Crown’s obligation to uphold Te Tiriti and protect and promote Māori health and equity. The principles of Te Tiriti, as articulated by the courts and the Waitangi Tribunal, underpin all actions in this strategy.

- Equity

All people in Aotearoa should experience the best support and care, regardless of where they live or who they are. The equity principle recognises that people have different levels of advantage and experience and require different approaches and resources to obtain equitable outcomes. This principle informs all the supports and services offered through this strategy.

- People and whānau at the centre

This principle is about strengthening the capacity of people and whānau to lead their own pathways to wellbeing through preventing and minimising gambling harm, while ensuring support is easily available and appropriate to their needs. This principle requires involving people with lived experience and their whānau and communities in the design and delivery of support and services.

⁵¹ *Kia Manawanui* builds on the direction set out in *Kia Kaha, Kia Māia, Kia Ora Aotearoa: COVID-19 Psychosocial and Mental Wellbeing Plan*.

- Community focus

This principle seeks to build on the strengths and assets of communities so that they can best support whānau and individuals. Strong communities provide a foundation of support and connection which is vital to prevent and minimise gambling harm. Communities may be based around a particular locality (such as a suburb or town), a particular identity or common interests/purpose (such as a profession, sports club or school).

- Collaboration

Collaboration recognises that issues are often interlinked and cannot be dealt with in isolation. Strong, trusting relationships are at the heart of collaboration. Collaboration recognises many organisations and people have roles to play in preventing and minimising gambling harm, including central government agencies, district health boards, local authorities, whānau, hapū and iwi, community organisations and educational institutions

- Innovation⁵²

The principle of innovation is about continuing to encourage and support new approaches, to achieve mental wellbeing. Innovation includes changing the way we deliver and design our services, to create more effective responses and more equitable outcomes.

These principles will be visible in everything we do: from the strategic framework itself to the service plan, our service commissioning and monitoring approaches, and in the way that we work with others. They will drive not only our activities, but the way we deliver our activities. A table illustrating how these principles align with preventing and minimising gambling harm is provided at **Appendix 2**.

Outcomes

The proposed strategic framework has new outcomes that are based on *Whakamaua*, with some adjustments to make them applicable to Māori and the broader population of Aotearoa New Zealand, as follows.

- Māori and all communities in Aotearoa New Zealand can exercise their authority to improve their health and wellbeing.
- The health and disability system and wider system to prevent and minimise gambling harm is fair and sustainable and delivers more equitable outcomes for all.
- The health and disability system and wider system to prevent and minimise gambling harm addresses racism and discrimination in all their forms.
- The inclusion and protection of mātauranga Māori throughout the health and disability system.

⁵² *Kia Kaha* also includes the principle of human rights, largely in relation to compulsory treatment in the mental health system. We have excluded this principle in this draft strategy as it has limited relevance to gambling prevention and harm minimisation.

Objectives

Set out below are four objectives to shape our strategic approach and service plan. These objectives provide a framework that other groups or organisations, including other Government agencies, local government, community organisations and civil society might find useful. The four proposed objectives align with the eleven strategic objectives of the current strategy (see **Appendix 3**).

All four objectives have been designed to align and enable the five *Hauora* principles (tino rangatiratanga, partnership, equity, active protection, and options) to be implemented in the arena of the prevention and minimisation of gambling harm.

Submissions generally supported the proposed strategic objectives and actions, although several submissions suggested changes and others sought more information about how these would be implemented and measured.

Objective 1: Create a full spectrum of services and supports

This objective acknowledges that one of the Ministry's key statutory roles is to provide services and supports that prevent and minimise gambling-related harm. It incorporates the public health concept that the needs and strengths of a population lie along a continuum or spectrum, and therefore support, including service responses, should as well.

The harm needs assessment confirmed the Ministry should continue to address gaps in the spectrum of services and supports that are currently provided, particularly in the areas of peer support, intensive treatment and for specific groups, such as people who have relapsed and families and whānau who are affected by gambling.

Objective 2: Shift cultural and social norms

This reflects a key objective of *Whakamaua* that is directly relevant to gambling harm prevention and minimisation and reflects a core aspect of the public health approach: a focus on building healthy environments through a range of methods, including public policy, health promotion and direct engagement with people. This objective is also informed by research findings that gambling behaviour, help-seeking behaviour and the concept of harm are all informed by cultural and social norms, attitudes, and beliefs.

The needs assessment found that there is a need to increase public awareness about the nature of harmful gambling and how to provide support for those with gambling problems, including de-stigmatisation. In this objective, the Ministry will be working closely with other agencies and interested parties.

Objective 3: Strengthen leadership and accountability to achieve equity

This reflects a key objective of *Whakamaua*. All systems require leadership, especially complex systems, such as harm prevention and minimisation. Without leadership, any system tends to decay into disorganisation, leading to confusion, duplication and gaps, lost opportunities, increased risks and reduced benefits. The Ministry is responsible for the overall system that relates to health services to prevent and minimise gambling harm, which includes components covering strategy, policies, research, and services and workforce. This system itself is part of the broader mental health and addiction and wellbeing sectors. This objective recognises the importance of strong system leadership to improve outcomes and complements DIA's focus on leadership of the gambling regulatory system.

Submissions tended to support the needs assessment findings that the Ministry could play a stronger leadership role in gambling harm prevention and reduction, by engaging with gambling harm services, gambling operators, researchers and communities and developing mutually respectful partnerships and relationships.

Objective 4: Strengthen the health and health equity of Māori, Pacific peoples, Asian peoples, and young people / rangatahi

This objective reinforces the commitment to address health inequities and risks of harm from gambling that research shows continue to disproportionately affect Māori and Pacific peoples for some time (compared with European/ Other New Zealanders. It is derived from and supports *Whakamaua*, the *Pacific Health and Wellbeing Action Plan 2020–2025 Ola Manuia*,⁵³ and the *Child and Youth Wellbeing Strategy*.⁵⁴ The 2020 HLS results indicated that Māori were 3.13 more likely to be moderate-risk or problem gamblers than non-Māori and non-Pacific and that Pacific peoples were 2.56 times more likely to be moderate-risk or problem gamblers than non-Māori and non-Pacific peoples.

Similarly, an analysis of research over several years' HLS, accounting for ethnicity, gender and socioeconomic deprivation, has found that compared with European/other New Zealanders, of those who gamble the Asian group's risk factor is 9.5 times higher. The 2021 needs assessment notes that internationally, the risk factors for developing harmful gambling include: being male, being young, belonging to a particular ethnic group, single marital status, low educational and/or occupational status and residence in urban areas.

⁵³ Focus area 6 of *Ola Manuia* is centred on mental wellbeing, including improving mental wellbeing for Pacific communities. One of the outcomes for this focus area is to 'strengthen initiatives to prevent and minimise harmful gambling in Pacific communities.

⁵⁴ Discussed further below in the 'Priority Populations' section.

Priority action areas

The priority action areas have been designed to reflect the key actions to be taken to achieve the corresponding objective. These are drawn from the needs assessment, build on previous strategy proposals, and are expected to be reviewed after six years.

The priority action areas also reflect the contributions of DIA and Te Hiringa Hauora because their activities in the gambling arena will also affect whether the strategy will achieve its goal. The proposed priority action areas are as follows.

Action areas for objective 1: Create a full spectrum of services and supports

- Identify barriers to accessing gambling-harm minimisation services and supports (including identifying gaps) (Ministry of Health).
- Design and deliver quality gambling-harm minimisation services and supports (Ministry of Health).
- Develop a skilled, enabled, culturally safe and responsive workforce that includes expertise from clinical and lived experience perspectives (Ministry of Health).

The actions in this area align to the *Hauora* principles of equity and options and supports the four *Whakamaua* outcomes, as well as *pae ora*, to be realised in the prevention and minimisation of gambling harm. Key strategy principles that will be activated include upholding Te Tiriti, equity, people and whānau at the centre, community focus, collaboration and innovation.

Action areas for objective 2: Shift cultural and social norms

- Ensure that people have the information and support to make healthy choices about gambling for themselves and others (Ministry of Health, Te Hiringa Hauora, gambling industry operators).
- Support people to participate effectively and equitably in decisions about their communities⁵⁵ (Ministry of Health and DIA, territorial authorities).
- Reduce the stigma attached to gambling harm that prevents people from accessing services and supports (Ministry of Health and Te Hiringa Hauora).

The actions in this area align to the *Hauora* principles of active protection, equity and partnership to be realised in the prevention and minimisation of gambling harm. Key strategy principles that will be activated are upholding Te Tiriti; equity; people and whānau at the centre and community focus.

⁵⁵ For example, through providing information to increase community awareness of gambling harm, grant distribution and related issues.

Action areas for objective 3: Strengthen leadership and accountability to achieve equity

- Support healthy policies at national, regional and local levels that prevent and minimise gambling harm (Ministry of Health DIA, and territorial authorities).
- Identify improvements to the legislative and regulatory framework to reduce gambling-related harm (DIA).
- Ensure gambling operators are effectively preventing and minimising harm from gambling and support the improvement of harm minimisation practices (DIA).

The actions in this area align to the *Hauora* principles of tino rangatiratanga, active protection and equity, and enable them to be realised in the prevention and minimisation of gambling harm. Key strategy principles that will be activated are upholding Te Tiriti; equity; people and whānau at the centre; community focus; collaboration and innovation.

Many submissions mostly from NCGM, services and lived experience sectors also sought changes to the broader gambling policy, legislative or regulatory frameworks. This was expressed through calls to reduce NCGM venues and machine numbers, to strengthen local authority roles, host responsibility training and accountability, to further limit advertising and sponsorship, and set tighter controls. As noted above, the Government has also committed in Kia Manawanui to a review of the Gambling Act with a particular focus on reducing harm from online gambling and pokies.

Action areas for objective 4: Strengthen the health and health equity of Māori, Pacific peoples, Asian peoples and young people / rangatahi

- Collaborate and co-design with iwi and other Māori organisations; Pacific and Asian communities; young people/rangatahi; and people with lived experience of gambling harm to prevent and minimise gambling harm (Ministry of Health).
- Enable the development of kaupapa Māori and gambling-harm prevention and minimisation services centred around the whānau (Ministry of Health).
- Enable the development of Pacific values-based gambling-harm prevention and minimisation services (Ministry of Health).
- Enable the development of Asian values-based gambling-harm prevention and minimisation services (Ministry of Health).

The actions in this area align to the *Hauora* principles of tino rangatiratanga, partnership, active protection, options and equity and enable them to be realised in the prevention and minimisation of gambling harm. Key strategy principles that will be activated are upholding Te Tiriti; equity; people and whānau at the centre; community focus; collaboration and innovation.

Many submissions recommended engaging with relevant priority populations and lived experience voices in a collaborative way, and some questioned how the Ministry would give effect to Te Tiriti, for example in co-design. The Ministry notes these matters are also part of the sector transformation and is committed to implementing these over the next levy period. The impact of the health sector transformations, including the roles of the Māori Health Authority and local iwi-Māori partnership boards, can be determined once the enabling legislation is finalised in 2022. The Ministry will develop action plans for each priority population and will incorporate the new roles noted above as appropriate once the details are known, as the strategy is implemented.

Promoting health equity is highlighted in this objective, but equity is inherent in all four objectives and as such will be promoted through all action areas.

Priority populations

Submissions endorsed the priority populations identified for the strategy as: Māori, Pacific peoples, Asian people and young people/rangatahi. The first three groups were priority populations for the previous strategy, and their risk has not reduced to a level that would suggest a population-neutral or universal approach should be taken.

Submissions confirmed the importance of engaging with young people/rangatahi⁵⁶ and including them in developing public health and early intervention services, with an emphasis on education. The feedback validated the growing research evidence that online gambling can increase young people's vulnerability to gambling harm. Adding this group aligns with the Child and Youth Wellbeing Strategy (CYWS). For example, supporting whānau to address gambling harm contributes to ensuring children and young people/rangatahi 'are loved, safe and nurtured' (CYWS outcome 1). Similarly, when gambling does not negatively impact on the material wellbeing of the whānau, children and young people/rangatahi are more likely to 'have what they need' (CYWS outcome 2), and when their own mental wellbeing is supported to address and prevent gambling harm, children and young people/rangatahi are 'happy and healthy' (CYWS outcome 3).

We note that these population groups are not homogenous and there is diversity within each of them. There is also significant crossover in these groups, for example, Māori and Pacific populations are youthful, more likely to have low incomes and disproportionately experience gambling harm. Disability is also associated with lower incomes. Some submissions questioned why we had not identified other groups. The priority groups are those based on research evidence; to identify where to focus services, however, we expect services to be accessible and responsive to address gambling harm related needs of anyone who needs them.

⁵⁶ In this draft strategy, young people / rangatahi relates to people aged under 25 years, as set out in the Child and Youth Wellbeing Strategy (see the Child and Youth Wellbeing Strategy website at: <https://childyouthwellbeing.govt.nz/resources/child-and-youth-wellbeing-strategy>).

Figure 4: Draft strategic framework outcomes and objectives

Population outcome: pae ora – healthy futures for Māori and all New Zealanders				
Strategic goal: To promote equity and wellbeing by preventing and reducing gambling-related harm				
Objectives for the PMGH strategy	Whakamaua health and disability system outcomes [adapted for gambling harm]			
	Māori and all communities in Aotearoa New Zealand can exercise their authority to improve their health and wellbeing.	The health and disability system and wider system to prevent and minimise gambling harm is fair and sustainable and delivers more equitable outcomes for all.	The health and disability system and wider system to prevent and minimise gambling harm addresses racism and discrimination in all their forms.	The inclusion and protection of mātauranga Māori throughout the health and disability system.
1. Create a full spectrum of services and supports	Identify barriers to accessing gambling-harm minimisation services and supports (including identifying gaps)			
	Design and deliver quality gambling-harm minimisation services and supports			
	Develop a skilled, enabled, culturally safe and responsive workforce that includes expertise from clinical and lived experience perspectives			
2. Shift cultural and social norms	Ensure that people have the information and support to make healthy choices about gambling for both themselves and others			
	Support people to participate effectively and equitably in decisions about their communities			
			Reduce the stigma attached to gambling harm that prevents people from accessing services and supports	
3. Strengthen leadership and accountability to achieve equity	Support healthy policies at national, regional and local levels that prevent and minimise gambling harm			
	Identify improvements to the legislative and regulatory framework to reduce gambling-related harm	Ensure gambling operators are effectively preventing and minimising harm from gambling and support the improvement of harm minimisation practices		
4. Strengthen the health and health equity of Māori, Pacific peoples, Asian peoples and young people / rangatahi	Collaborate and co-design with iwi and other Māori organisations; Pacific and Asian communities; young people / rangatahi; and people with lived experience of gambling harm to prevent and minimise gambling harm			
	Enable the development of kaupapa Māori and gambling-harm prevention and minimisation services centred around the whānau			
	Enable the development of Pacific values-based gambling-harm prevention and minimisation services		Enable the development of Asian values-based gambling-harm prevention and minimisation services	

 Ministry of Health

 Ministry of Health and DIA

 Ministry of Health and Te Hiringa Hauora

 DIA

What needs to change

Based on the above, the key changes to implement the strategy should:

- strengthen system leadership, which is wider than just gambling harm and the mental health and addiction sector, and involves working across government as well as with communities and the sector
- strengthen the focus on equity and public health approaches, which includes addressing the stigma associated with gambling and gambling harm that prevents people from seeking help
- strengthen collaboration and opportunities to engage and support Māori and Pacific people, Asians communities, young people/rangatahi, people with lived experience and the sector
- empower affected communities and priority populations and lived experience to have a greater involvement in the design and delivery of services and supports
- focus on developing a skilled, culturally safe, diverse and appropriate workforce, including supporting entry into the workforce for Māori, Pacific peoples, Asian peoples, young people/rangatahi and people with lived experience
- continue to develop and test innovative service and support models – with a focus on groups that experience the highest levels of gambling harm and expanding digital services and supports
- continue to use research and evidence to inform our approach.

These shifts in focus, together with the principle to 'put people and communities at the centre', will enable us to better address inequities for priority populations. Refer to the draft service plan for further information about proposed service activities.

How we will measure progress

Several submissions wanted more details about how we would monitor progress, which submissions from industry recommending performance targets.

We will know if we have made a difference by listening to the feedback we receive, for example, from our communities, service providers and expert advisory and lived experience groups, and through analysing data and evidence, including research, evaluation and service data.

We will measure and report on progress by:

- publishing data, evidence and research, including clear accessible summaries of key findings. We currently publish research and evaluation reports, clinical service data, prevalence data, as well as information about services on our website⁵⁷
- commissioning and publishing a needs assessment every three years. The next needs assessment, due to be commissioned in 2023, will consider the impact of the strategy including any of proposed changes outlined in this draft that are adopted.

We will also explore the development of a set of service- and system-level indicators for gambling harm. In response to submissions noted above, we will consult with interested stakeholders as we develop long term indicators. These indicators may include rates of harm and service access with an equity lens, for example, by population group and geographical location. They will take account of work currently being done by the Ministry and Mental Health and Wellbeing Commission as well as the transformation of the health and disability system.

⁵⁷ www.health.govt.nz/our-work/mental-health-and-addiction/addiction/gambling

4 Draft service plan 2022/23 to 2024/25

Purpose of the service plan

The proposed service plan below sets out the Ministry's service and investment priorities and budgets for the three years from 1 July 2022 to 30 June 2025.

These are the Ministry's commitments for how it will work towards delivering the strategic goals, outcomes, objectives and priority action areas outlined in the strategic plan. This covers priority action areas led by the Ministry and Te Hiringa Hauora, in collaboration with DIA and other stakeholders.

The proposals respond to recommendations from the needs assessment, feedback from consultation hui and submissions, and findings from other available research. They also build on progress and lessons taken from the current service plan.

We are committed to strengthening system leadership and collaboration to reduce longstanding inequities in gambling harm.

We recognise that gambling harm inequities continue to affect priority populations (Māori and Pacific people, Asian people and rangatahi). Each of these groups has called for greater involvement in service design, evaluation, and research, to develop services and supports that innovate and respond to this diversity.

We are also committed to increasing access to services and supports and reversing the trend where we see client interventions declining whilst numbers experiencing gambling harm increase with population growth.

We have listened to and considered consultation feedback and are proposing to increase investment in new and enhanced activities because we believe that this is necessary to enable more effective system-wide leadership and response to prevent and minimise gambling harm.

The table below summarises the proposed service and investment priorities.

Table 1: Summary of service and investment priorities

Service and investment priorities	Summary of service plan commitments
Strengthen our public health approach including prevention	We will fund public health services and initiatives to building community awareness and resilience, address stigma and barriers, and enable access to services and supports. This will reflect the diverse experiences of priority populations, including young people, and people with lived experience.
Enable innovative, culturally appropriate service and support models	The Ministry will re-tender for public health and clinical intervention services in early 2022. This will include kaupapa Māori services and services based on Pacific and Asian world views. We are proposing to increase investment in clinical services to increase the FTE rate for gambling harm clinical intervention and support services to align with other Ministry-funded mental health and addiction clinical FTE rates. We will also develop and evaluate innovative service models and approaches.
Invest in digital services and supports	We will develop digital service and supports to provide choice and be more accessible, innovative and responsive to different needs and preferences.
Strengthen system and sector leadership and collaboration	We will work in collaboration with Māori and other priority populations, service providers, agencies, the research and evaluation section gambling industry. We will commission and work with services to enable sector and community leadership. We will invest in the National Coordination Service and International Gambling Conference and Think Tank.
Sustain funding in research and evaluation	This will better inform our understanding of gambling behaviour and service efficacy, informed by greater engagement with affected communities. This includes further research into youth and online gambling.
Invest in developing a skilled, enabled, culturally safe and responsive workforce	We will strengthen training pathways to develop and diversify the gambling harm and peer workforce. This will include a range of scholarships for priority populations and people with lived experience to enter the gambling harm workforce, including New Zealand Qualification Authority (NZQA) level 7 and lower level qualifications and peer workforce qualifications. We will continue to invest in workforce development for the contracted public health and clinical gambling harm workforce.
Invest in stronger Ministry leadership and delivery	We are proposing an increased to the Ministry's operating costs to strengthen the Ministry's leadership function and deliver an expanded work programme.

How the service plan aligns with the strategic framework

The strategic framework highlights the priority action areas that align with the service plan, these include

- placing people at the centre, including lived experience of gambling harm, affected groups, communities and stakeholders
- a stronger focus on equity and supporting priority populations: Māori, Pacific peoples, Asian peoples and young people/rangatahi, by developing age and culture appropriate services and support
- strengthening public health prevention and education, including a new focus to support for young people/rangatahi and to address stigma related to gambling and gambling harm
- an increased focus on creating a diverse, skilled, culturally responsive and safe workforce, including support for Māori, Pacific peoples, Asian peoples, young people/rangatahi and people with lived experience enter the workforce
- better sharing of information and evidence from research and evaluations to enable robust, evidence-based decisions about services and policies.

Most of the submissions that commented on the service plan supported the overall scope and mix of services, the proposed research priorities and new investments, particularly activities to:

- address health inequities, including rangatahi as a priority population, and investments to develop the gambling harm and peer workforce
- develop more culturally appropriate and intensive support models of care, to improve access and choice
- strengthen the approach to public health, to address stigma and improve health education
- strengthen the voice of lived experience and peer support, and
- continue developing technological and service innovations.

We note that several of the proposed strategic priority actions and objectives described in the strategic plan will permeate throughout the service plan. For example, the strategic focus to address equity issues and to provide a spectrum of services and support necessarily requires identifying and responding to the needs of Māori, Pacific, Asian and young people (the priority populations) and placing people at the centre, which will be reflected to varying degrees in each of the activities described in the service plan. For example, to:

- ensure there is meaningful, inclusive engagement, to collaborate with affected communities and lived experience in service design, delivery, and evaluation
- provide age appropriate, culturally responsive and holistic service models, such as to support Kaupapa Māori services or services based on Pacific and Asian world views. This will identify barriers to equitable access and provide a range of services and supports along a continuum of need

- improve awareness of the risks and signs of gambling harm, how to seek help and making positive behaviour and lifestyle changes and enable supportive conversations to challenge stigma and enhance mana
- enable innovation and flexibility, supported by evidence from research and evaluation to improve equitable access and outcomes
- develop a diverse, skilled, culturally responsive and safe gambling harm workforce.

Table 2 shows how the activities in the proposed service plan align with the strategic objectives that they are most likely to impact.

Some submissions suggested the proposed changes did not go far enough to address the causes of problem gambling and should be 'bolder' and more was required in research. Industry submissions, mostly from NCGM sector, did not support "more of the same" or additional funding unless it would make the strategy more effective. They called for an overhaul of services, to improve access to face-to-face counselling, after-hours, and weekend support, and provide for more longer term, holistic support.

We acknowledge many submissions affirmed the needs assessment conclusion that more progress needs to be made. The proposed service plan described below includes additional new investments to address identified gaps and priorities that we expect will contribute to this change. As discussed in the strategic framework above, change also needs to be balanced against the need to provide for continuity of services to meet the needs of cohorts within the population.

Societal and cultural change of the kind required to achieve our strategic goal: 'promoting equity and wellbeing by preventing and reducing gambling-related harm', will take time to impact on our priority populations (Māori, Pacific peoples, Asian peoples and young people/rangatahi) as will changes to enablers such as attitudes to gambling harm, service models and workforce mix, capacity, and capability. The current strategic framework has a six-year timeframe, and work is proposed to develop long term indicators to measure progress towards improving the health equity and wellbeing in relation to gambling harm.

Table 2: Service plan activity by strategic objectives

Service plan activity area	Objective 1 Create a full spectrum of services and supports	Objective 2 Shift cultural and social norms	Objective 3 Strengthen leadership and accountability	Objective 4 Strengthen the health and health equity of Māori and Pacific peoples, Asian peoples and young people/rangatahi
Public health				
Primary prevention (public health action)	✓	✓	✓	✓
Workforce development (public health)	✓	✓	✓	✓
Awareness and education programme (include youth)	✓	✓		✓
De-stigmatisation media campaign – new		✓		✓
National coordination service			✓	✓
Gambling Harm Lived Experience Advisory Group	✓	✓	✓	✓
MVE administration service and database	✓			✓
Conference support			✓	
Clinical intervention				
Clinical interventions and support	✓	✓		✓
Helpline and web-based services (e-services)	✓	✓		✓
Data collection and reporting			✓	✓
Workforce development (clinical)	✓	✓	✓	✓
Research/evaluation				
Research	✓	✓	✓	✓
Evaluation (including outcomes reporting)	✓	✓	✓	✓

Service plan activity area	Objective 1 Create a full spectrum of services and supports	Objective 2 Shift cultural and social norms	Objective 3 Strengthen leadership and accountability	Objective 4 Strengthen the health and health equity of Māori and Pacific peoples, Asian peoples and young people/rangatahi
New services and innovation				
New ways to address inequity (public health and intervention services)	✓	✓		✓
Technology, digital tools and services	✓	✓	✓	✓
Intensive support model	✓			✓
Peer workforce and expansion	✓	✓		✓
Developing NZQA level 7 gambling harm content	✓		✓	✓
Gambling Harm workforce scholarships – new	✓		✓	✓
Ministry operating costs				
Advice about gambling harm, strategy and policy	✓	✓	✓	✓
Contract management (services, R&E)	✓	✓	✓	✓
Data analysis	✓	✓	✓	✓

Indicative budget for 2022/23 to 2024/25

The proposed service plan outlines the services that the Ministry considers it will require for the 2022/23 to 2024/25 levy period to make further progress towards the strategy's goal and objectives. The plan also sets out the estimated costs of providing the activities to prevent and minimise gambling harm.

The draft service plan outlines a total investment package of \$76.123 million over three years, which is a proposed increase of \$15.784 million from the current levy period. These costs cover the four nominal budget areas, plus a line item for new services and innovation:

- public health services
- clinical intervention and support services
- research and evaluation
- new services and innovation
- Ministry operating costs.

Table 3 below shows the indicative cost of the budget proposed for the new levy period from 1 July 2022 to 30 June 2025. These totals include the costs incurred from activities that were planned for the current levy period will not be completed until the new levy period. These delays, due to impacts from the response to COVID-19, contributed to a forecast underspend of \$6.452 million approximately that will be carried forward. This spending is included in the total costs for the 2022/23–2024/25 period.⁵⁸

Table 3: Budget to prevent and minimise gambling harm (GST exclusive), 2022/23 to 2024/25

Service area	2022/23 (\$m)	2023/24 (\$m)	2024/25 (\$m)	Total (\$m)
Public health services (harm prevention and minimisation)	8.050	8.800	7.990	24.840
Clinical intervention and support services	10.571	11.571	12.071	34.213
Research and evaluation	1.765	2.393	1.500	5.658
New services and innovation	2.831	2.769	2.341	7.941
Ministry operating costs	1.157	1.157	1.157	3.471
Total (\$m)	24.374	26.690	25.059	76.123

Note: The service areas are discussed in more detail later in this document. Budget totals may not sum due to rounding.

⁵⁸ The forecast underspend is a consequence of \$5 million underspend being transferred into the current levy period, with some delays in spending because of the response to COVID-19.

Areas of additional investment

Table 4 shows the changes in funding by service area compared with the budget for the current strategy period.

Table 4: Proposed budget changes compared with current levy period (over three years)

Service area	Change (\$m)	Total (\$m)
Areas increased		Total
Public health services (harm prevention and minimisation)	+4.310	+16.755
Clinical intervention and support services	+8.970	
New services and innovation	+2.941	
Ministry operating costs	+0.534	
Areas decreased		
Research and evaluation	-0.971	-0.971
Total change		+15.784

The Ministry has considered the submissions and where appropriate has revised proposals and funds allocated to position services so they will have the greatest impact on preventing and minimise gambling harm.

The key areas of additional investment compared with the current strategy are listed below, showing the three-year total funding allocated to each of these:

- strengthen public health and education services, including addressing stigma and for young people/rangatahi (\$0.650 million)
- dedicated funding for the multi-venue exclusion administration service and database (\$0.800 million)
- building workforce capability and capacity through scholarships (\$0.489 million), Level 7 paper on gambling harm (\$0.200 million).
- increase the FTE rate for gambling harm clinical intervention and support services to align with other Ministry-funded mental health and addiction clinical FTE rates (\$6.796 million increase on current strategy budget)
- invest in digital/online services and supports \$2.500 million (included in the clinical services helpline and web support three-year total of \$5.800 million)
- address the stigma and discrimination experienced by people who experience gambling harm (\$3.000 million)
- increase Ministry operating costs to deliver an expanded work programme (\$3.741 million).

The rationale for each item listed is discussed in the relevant section of the service plan.

Public health services

Internationally, Aotearoa New Zealand's public health approach to preventing and minimising gambling harm is seen as a strength of our integrated strategy.

Public health services are focused on enabling people to be healthy and improving the health of populations. These services cover health promotion; engaging with local community groups; including iwi; increasing community action; raising community awareness about gambling and gambling harm; working with territorial authorities on their gambling venue policies; and supporting the public health awareness and education programmes at a local and regional level.

Submissions broadly agreed on the importance of health promotion, prevention and early intervention, but submissions from service providers, lived experience and priority populations expressed concerns that a one-size-fits all approach to health promotion did not meet the needs of priority populations and called for greater involvement in service development.

We intend to direct this to the actions as shown in Table 5 below.

Table 5: Summary of public health key actions

Investment area	Actions
Develop quality gambling harm minimisation services and supports	<ul style="list-style-type: none"> Continuing investment in primary prevention (public health services) to empower people and communities to take control of their health and wellbeing to reduce gambling-related harm Invest in digital services and support FTE rates for workers in gambling harm public health services will be standardised across service providers). Enabling and embedding lived experience representation and input through the Gambling Harm Lived Experience Advisory Group.
Develop a skilled, enabled and culturally responsive workforce	<ul style="list-style-type: none"> Continuing investment in primary prevention (public health services) to empower people and communities to take control of their health and wellbeing to reduce gambling-related harm (includes standardising FTE rates for workers in gambling public health services). Enabling and embedding lived experience representation and input through the Gambling Harm Lived Experience Advisory Group.
Ensure that people have the information and support to make healthy choices about gambling for both themselves and others	<ul style="list-style-type: none"> Continuing to invest in a health promotion programme to raise awareness and educate people about the signs and risks of harmful gambling and how they can respond and seek help. Develop and promote gambling harm material for young people/rangatahi.
Reduce the stigma attached to gambling harm that prevents people from accessing services and support	<ul style="list-style-type: none"> Investing in a de-stigmatisation initiative focused on priority populations to reduce the stigma attached to gambling harm and encourage people to access services and supports.
Support healthy policies at national, regional and local levels that prevent and minimise gambling harm	<ul style="list-style-type: none"> Enabling collaboration and leadership across the gambling sector by continuing investment in the National Coordination Service and international gambling conference and think tank. Continuing to fund the MVE database and administration service to support people who have opted to avoid gambling venues. Enabling and embedding lived experience representation and input through the Gambling Harm Lived Experience Advisory Group.

Table 6: Public health budget (GST exclusive), by service area, 2022/23 to 2024/25

Service area	2022/23 (\$m)	2023/24 (\$m)	2024/25 (\$m)	Total (\$m)
Primary prevention (public health services)	4.700	4.700	4.700	14.100
Workforce development (public health)	0.130	0.130	0.130	0.390
Awareness and education programme	1.680	1.680	1.680	5.040
De-stigmatisation initiative	0.900	1.440	0.660	3.000
National Coordination Service	0.130	0.130	0.130	0.390
Gambling Harm Lived Experience Advisory Group	0.130	0.130	0.130	0.390
MVE administration service and database	0.180	0.310	0.310	0.800
Youth Public Health in Schools	0.200	0.200	0.250	0.650
Conference support	0.000	0.080	0.000	0.080
Total (\$m)	8.050	8.800	7.990	24.840

Note: budget totals may not sum precisely due to rounding.

Key areas of new investment that described below include:

- destigmatisation, with support to engage with priority populations
- young people/rangatahi as a new priority population
- additional support for the MVE service.

Primary prevention public health services

The Ministry will tender for new service contracts to begin on 1 July 2022, aligning with the new levy period. We intend to standardise the FTE rates across providers of public health gambling harm services. This will follow a review of the geographical distribution of funding for public health services, to prioritise funding more equitably towards areas experiencing higher levels of gambling harm and with higher Māori, Pacific and Asian populations. The Ministry will continue to support culturally appropriate community engagement through the funding of culturally responsive public health services.

Workforce development (public health)

The Ministry will continue to fund workforce development for the gambling-harm public health workforce.

The core competencies (including cultural competencies) for the public health workforce are identified in the Core Competencies for the Preventing and Minimising Gambling Harm Public Health Workforce.⁵⁹ These tools are available to enable the public health workforce to assess their competency levels as well as associated training and development needs.

In addition, we will commission training and support to build workforce competence in delivering public health activity that aligns to the following five PMGH public health areas:

- Policy Development and Implementation
- Safe Gambling Environments
- Supportive Communities
- Aware and Motivated Communities
- Effective Screening Environments.

The public health workforce will be expected to demonstrate their competence and capability throughout their work. This will include an emphasis on understanding different world views through cultural competence training, including their ability to work with Māori, Pacific and Asian communities and rangatahi.

Awareness and education programme

The Ministry will continue to invest in a health promotion programme to raise awareness and educate people about the signs and risks of harmful gambling and how they can respond and seek help. We expect that this will build on work being delivered under the current strategy led by Te Hiringa Hauora (described earlier).

Key priorities for the new levy period will include:

- improving awareness of gambling harm amongst Māori and Pacific peoples, Asian peoples and young people/rangatahi (see below), including recognising the risks and signs of harmful gambling; enabling supportive conversations and challenging stigma; knowing how to seek help and making positive behaviour and lifestyle changes. The focus on young people/ rangatahi is new and additional resources are proposed to develop appropriate supports.
- promoting the national Gambling Helpline and Asian Helpline; face-to-face services and the rebranded national gambling campaign Safer Gambling Aotearoa (previously Choice Not Chance)

⁵⁹ <https://www.hetaumata.co.nz/public-health/pou-toru-core-competencies>

- developing potential self-help digital tools to improve access to relevant information, help and online support
- improving gambling environments and host responsibilities through online training and gamble host resources, including translations into te reo Māori, Pacific, and Asian languages. Listening to people with lived experience of gambling harm will help identify barriers to service access and inform the design of better access to help-seeking services.

Support for young people / rangatahi

As noted above, in response to submissions, we propose to develop a public health approach to preventing and minimising gambling harm for young people/rangatahi, to be implemented in schools. For rangatahi, gambling is often associated with other harms including from substances and there is already work underway to address this. We therefore intend to maximise opportunities to work with existing approaches to prevent harm (from substance abuse) in the health and education settings.

De-stigmatisation initiative

The Ministry proposes to commission a de-stigmatisation initiative, with a focus on priority populations, to address the stigma and discrimination experienced by people who experience gambling harm and enhance mana. This was highlighted in the 2021 needs assessment.

We recognise stigma comes in many forms and the concept of stigma itself may be identified differently in different communities, however we are using stigma related to gambling harm to encompass the range of perspectives and cultural differences that deter people seeking help or accessing services and support. Stigma has many components and can be experienced at an individual, community or institutional level, or by association. For example, this may be experienced as feeling shame, losing face, low self-esteem, negative stereotyping and discriminatory behaviours. Similarly, families and friends may experience stigma by association or from the reaction of others.

Submissions confirmed stigma was a barrier to seeking help for oneself or others, and deterred people from working in gambling harm services. Submissions from priority populations, and people with lived experience, stressed that a 'one size fits all' approach would fail to meet their needs. There were calls to collaborate with Māori, Pacific, Asian and young people respectively, including with affected communities and people with lived experience, to really understand different cultural dynamics, barriers and influences that apply. This approach would identify cultural differences that are inherent within broad population groupings and allow for the initiatives to be targeted to meet these different needs.

In response the Ministry proposes to increase the funding for the de-stigmatisation initiative to enable a focus on priority population groups designed in collaboration with people with lived experience, priority populations, affected communities and the gambling sector.

We will work with Te Hiringa Hauora/Health Promotion Agency to ensure this work is developed in a way that meets the expectations of priority populations for more agile and targeted messaging that is relevant and appropriate to specific communities. The funding will cover market research and engagement with affected communities to inform a second phase of participatory design/co-construction design to identify, develop, test and deliver age and culture appropriate messaging and approaches. This will be designed to challenge negative perceptions and stereotypes, to convey positive images of people who have gambling problems and encourage people to seek help from available services.

This initiative is expected to build on and align with the public health messaging of the awareness and education programme but has additional resourcing to ensure effective and appropriate messaging is developed for different priority populations to challenging the stigmas relating to gambling harm as they affect each of their communities.

National Coordination Service

The National Coordination Service (NCS) is a key support for services preventing and minimising gambling harm. It informs all service providers of significant developments, facilitates training opportunities, provides regular updates and administers an advisory group for infrastructure services. This group comprises representatives from the gambling harm sector with expertise of public health, counselling and lived experience, Māori, Pacific, Asian communities.

The Ministry acknowledges the needs assessment findings that all interviewed stakeholders felt there needed to be stronger partnerships and leadership through improved communication and engagement. The NCS will be one of the key mechanisms for enabling this.

Gambling Harm Lived Experience Advisory Group

The Ministry will continue to fund the Gambling Harm Lived Experience Advisory Group (previously referred to as the 'consumer network'). Established during the current strategy, this group will continue to inform service design, research and evaluation, and the education and awareness campaign through engagement with the Ministry and other agencies.

The indicative costs (see Table 6) cover group travel, meeting, work activity and coordination costs. This proposal aligns with the Ministry's Mental Health and Addiction Directorate commitment to encourage lived experience participation and strengthen their networks, reach and influence.

Multi-venue Exclusion Administration Service and database

Established in 2018, the national Multi-venue Exclusion (MVE) Administration Service will continue to administer and coordinate the operation of the MVE process in Aotearoa New Zealand.⁶⁰ MVE enables an individual to self-exclude from multiple gambling venues. The administration service is essential for the continued effectiveness of the MVE process. It maintains working relationships with MVE stakeholders (including NCGM societies and venues, the supplier of the gambling exclusion electronic database, gambling harm service providers and DIA).

Alongside the MVE service, the Ministry will continue to fund an electronic database to serve as a central repository for all venue exclusions. The database that is being trialled, went live on 20 July 2020. As its key user, the MVE service will continue to work closely with the database supplier and maintain links with other users. Both services are contingent on each other's operations for the successful management of the MVE process in Aotearoa New Zealand.

Conference support

The Ministry contributes part funding for a biennial international gambling conference held in Aotearoa New Zealand as well as an associated international think tank. The conference had been planned to take place in June 2020 but was postponed due to COVID-19. The next conference will be held in 2022, funded under the current levy period.

⁶⁰ This was previously funded from the primary prevention (public health action) budget. Creating a separate budget line provides for surety of funding and an improved line of sight for this spend.

The Ministry intends to continue to contribute to the costs of hosting this biennial conference. The indicative budget includes \$80,000 for the Ministry's contribution towards the costs of the conference and think tank expected to take place in 2024.

Holding international conferences on gambling harm in Aotearoa New Zealand promotes the country as a world leader in preventing and minimising gambling harm. It also enables practitioners, researchers, industry representatives and government officials from around the world to meet and exchange ideas specific to gambling harm. The needs assessment highlighted the need for effective leadership and partnerships to improve the coordination of the gambling sector and strengthen internal communication and collaboration. Some participants in the conference recognised the think tank and conference as providing a forum and opportunity for shared and collective collaboration.

Clinical intervention and support services

This section covers services to treat and assist people affected by gambling harm including families, whānau and affected others.

The indicative budget for these services is \$34.213 million for the 2022/23–2024/25 period. Indicative priority areas for 2022/23 to 2024/25 are to:

- deliver services that respond to the needs of different population groups; in particular, those groups where there is strong evidence of inequality and inequity in gambling harm
- increase the FTE rate for gambling harm clinical intervention and support services to align with other Ministry-funded mental health and addiction clinical FTE rates
- continue to explore innovative ways to provide treatment for the whole person through joined-up gambling, drug, alcohol and mental health services (within the constraints of the levy regulations), for example, service approaches based on whānau ora.

There are also new ways of working proposed, detailed in the new services and innovation section, that will lead to improved clinical services. This will cover new service models to address inequities and gaps, develop the clinical and peer workforce, and to improve cultural responsiveness.

Table 7: Intervention services budget (GST exclusive), by service area, 2022/23 to 2024/25

Service area	2022/23 (\$m)	2023/24 (\$m)	2024/25 (\$m)	Total (\$m)
Clinical interventions and support	9.256	9.256	9.256	27.768
Helpline and web-based services (including new investment for digital services and support)	1.100	2.100	2.600	5.800
Data collection and reporting	0.015	0.015	0.015	0.045
Workforce development (clinical)	0.200	0.200	0.200	0.600
Total (\$m)	10.571	11.571	12.071	34.213

Note: budget totals may not sum precisely due to rounding.

Key areas of new investment that described below include:

- increasing FTE rates for clinical intervention services
- developing and expanding digital services and support.

Clinical intervention and support

Clinical intervention and support services line includes a range of interventions delivered in a variety of settings (including prisons) to people who are experiencing gambling harm, including people who gamble and those affected by someone else’s gambling.

The four core intervention areas are: brief intervention, full intervention (individual or group therapy), facilitation and follow-up services. ‘Brief intervention’ in this context refers to brief screening for problems, typically in a non-clinical environment. This should not be confused with brief clinical interventions, for example, by telephone.

We fund general services and dedicated Māori, Pacific and Asian services. All services are open to people experiencing gambling harm. General services aim to minimise gambling-related harm for all members of the community and consider how to deliver appropriate services for Māori and Pacific peoples, Asian peoples and other priority population groups.

We are committed to improving access to services for all people adversely affected by gambling. Services and activities designed to identify people who are experiencing harm are crucial in providing early prevention and intervention treatment. This approach enables us to work actively to minimise the impact harmful gambling has on individuals, their families and whānau, and affected others.

We acknowledge the needs assessment's findings that services need to be more equitable, culturally responsive and safe. We intend to re-tender for clinical intervention in early 2022 for contracts to begin with the new levy period on 1 July 2022. This will include undertaking Māori and Pacific tenders for Māori and Pacific services as well as tenders for general and Asian services.

We also intend to increase the FTE rate for gambling-harm intervention services to achieve parity with other Ministry-funded mental health and addiction services. This will help address long-standing issues in recruitment and retention in the gambling-harm sector and enable the development of a sustainable and quality workforce.

We expect that clinical intervention services can be provided within prisons and youth justice facilities within Aotearoa New Zealand where possible and appropriate.

Helpline and web-based services

Submissions from services, providers, NCGM and priority populations called for greater use of e-tools and emerging technologies (applications) to address gambling harm and improve access to and choice of information, services, and support, for example in the context of making services more accessible, particularly for young people. In response, the Ministry proposes to allocate additional resources to expand the online supports and services available, which could include self-help tools.

Helpline and web-based services provide:

- information
- access to intervention services for people who are unable or do not wish to access face-to-face services
- referral to other gambling harm service providers
- information on self-help, peer-to-peer support options and assessment guides.

Digital services and supports

The Ministry proposes additional investment to expand and develop digital tools, services and (self-help) supports available online. This would not extend to funding hardware. Submissions from services, providers, NCGM and priority populations called for greater use of e-tools and emerging technologies to address gambling harm and improve access to and choice of information, services, and support. Sector views differed on what would be best, with submissions from services in favour of expanding digital service offerings, while some industry submissions requested more direct technical support such as technology to expand the MVE system.

Helplines

The Ministry funds two forms of telephone-based gambling harm support, the national Gambling Helpline and the Asian Helpline.

The Gambling Helpline provides a free 24/7 service and is a first contact point for people in crisis as a result of harmful gambling. It also provides a back-up for other services, such as when face to face services are not available outside of working hours. It also provides coverage in rural areas, where there are no face-to-face services. This is critical to the Ministry's service delivery model. Performance improvement is a priority for this service, and a wide range of actions are planned or under way, including:

- ensuring the Gambling Helpline includes specialist addictions counsellors and all Gambling Helpline counsellors have completed gambling practitioner training
- delivering better outcomes for Māori and Pacific, including building in te ao Māori and culturally appropriate service delivery, with bilingual and bicultural models of care using Māori and Pacific clinicians and specialists
- working with the gambling harm sector and providers to improve referral pathways to community-based services, with improved continuity of care
- improved data collection, expanding it to include data on demographics, service user experience and service user outcomes.

The Asian Helpline is a service for the Asian community. This is provided by PGF Group of the Problem Gambling Foundation of New Zealand and funded out of clinical intervention and support services. The helpline provides free and confidential services for Asian people experiencing gambling harm, with counsellors offering support in multiple languages.

Data collection and reporting

The Ministry largely carries out data collection and reporting internally. The small sum, specifically budgeted each year for collecting and reporting on data, allows for an external provider to address data collection issues that require institutional knowledge and to make small technical adjustments if required.

Workforce development (clinical)

The Ministry will continue to fund workforce development and support for the gambling-harm clinical workforce.

A qualified and culturally competent clinical workforce able to offer culturally responsive services is crucial in reducing the harm for people affected by gambling including families, whānau and affected others. Qualified clinicians use best practice evidence-based tools to help alleviate and minimise the effects of harmful gambling and build skills to prevent relapse. Building the competence of the workforce to treat and support clients who present with co-existing issues and teaching clinicians how to use different treatment modalities will be a key focus. Training will also include an emphasis on understanding different world views through cultural competence training, including their ability to work with Māori, Pacific and Asian communities and rangatahi.

New providers and clinicians will also be supported to access training and support to become competent clinicians working in this sector.

Research and evaluation

The Ministry will commission and deliver a research and evaluation programme targeting strategic priority areas.

While some submissions supported the consultation proposal to reduce research funding, several recommended more research was required to strengthen the evidence base and inform the priority areas listed below. Some submissions also recommended that researchers and evaluators need to engage more with people with lived experience and affected communities and populations, to inform research and evaluation design as well as report findings to those communities.

In response, we have increased the amount allocated to the research and evaluation programme to ensure that it will be able to effectively inform the strategy and service development proposed. The proposed budget for research and evaluation is \$5.658 million for the 2022/23–2024/25 period. This amount is \$0.971 million less than the current levy period as funds have been prioritised to gambling harm services and support.

This budget takes account of delays in commissioning some of the research and evaluation proposals for this levy period due to COVID-19 restrictions and includes funding for the delivery of current commitments in the next levy period beginning on 1 July 2022.

Table 8: Research and evaluation budget (GST exclusive), 2022/23 to 2024/25

Service area	2022/23 (\$m)	2023/24 (\$m)	2024/25 (\$m)	Total (\$m)
Research	1.340	2.048	1.300	4.688
Evaluation (including outcomes reporting)	0.425	0.345	0.200	0.970
Total (\$m)	1.765	2.393	1.500	5.658

Note: budget totals may not sum precisely due to rounding.

The increased funding identified above compared to the consultation document budget reflects a stronger commitment to the strategy and a focus on:

- research into young people’s gambling and online gambling, two inter-related topics. The increase allows for more than one research project to be commissioned
- research into co-existing conditions for greater understanding of the barriers to preventing and minimising gambling harm
- increasing action research and evaluation with affected communities.

Strategic priorities for 2022/23 to 2024/25

The proposed research and evaluation programme is designed to strengthen the evidence base that supports all our work by informing policy and operational decisions to prevent and minimise gambling harm. Evaluation is embedded into all new services and innovation activities. The priorities below take account of the submissions to the consultation document, feedback from the needs assessment and the strategic framework focus areas outlined earlier.

The strategy research priorities include:

- obtaining longitudinal and prevalence data about gambling from population level surveys, including gambling components in existing large-cohort longitudinal studies as appropriate⁶¹
- studying patterns and impact of gambling on young people/rangatahi, and online gambling (to inform gambling harm and prevention strategies)
- assessing the relationship between gaming and gambling in relation to preventing and minimising gambling harm
- assessing barriers to equitable service and support access and outcomes, including for subgroups, for example, Asian communities, young people/rangatahi, new migrants and the disability community
- research into preventing and reducing gambling relapse and treatment dropouts
- evaluation of new service and innovation , for which delivery will continue into the new strategy period.

⁶¹ Such as the Pacific Islands Families Study and Growing Up in New Zealand.

As noted above, some research and evaluation projects were delayed and will be continue in the new levy period.

The Ministry accepts that stakeholders want better information about how research will be used, and that research and evaluation findings could be more accessible to the whole gambling sector and communicated in ways that resonate with different communities. The Ministry commits to work more closely with the gambling sector to make research and evaluation findings more accessible, to better communicate findings to all stakeholders and affected communities, and support application of these learnings into gambling harm services.

Learning from evaluations

The evaluation allocation in the table above includes funding to evaluate all new service and innovation activities as well as new activities identified in this proposals document, developed in response to submissions. Evaluation is an important part of the learning process to develop and bed in new services and supports, to continue or expand promising approaches and improve services to prevent and minimise gambling harm.

New services and innovation

This area of the service plan identifies areas of significant investment to develop new services and ways to respond, including new service components or service models and innovations. There are focused to improve services and address areas identified in the strategy such as persistent gambling harm or health inequities.

Typically, these activities are tested and evaluated to identify learnings and changes to incorporate into the relevant area of the service plan. All evaluation costs are met from the research evaluation allocation.

There are two streams within this area of the service plan:

- delivery of existing commitments under the current strategy
- new proposals to strengthen and develop a skilled, diverse, and culturally responsive workforce.

Table 9: Budget for new services and innovation (GST exclusive), 2022/23 to 2024/25

Service area	2022/23 (\$m)	2023/24 (\$m)	2024/25 (\$m)	Total (\$m)
New activities to address inequity (public health and intervention services)	1.138	1.138	1.138	3.414
Technology-related innovation	1.000	0.500	–	1.500
Intensive support	0.100	0.160	0.240	0.500
Peer workforce and expansion	0.350	0.688	0.800	1.838
Developing gambling harm content for NZQA level 7 paper	0.080	0.120	–	0.200
Gambling harm scholarships	0.163	0.163	0.163	0.489
Total (\$m)	2.831	2.769	2.341	7.941

Note Budget totals may not sum due to rounding.

Continuing current commitments in the new strategy period

The current strategy includes commitments to deliver several new service models that address inequities related to public health and intervention services. These activities will be completed after 1 July 2022, there is forecast spend that will occur in the new levy period. These activities will develop and test:

- new ways of providing public health and intervention services, to address inequities for priority groups who experience the most gambling harm, with a focus on Māori and Pacific peoples
- a clinically robust model of care based on intensive treatment for people experiencing severe gambling harm
- innovative uses of technology to manage or mitigate gambling harm
- development of a peer workforce for gambling harm services.

New activities to address inequity (public health and intervention services)

The needs assessment and submissions strongly recommended prioritising equity.

The Ministry has committed under the current strategy to commission a range of new activities to address inequity. The activities provide for local co-design and delivery of new ways of providing public health and intervention services to address inequities for Māori and Pacific peoples. Table 9 includes funding committed in the current levy period that will be spent to complete these activities over the first two years of the new levy period.

We are committed to applying the lessons learnt from these activities and evaluations to enable local providers and communities to develop innovative and culturally appropriate approaches to preventing and minimising gambling harm that work locally.

Additional funding is proposed for 2024/25 to enable us to incorporate learnings to into clinical and public health services.

Intensive support model

This new service model will develop and test a clinically robust model of care based on intensive treatment for people experiencing severe gambling harm. An intensive support option for clients with high needs is in line with a stepped-care model, where treatment intensity increases as a client's needs increase.

We will engage with the gambling sector, including providers, to develop this model of care. The design of the model will be informed by the literature review of the provision and effectiveness of residential care for gambling harm treatment⁶² which shows there is support for providing an intensive support option, largely based upon expert opinion and experience as there is limited research evidence. The people most severely affected by their gambling are likely to have complex issues and needs, so could benefit from attending a residential programme to prevent distractions and pressures in the community that may otherwise impact negatively on their treatment and recovery.

Technology innovation

Submissions from services, providers, NCGM and priority populations all supported greater use of e-tools and emerging technologies to address gambling harm and improve access to and choice of information, services, and support. Sector views differed on what would be best, with submissions from services in favour of expanding digital service offerings, while some industry submissions suggested technical solutions such as enhancing the MVE system.

The current strategy includes an allocation for 'technology investment' to develop and/or test technology and online support tools and other technological solutions to prevent and minimise gambling harm.. This workstream covers funding for 2022/23 and 2023/24 for delivery that will occur in the new strategy period.

Additional funding for digital services and supports is proposed in the clinical services section.

⁶² Provided by ABACUS Counselling, Training and Supervision Ltd.

Enabling a diverse skilled, and responsive workforce

Many submissions, mostly from service and health providers, supported the proposed investments to strengthen and diversify the gambling harm workforce to improve workforce capacity and capability. The proposals included enabling and recognising the specialist skillsets required within gambling harm services, as well as the need for adequate cultural competence and cultural safety training across the health and disability sector.

We propose to develop a skilled, enabled and culturally responsive gambling harm workforce by investing in:

- expanding the peer workforce
- incentivising qualifications uptake with scholarships to support Māori and Pacific peoples, Asian peoples and people with lived experience of gambling harm to undertake an addiction relevant qualification to work in the gambling harm services sector
- developing a degree-level paper specific to gambling harm, which has been identified as a gap in current education and training provision.

This is in addition to investing in workforce development for the PMGH clinical and public health workforce as outlined in the above sections.

Peer workforce service model and expansion

The Ministry is funding a peer workforce service model (pilot) under the current service plan 2019/20 to 2021/22. The model will be based in Auckland and run by a peer-led organisation. The model will run over two years, with Māori and Pacific peer roles the first being developed, working with clinical intervention and support services. The design of this model has been informed by a literature review and proposal process that we commissioned in 2020 from Te Pou.⁶³ This included an expert advisory group, with people of lived experience and gambling harm and mental health and addiction service providers. The model will continue into the new levy period.

We also propose additional funding, once the model is evaluated, to expand the peer workforce across both intervention and public health services. We will engage with the gambling sector and peer workforce organisations to develop and refine the peer workforce roles based on the model evaluation findings.

⁶³ Te Pou is a national workforce centre for mental health, addiction and disability. For more information, see the website for Te Pou at: www.tepou.co.nz.

Developing NZQA level 7 content covering gambling harm

Health practitioners working in gambling harm need to understand the specific interventions available, the specific pathways to problematic gambling and the ways in which families, whānau and affected others can identify gambling issues in others.

The Ministry's expectation is that all intervention practitioners will be:

- registered as a health practitioner who is permitted to practise within a relevant scope of practice under the Health Practitioners Competence Assurance Act 2003, or
- registered or endorsed by the Drug and Alcohol Practitioners' Association Aotearoa-New Zealand (dapaanz)⁶⁴ as having demonstrated the relevant specific competencies, or
- equivalently registered with another relevant professional organisation (for example, a counsellor registered with the New Zealand Association of Counsellors, Te Roopu Kaiwhiriwhiri o Aotearoa, NZAC).

We recognise that currently relevant qualifications available to those wanting to enter the workforce do not include a focus on preventing and minimising gambling harm, and we intend to address this gap. We will work with dapaanz, NZAC, education and training providers and the gambling sector to develop either a level 7 gambling-harm qualification and/or gambling-harm-specific content or a paper to include in existing level 7 addiction qualifications.

The Ministry remains committed to supporting the clinical intervention gambling harm workforce to achieve, or be on a pathway to achieving, the appropriate NZQA level 7 qualifications. Some submissions expressed concerns a Level 7 qualification would exclude people entering the workforce, and others suggested we should only develop a module that that could be used in various addiction qualifications. As noted below there are alternative pathways and support available to encourage people from priority populations or with lived experience to be trained in an area of the PMGH workforce, with scholarships proposed (see section following below).

Gambling harm scholarships

Targeted scholarships will be developed to grow the diversity, capability and capacity of the gambling-harm workforce. The scholarships will be developed specifically to enable Māori and Pacific peoples, Asian peoples, young people/rangatahi and people with lived experience of gambling harm (peers) to do addiction relevant tertiary study that will help them enter the gambling-harm workforce.

⁶⁴ www.dapaanz.org.nz

The scholarships will include:

- funding to undertake an NZQA level 7 addiction qualification, alongside support for professional development and practicum placements with providers. Scholarship recipients will be expected to take a gambling-harm level 7 qualification/or component when this becomes available
- funding to study a lower level NZQA qualification relevant to gambling, and peer workforce qualifications. The specific qualifications are to be confirmed. These scholarships have been included in response to submissions seeking support for lower level qualifications and alternative training support for the peer workforce.

Ministry of Health operating costs

Ministry operating costs (departmental expenditure) includes:

- providing strategic advice and information about gambling harm, and harm prevention and harm minimisation
- contributing to cross government strategy and policy to prevent and minimise gambling harm
- commissioning to deliver service plan commitments
- managing contracts, the research and evaluation programme and Client Information Collection (CLIC) database
- leadership and service development, helping to position gambling harm activities and services for the future. This would include aligning with the new health and disability system.

The Ministry proposes an increase to its operating costs to enhance its leadership function and ensure we can deliver the proposed expanded work programme and commitments outlined.

Table 10: Budget for Ministry operating costs (GST exclusive), 2022/23 to 2024/25

	2022/23 (\$m)	2023/24 (\$m)	2024/25 (\$m)	Total (\$m)
Total operating costs (\$m)	1.157	1.157	1.157	3.471

5 Draft levy rates for 2022/23 to 2024/25

Section 319(2) of the Gambling Act 2003 (the Act) states that the purpose of the levy is to 'recover the cost of developing, managing, and delivering the integrated problem gambling strategy'. The levy rates are set by regulation at least every three years. The next levy period is from 1 July 2022 to 30 June 2025 to match the next strategy.

Since the levy was first set in 2004, it has applied to gambling operators in four sectors: NCGM operators, casinos, TAB NZ and Lotto New Zealand.

Process for setting the levy rates

The Act sets out the process for developing and setting the levy rates needed to recover the cost of the strategy (see sections 318–320 of the Act).

As part of this process, the Ministry consulted on its estimated annual funding requirements and four alternative sets of estimated levy rates for 1 July 2022 to 30 June 2025. The figures in the four alternative levy calculation options discussed below should be considered indicative at this stage. Further details of costs and overall indicative budget are discussed in the relevant sections of the service plan.

The Ministry's consultation period ran from 29 August 2021 until 8 October 2021. The Ministry has considered the submissions received during that period when it developed this proposals document. It has now submitted this proposals document to the Minister of Health, the Minister of Internal Affairs and the Gambling Commission.

Submissions that commented on the proposed funding requirements and levy options were divided. While two thirds supported the proposed funding mix, NCGM and some industry submissions did not support further investment arguing the strategy had been ineffective in reducing harm and require bold change, not "more of the same". Some submissions argued funding should be reduced and services cut back, as presentations to services were declining. Others offered qualified support for additional spending if measures were introduced to make services accountable and assess their impact in reducing gambling harm.

Submissions from other sectors either supported the proposed funding and investment priorities or argued that much more funding would be required to effect real change or to compensate for increased operating costs.

The Ministry notes the Synergia 2019 report to the Gambling Commission which concluded that given gambling expenditure continues to rise, presentations are decreasing, and the prevalence of gambling harm is keeping pace with population growth, there is evidence to suggest that the levy funding should be increased to reflect the population growth and increased costs to providers.⁶⁵ This report also commented that 'rather than accept a historically determined budget envelope, the Ministry should assess what the needs are and develop a comprehensive strategy based on those needs. The levy should be based on the level of gambling harm and a robust strategy designed to address it'.

This section sets out the levy rate proposals in this document that have been referred to the Gambling Commission. The Gambling Commission may then obtain its own advice around the proposed levy rates and will convene a consultation meeting. It will subsequently make recommendations to the responsible Ministers. Cabinet will then approve the strategy, determine the level of funding to recommend to Parliament as the Ministry's appropriation, and endorse responsible Ministers' recommendations to the Governor-General on regulations setting out the sectors that will pay the levy and the relevant levy rates.

The levy formula

The formula listed in section 320 of the Act 'provides a mechanism for allocating among gambling operators, and collecting from them, the approximate cost' of the strategy.

The formula is:

$$\text{Levy rate for each sector} = \frac{\{(A \times W1) + (B \times W2)\} \times C}{D} \text{ plus or minus } R$$

where:

- A** = the estimated current player expenditure in a sector divided by the total estimated current player expenditure in all sectors that are subject to the levy
 - B** = the number of client presentations to problem gambling services that can be attributed to gambling in a sector divided by the total number of client presentations to problem gambling services in which a sector that is subject to the levy can be identified
 - C** = the funding requirement for the period for which the levy is payable
 - D** = the forecast player expenditure in a sector for the period during which the levy is payable
 - R** = the estimated under- or over-recovery of levy from a sector in the previous levy periods⁶⁶
- W1** and **W2** are weights, the sum of which is 1.

⁶⁵ Review of Ministry of Health Strategy to Prevent and Minimise Gambling Harm, Service Plan, and Formula For Levy Calculation – Report for the Gambling Commission – 8 February 2019.

⁶⁶ **R** was added to the formula by section 107 of the Gambling Amendment Act 2015, which came into effect on 3 March 2015.

The top line of the formula determines the dollar amount to be paid by each sector as its share of the total levy amount, taking into account any over- or under-recovery in previous levy periods.

The bottom line of the formula (**D**, forecast player expenditure in the sector) determines the levy rate that is necessary for a sector to pay its required contribution (the dollar amount) determined by the top line of the formula.

All other things being equal, the higher the forecast player expenditure for a sector, the lower that sector's levy rate will be. Player expenditure for each sector is defined in section 320(3) of the Act. For example, each levy rate is the amount per dollar of player expenditure a sector must pay. A rate of 0.85 means a sector must pay 0.85 cents for every dollar of player expenditure in the levy period to which the rate applies.

Estimated current player expenditure (A)

The formula in the Act requires the levy rate calculation take into account the latest, most reliable and most appropriate sources of information. The Ministry will use 2020/21 data, if available, for the final strategy document and levy calculations, but these were not available at the time of preparing this document.

The DIA has estimated current player expenditure using a variety of sources of information, including its NCGM electronic monitoring system (EMS), gambling operators' annual and half-yearly reports and information from the Inland Revenue Department (IRD).⁶⁷ Other data on gambling expenditure is available on DIA's website (www.dia.govt.nz).

Player expenditure by the four main gambling sectors for the years up to 2019/20 is shown in Table 11 below.

⁶⁷ The IRD provides gaming duty and problem gambling levy data to the DIA. The Tax Administration Act 1994 requires the IRD to use its best endeavours to protect the integrity of the tax system by (among other things) maintaining the confidentiality of the affairs of taxpayers.

Table 11: Gambling expenditure and proportions from the four main gambling sectors, 2009/10 to 2019/20

Year	NCGMs		Casinos		TAB NZ		Lotto New Zealand		Total
	\$m	%	\$m	%	\$m	%	\$m	%	\$m
2009/10	849	44.4	440	23.0	278	14.5	347	18.1	1,914
2010/11	856	43.2	448	22.6	273	13.8	404	20.4	1,982
2011/12	854	41.9	483	23.7	283	13.9	419	20.5	2,038
2012/13	827	40.5	490	24.0	294	14.4	432	21.1	2,042
2013/14	806	39.0	486	23.5	310	15.0	463	22.4	2,065
2014/15	818	39.1	527	25.2	325	15.5	420	20.1	2,091
2015/16	843	38.2	586	26.5	342	15.5	437	19.8	2,209
2016/17	870	37.3	572	24.5	338	14.5	555	23.8	2,334
2017/18	895	37.6	578	24.3	350	14.7	561	23.5	2,383
2018/19	924	38.5	616	25.6	332	13.8	530	22.1	2,402
2019/20	802	35.6	504	22.4	315	14.0	631	28.4	2,252

Notes: All values are actual (not inflation adjusted), in NZ dollars, GST inclusive and rounded to the nearest million. The sum of the rows may differ from the total shown in the 'Total' column due to rounding.

Source: The DIA expenditure figures from its website: www.dia.govt.nz/gambling-statistics-expenditure (accessed 12 March 2021).

Presentations (B)

The formula in the Act requires the levy rate calculation to take into account the latest, most reliable and most appropriate sources of information from the Ministry on client presentations to problem gambling services that can be attributed to a gambling sector required to pay the levy.

We generated the presentation figures used in the levy calculations in this document from data collected by our psychosocial intervention service providers. The figures relate to all clients who received a full facilitation or follow-up intervention session during the 12 months from 1 July 2020 to 30 June 2021.

Each qualifying client within each service provider counts as only one presentation for any specified time period (eg, during the course of a given 12-month period).

The figures exclude brief screening interventions and primary problem gambling modes (PPGM) in gambling sectors that are not subject to the levy (although these are recorded). Brief interventions essentially mean brief screenings carried out in non-clinical settings. They are excluded mainly because they are considered unrepresentative of a sector. This is because a sector's share of brief interventions will vary depending on the settings in which service providers decide to undertake them.

No changes have been made to the way in which we have recorded or weighted PPGMs since the last levy period. As previous documents have discussed the meaning of PPGMs at length, we do not intend to repeat that detail in this document but can provide an in-depth description if required.

Table 12 below show the presentations attributed to each of the four levy-paying sectors each year from 2011/12 to 2020/21.

Table 12: Presentations and proportions attributed to the four main gambling sectors, 2011/12 to 2020/21

Year	NCGMs		Casinos		TAB NZ		Lotto New Zealand		Total
	n	%	n	%	n	%	n	%	n
2011/12	3,708	64	1,188	21	548	9	339	6	5,783
2012/13	3,721	59	1,403	22	568	9	652	10	6,344
2013/14	3,871	59	1,413	22	651	10	590	9	6,525
2014/15	3,674	57	1,449	22	729	11	624	10	6,476
2015/16	3,251	54	1,221	20	696	12	812	14	5,980
2016/17	3,060	54	1,240	22	593	10	820	14	5,713
2017/18	2,635	53	1,135	23	515	10	657	13	4,941
2018/19	2,403	55	942	22	489	11	514	12	4,348
2019/20	2,098	54	898	23	405	10	508	13	3,909
2020/21	2,331	57	845	21	422	10	513	12	4,110

Note: The sum of the rows may differ from the total shown in the 'Total' column due to rounding. The figures in this table are lower than service data presentations described earlier because the levy calculation is based only on presentations attributed to the four main levy paying sectors.

Source: Service user data, Ministry of Health and 2020/21 CLIC data. URL: www.health.govt.nz/our-work/mental-health-and-addictions/problem-gambling/service-user-data/intervention-client-data (accessed 12 November 2021).

When considering the data presented in Table 12, note that from 1 October 2011, the Ministry required service providers to enter as PPGMs all forms of gambling that were causing a client 'significant harm' and to enter as secondary modes of problem gambling all forms of gambling that were causing a client 'harm' (up to a maximum of five in each case). Accordingly, the Ministry considers that its presentation figures from 2012/13 onwards are more reliable and appropriate than its earlier figures.

Other points to note from this table are as follows.

- The number of NCGM presentations peaked in 2009/10, but the share of NCGM presentations peaked in 2004/05. Both figures have been declining unevenly since those respective dates. These patterns probably largely reflect the trend for reductions in both the number of NCGMs and NCGM venues and in the total NCGM sector expenditure as a proportion of the total gambling expenditure. Since 2015/16, the NCGMs' share has remained at 53–57 percent.

- The *number* of casino presentations has increased each year since 2004/05 until peaking in 2014/15 and has declined slightly since. However, the casino *share* of presentations has remained steady at around 21–23 percent since 2016/17.
- The *number* of TAB NZ presentations has risen each year since 2004/05 until peaking in 2014/15. The *share* of TAB NZ presentations has remained steady at about 10–11 percent since 2016/17.
- The *number* of Lotto New Zealand presentations has continued to increase since 2013/14 and peaked in 2016/17. The *share* of presentations also peaked in 2016/17 and has remained steady at 12–14 percent over the last few years. These patterns coincide with the increase in expenditure over this time.

The funding requirement (C)

The funding requirement represented by **C** in the formula is the total cost of the strategy for 2022/23 to 2024/25, which the Ministry estimates as \$76.123 million.

The draft service plan described in **section 4** above sets out details about the \$76.123 million cost to provide and implement the strategy. This amount is \$15.784 million more than for the current levy period. The reasons for this additional funding are discussed in the Service Plan.

Forecast player expenditure (D)

The amounts represented by **D** in the formula are sector-by-sector forecasts of the amounts that DIA expects people who gamble to spend on the gambling products of the four levy-paying gambling sectors in the period 2022/23–2024/25. The higher the forecast expenditure, the lower the levy rate necessary for a sector to pay its required contribution (as determined by the top line of the formula).

As noted above, these forecasts by DIA took into account the latest, most reliable and most appropriate sources of information on player expenditure, including its NCGM EMS, gambling operators' annual and half-yearly reports and information from IRD. The reasoning behind the DIA forecast for each sector is set out below.

Future changes in gambling regulation could have an impact on the levy rates and levy amount collected. These forecasts assume the current regulatory settings will remain and there is no significant shift in gambling expenditure patterns, for example towards offshore online gambling. There may be changes in gambling expenditure as a result of future changes to the Act or regulations, for example many people are of the view there should be stronger regulatory control on NCGM. Should there be changes to the Act or regulations, this could have an impact on expenditure. However, it is not possible to forecast the likely impact of any changes until the nature of any legislative or policy changes has been made clear.

Non-casino gaming machines

The number of NCGMs has declined from 25,221 in 2003 to 14,704 as of 30 June 2021 (there are 1,059 active venues).⁶⁸ NCGM expenditure also declined for several years but has seen yearly increases since 2013/14. For example, from a historical low of \$806 million in 2013/14, expenditure increased to \$818 million in 2014/15, \$843 million in 2015/16, \$870 million in 2016/17, \$895 million in 2017/18 and \$924 million in 2018/19. There was a noticeable decrease down to \$802 million in 2019/20, reflecting the impacts of COVID-19 restrictions as NCGM venues were closed during the COVID-19 lockdown. That said, expenditure for 2020/21 was \$987 million, making this the highest 12-month period on record.

DIA forecasts expenditure to continue with small annual increases over the next three years. Some variation in expenditure from year to year is expected, but the size of that variation cannot be forecast in advance.

Casinos

Over the last three years, spending on casino gambling has fluctuated. Figures from the DIA show expenditure of \$578 million in 2017/18, \$616 million in 2018/19 and \$504 million in 2019/20. Casino expenditure is impacted by variations in international tourist numbers, including 'VIP'(high-stakes) gamblers. This has been most noticeable in the 2019/20 year given the restrictions due to COVID-19, which are ongoing at the time of preparing this document. DIA anticipates some growth in expenditure for 2020/21 to 2024/25, but its forecast is relatively conservative.

TAB NZ

Spending on TAB NZ products was relatively flat for some years. However, it hit a high of \$350 million in 2017/18, with slight declines to \$332 million in 2018/19 and \$315 million in 2019/20. DIA anticipates modest expenditure growth in the next three-year period. Potential increases in expenditure brought about by technical innovations and product developments may be impacted by competition in the racing and sports betting market from offshore betting agencies.

⁶⁸ Data taken from the Gaming machine profits (GMP dashboard) webpage on the website for Te Tari Taiwhenua, Department of Internal Affairs at: <https://www.dia.govt.nz/gambling-statistics-gmp-dashboard> (accessed 9 November 2021).

Lotto New Zealand

Spending growth on Lotto New Zealand products has been relatively high, but volatile, since 2005/06. This volatility appears to relate to the number of large jackpots in a year. Strong growth has continued over recent years: DIA noted player expenditure of \$555 million in 2016/17, \$561 million in 2017/18, \$530 million in 2018/19 and \$631 million in 2019/20. The significant increase in 2019/20 has been attributed to the rare occurrence of a Powerball Must-be-Won draw in February 2020, and their ability to continue operating during the COVID-19 lockdowns.⁶⁹

Lotto New Zealand is also working to diversify its portfolio by introducing new games, like online bingo,⁷⁰ to help mitigate fluctuations in spending on its lottery products.

DIA expenditure forecasts by year and sector are shown in Table 13. DIA forecasts that Lotto New Zealand will experience stronger expenditure growth but that the other three sectors will experience steadier expenditure growth over the same period.

Table 13: Forecast expenditure by sector (GST-inclusive), 2022/23 to 2024/25

Forecast expenditure	NCGMs	Casinos	TAB NZ	Lotto New Zealand
2022/23 (\$m)	1051.51	618.74	359.98	707.00
2023/24 (\$m)	1076.44	630.30	365.54	742.00
2024/25 (\$m)	1105.91	641.87	371.11	762.00

Note: These forecasts are for the next levy period. They are based on best estimates at this time; but were made before the actuals for 2020/21 (expected in early 2022) were available. The further we forecast out, the less reliable that forecast can be. Therefore, we advise that while these 'out years' follow a general trend, they are not as reliable as a yearly forecast, for the next year ahead.

Estimated levy under- or over-recovery, by sector (R)

Section 107 of the Gambling Amendment Act 2015 came into effect on 2 March 2015. It requires the calculation of each sector's levy rate to take into account any underpayment or overpayment from that sector in previous levy periods. This change ended the previous system, which had been deemed unfair, whereby all four gambling sectors were required to meet any net underpayment or overpayment of the levy amount across all sectors from the previous levy period.

⁶⁹ Lotto NZ Statement of Intent 2022-2025 <https://assets.mylotto.co.nz/assets/uploads/abf813a2-d920-11eb-bad1-a613caf5faf2.pdf>.

⁷⁰ <https://www.gets.govt.nz/NZLC/ExternalTenderDetails.htm?id=23370625>

In its 2019 report to the responsible Ministers, the Gambling Commission commented that R should be calculated by hindsight adjustment of earlier estimates of both C and D to produce (amend) the previously expected relative contribution from each sector to a corrected calculation of the actual cost of the strategy to the end of the previous levy period.^{71 72} The Commission considered this approach to be consistent with the objective intent of the 2015 amendments to the Act and to provide a fairer allocation of any underpayment or overpayment, as adjustments to each sector would be made in the same proportions as received.

Accordingly, the Ministry has calculated R by calculating its projected total spending for the period 2004 to 2022 by:

- using the actual spending for the 2015/16 to 2020/21 period
- using estimated expenditure for 2021/22
- adding these sums to the actual spending recorded for the levy period for each previous year between 2004/05 and 2014/2015.

This totals to \$314.789 million, which becomes the target recovery amount from the four levy-paying gambling sectors. We estimate the levy payments received by IRD will total \$319.991 million by 30 June 2022. We calculated this by totalling actual payments from each sector made to IRD up to 30 June 2021, together with the estimates of sector payments up to 30 June 2022. We then calculated the amount of levy that each sector was expected to pay by:

- referring to the relevant Cabinet-approved strategy before the start of each levy period to identify each sector's expected share of the levy requirement for each three-year period
- using those shares to calculate the amount each sector was expected to pay as its contribution to the Ministry's spending in each levy period
- totalling these amounts across all levy periods to arrive at the amount each sector was expected to pay up to 30 June 2022.

R is the difference between the expected levy payments for each sector and the actual amount received in payments. Table 14 shows the values of R obtained. Overpayment amounts are deducted from (credited to) the next levy period amounts required from each sector, while any underpayments are added to those amounts.

⁷¹ This takes account of any underspend for the 'previous levy period'.

⁷² Gambling Commission. *Report On The Proposed Problem Gambling Levy: 2019–2022*. 13 February 2019.

Table 14: Estimated underpayment or overpayment of problem gambling levy, 2004/05 to 2021/22, by sector

Sector	\$m (GST exclusive)
NCGMs	-3.758
Casinos	0.128
TAB NZ	0.060
Lotto New Zealand	-1.632
Net difference (total)	-5.202

Note: A negative figure indicates an expected overpayment for the levy periods to 30 June 2022.

The weightings (W1 and W2)

The Act requires the Ministry to apply a weighting between current player expenditure (**W1**) and presentations (**W2**) to help determine the cost (**C**) that each sector is required to pay in levy.

The levy is intended to recover the cost of developing and implementing a strategy to prevent and minimise gambling harm. The definition of 'harm' in the Act is very broad. Presentations represent only a small subset of gambling harm, and one that tends to be at the acute end of the continuum. Those who seek help represent only a small proportion of those who experience harm. There can be no assurance that gambling sectors are associated with harm across the continuum of harm in precisely the same proportions as they are associated with presentations to intervention services.

The Act specifies that, in addition to intervention services, the strategy must include measures to promote public health by preventing and minimising the harm from problem gambling. It must also encourage gambling research (not just problem gambling research) and evaluation. The proportion of presentations to intervention services attributable to a particular gambling sector is not necessarily an appropriate indicator for determining the share that sector should bear of public health, research and evaluation costs.

The table below shows the proportion of expenditure (**A**) for the 1 July 2019 to 30 June 2020 financial year (to be updated when 2020/21 data become available) and presentations (**B**) attributed to each levy-paying sector for the 1 July 2020 to 30 June 2021 financial year.

Table 15: Share of expenditure and presentations by sector, 2020/21

NCGMs		Casinos		TAB NZ		Lotto New Zealand	
Expenditure	Presentations	Expenditure	Presentations	Expenditure	Presentations	Expenditure	Presentations
0.356	0.567	0.224	0.206	0.140	0.103	0.280	0.125

The top line of the levy formula determines the amount each sector shall pay. When a sector's proportion of expenditure is substantially different from its proportion of presentations (W1 and W2 respectively), the weighting between expenditure and presentations is critical to determine how much each sector will be required to pay.

The strategy is intended to prevent and minimise gambling *harm*; it is not intended to address the amount spent by people who gamble per se.

In the 2018 proposals document the Ministry indicated it considered any weighting of more than 30 percent on expenditure would be inappropriate, because it would unfairly penalise operators of relatively benign forms of gambling with high expenditure. A weighting of 30 percent or less on expenditure necessarily implies a weighting of 70 percent or more on presentations.

Each 'presentation' represents a person who is seeking help because they have been harmed, either by their own or by someone else's gambling. Each presentation is attributed across the PPGMs for that client. Therefore, the Ministry has considered that presentations, as one indicator of harm, albeit harm at the acute end of the continuum, should be allocated a substantially heavier weighting than expenditure. This also tends to support a weighting of at least 70 percent on presentations and no more than 30 percent on expenditure.

That said, the Ministry also recognises that too high a weighting on presentations alone does not adequately attribute to each sector its fair share of costs for low to moderate harm, or of strategy activities such as public health not covered by presentations to intervention services.

The Gambling Commissions 2019 report⁷³ recommended a 30/70 weighting for the reasons summarised above. Consequently, a 30/70 weighting was chosen for the 2019/20 to 2021/22 period, which was a change from all previous levy periods that have used the 10/90 weighting.

The Ministry notes that any weighting from 30/70 to 5/95 would comply with the provisions in the Act. We have previously recommended a 30/70 weighting but have not yet concluded whether we will make a similar recommendation this time to inform Ministers' decision-making. We are not aware of any factors that might suggest an alternative weighting should be considered this time but would be interested in the Gambling Commission's views on the appropriate levy weighting that should apply for the next levy period.

⁷³ Gambling Levy Main Report: Hon Tracey Martin and Hon Jenny Salesa – 13 February 2019 https://www.gamblingcommission.govt.nz/GCwebsite.nsf/wpg_URL/Reports-Publications-Problem-Gambling-Levy-2019-2022!OpenDocument.

Options

Levy calculations for each option

Tables 16–19 set out the implications for each of the four alternative levy weightings 5/95, 10/90, 20/80 and 30/70 respectively, based on an appropriation of \$76.123 million to the Ministry for problem gambling activities for 2022/23 to 2024/25. Each table shows the levy rate per sector and the expected amount of levy payments over the three-year period and compares these with each sector’s levy payments for the current levy period. A positive figure indicates that the sector is expected to pay more in the next levy period, and a negative figure indicates that the sector is expected to pay less.

Table 16: Estimated levy rates and payments (\$m) per sector, 5/95 weighting

Collection period starts 1 July 2022 (all GST exclusive)	NCGMs	Casinos	TAB NZ	Lotto New Zealand
Sector levy rates (%)	1.19	0.84	0.73	0.38
Expected levy payment (\$m)	38.483	15.884	8.005	8.402
(\$m) Comparison with current levy payments (negative = less)	15.516	4.671	1.831	0.496

Table 17: Estimated levy rates and payments (\$m) per sector, 10/90 weighting

Collection period starts 1 July 2022 (all GST exclusive)	NCGMs	Casinos	TAB NZ	Lotto New Zealand
Sector levy rates (%)	1.17	0.84	0.74	0.41
Expected levy payment (\$m)	37.836	15.884	8.115	9.065
(\$m) Comparison with current levy payments (negative = less)	14.869	4.671	1.941	1.159

Table 18: Estimated levy rates and payments (\$m) per sector, 20/80 weighting

Collection period starts 1 July 2022 (all GST exclusive)	NCGMs	Casinos	TAB NZ	Lotto New Zealand
Sector levy rates (%)	1.12	0.85	0.77	0.46
Expected levy payment (\$m)	36.219	16.073	8.444	10.171
(\$m) Comparison with current levy payments (negative = less)	13.252	4.860	2.270	2.265

Table 19: Estimated levy rates and payments (\$m) per sector, 30/70 weighting

Collection period starts 1 July 2022 (all GST exclusive)	NCGMs	Casinos	TAB NZ	Lotto New Zealand
Sector levy rates (%)	1.07	0.86	0.80	0.52
Expected levy payment (\$m)	34.602	16.262	8.773	11.497
(\$m) Comparison with current levy payments (negative = less)	11.635	5.049	2.599	3.591

Comment on weighting options

The above tables show that, under each scenario:

- the higher the weighting on expenditure:
 - the higher the share of the levy to be paid by Lotto New Zealand because that sector's proportion of gambling expenditure is much higher than its proportion of presentations
 - the higher the share to be paid by the TAB NZ
- the higher the weighting on presentations:
 - the higher the share to be paid by the NCGM sector (because a higher percent of presentations are attributed to that sector, but its proportion of expenditure is much lower)
 - the lower the share to be paid by Lotto New Zealand and the TAB NZ
- the share of the levy to be paid by casinos is not very sensitive to any weighting changes because that sector's proportion of expenditure is relatively close to its proportion of presentations.

The proposed levy rates for each gambling sector, would be higher under any weighting option for 2022/23 to 2024/25 than they are for the current levy period; based on levy payments received, forecast expenditure for the remaining three-year period to 30 June 2022 and the proposed budget appropriations. Sector payments would also increase compared with what they pay now.

While overpayments are predicted for the levy periods to 30 June 2022, the overpayment amount is much smaller than it was at 30 June 2019. Because the overpayments are lower and the Ministry's proposed appropriation is higher, the proposed levy rates and expected levy payments are higher. The levy formula adjusts for these factors in generating levy rates for the next levy period.

Appendices

Appendix 1: Aligning with other strategic documents

This draft strategic plan aligns with and complements a range of other strategic documents, as discussed below.

Whakamaua: Māori Health Action Plan 2020–2025 (Whakamaua)

Whakamaua sets out a pathway for the health and disability system to achieve pae ora – healthy futures for Māori. Its framework includes four objectives to: accelerate the spread of kaupapa Māori and services centred around whānau, shift social and cultural norms; strengthen system leadership; and reduce health inequities and health loss for Māori.

We have adopted the latter three as objectives in the draft strategic framework, expanding the ‘reduce health inequities and health loss for Māori’ objective to include Pacific peoples, Asian peoples and young people / rangatahi.

We have incorporated the ‘accelerate the spread of kaupapa Māori and services centred around whānau’ objective as a priority action area under a new objective: ‘strengthen the health and health equity of Māori, Pacific peoples, Asian peoples and young people / rangatahi’.

Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025 (Ola Manuia)

Ola Manuia is the key overarching document for improving health outcomes for Pacific peoples in Aotearoa. Developed in 2019/20, with input from Pacific communities, *Ola Manuia* is designed as a high-level guide for reflecting the needs and aspirations of the Pacific peoples of Aotearoa across the health and disability system. Focus area 6 of *Ola Manuia* is centred on mental wellbeing, including improving mental wellbeing for Pacific communities. One of the outcomes for this focus area is to ‘strengthen initiatives to prevent and minimise harmful gambling in Pacific communities.

Pacific communities believe success will have been achieved for this focus area when Pacific peoples have:

- awareness of key mental health issues for Pacific communities
- knowledge and skills to improve mental wellbeing and resilience in Pacific youth and young adults
- knowledge of mental health and wellbeing support services
- reduced levels of psychological distress
- increased access to, and use of, primary and secondary mental health services
- decreased rates of attempted and achieved suicides in young people.

“Pacific people have equitable health outcomes” is one intended outcome of *Ola Manuia*. We have incorporated this outcome in the draft strategic framework. *Ola Manuia* explicitly recognises that strengthening initiatives to prevent and minimise harmful gambling in Pacific communities is a key part of achieving better wellbeing for Pacific people. It also has a strong focus on workforce development across the health and disability sector. This draft strategy includes service and workforce proposals that will help achieve these goals.

Pacific Aotearoa Lalanga Fou (Lalanga Fou)

Lalanga Fou was developed in 2018 and was based on engagements that the Ministry for Pacific Peoples undertook with over 2,500 Pacific people across Aotearoa New Zealand. *Lalanga Fou* contains the needs and aspirations for Pacific peoples to ensure we can achieve the Pacific Aotearoa vision: ‘we are confident in our endeavours; we are a thriving, resilient and prosperous Pacific Aotearoa’. From these engagements, four goals were developed, the third of which is ‘Resilient and healthy Pacific peoples’. The sub-goals that sit within this third goal are as follows.

- There is a stronger focus on improving preventative and integrated primary and behavioural health and social services for Pacific families and communities and less reliance on acute care.
- Pacific peoples’ values and experiences lead the design and delivery of health and wellness services.
- Mental health and wellness are better supported, from both within and outside Pacific communities, with services specifically developed utilising Pacific cultural frameworks and contexts.
- Pacific children have a healthy start in life.

These sub-goals are reflected in our draft strategy.

Delivering community wellbeing through reducing gambling-related harms: Gambling Group Strategic Direction 2020–23

DIA's new strategic direction pivots the regulator's focus toward reducing gambling-related harms. DIA is also taking a system leadership approach to regulating gambling in Aotearoa New Zealand by understanding the roles of interested parties, driving innovative approaches to addressing gambling harms and preparing for future challenges before they occur.

The strategic direction has committed DIA to five key focus areas: effective Treaty partner, enabled workforce, regulatory excellence, evidence-based and informed, and system leadership. These focus areas will guide DIA's approach to reducing gambling-related harms over the following two years.

Appendix 2: Bringing our principles to life

Table 20 below shows how the proposed principles of this draft strategy have been expressed in the draft strategic framework and service plan.

Table 20: Expressing the principles through the strategic framework and service plan

Principle	As expressed in the draft strategic framework and service plan
Te Tiriti o Waitangi	The strategic framework links to the principles of Te Tiriti via <i>Whakamaua</i> . Actions are proposed that can be mapped to each of the principles, and these links are explained in more detail in the body of this draft strategy.
Equity	Both the strategic framework and the service plan focus strongly on equity, as recommended by the needs assessment.
People and whānau at the centre	The strategic framework puts people who gamble, their families and whānau, and the gambling-harm prevention and minimisation workforce at the centre of several proposed objectives and approaches. The service plan proposes increased support for the peer workforce and for approaches to bring the voice of lived experience into everything we do under the strategy.
Community focus	Gambling-harm prevention and minimisation is supported not only by the strategy but also by requirements under the Gambling Act for each territorial authority to develop and review its own gambling policy, covering how gambling services in its district will be provided. Councils must make an assessment of the social impacts of gambling within their communities when reviewing their policies every three years. Public health services commissioned under the strategy support communities to engage in this type of proposal. The majority of gambling-harm prevention and minimisation services are delivered by non-governmental organisations (NGOs) with strong community links and supporting these NGOs to be successful is essential.
Collaboration	In this strategy, we will look for opportunities to collaborate with other services and supports that work with the same communities or in the same location as gambling-harm prevention and harm minimisation services.
Innovation	The draft service plan continues the recent focus on innovation and expands it from a focus on technology to a focus on new ways of delivering service (that is, service modes such as online options) and new ways of commissioning services (that is, <i>kōrero Māori</i> commissioning approaches).

The table below works through the practical implications for the Ministry and its service providers of operating the principles in all work undertaken under the strategy. These behaviours will be incentivised by Ministry support and incorporated into Ministry contracts as opportunities arise.

Table 21: Operating the principles in practice

Principle	Examples of upholding behaviours
Upholding Te Tiriti o Waitangi	<ul style="list-style-type: none"> • Ensuring mainstream services support mana motuhake (Māori self-determination) • Supporting and funding kaupapa Māori services to ensure they succeed • Ensuring all services and approaches actively protect Māori who are affected by gambling • Planning and taking opportunities to build partnerships with iwi and other Māori groups and organisations at every level (including strategic and service)
Promoting equity	<ul style="list-style-type: none"> • Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes • Understanding that a health inequity is a difference that we can attribute to social, cultural and economic factors, rather than biomedical ones, and that such inequities are not random • Being proactive in identifying and addressing inequities • Monitoring service delivery, funding and outcomes by population group • Taking steps to address unfair differences between groups in every area (that is, access, suitability/quality of service, outcomes)
Putting people and whānau at the centre	<ul style="list-style-type: none"> • Valuing, including and supporting the voices of lived experience • Making sure services are welcoming for people and their families and whānau • Building a sustainable peer workforce • Enhancing and supporting kaupapa Māori, Pacific and Asian services • Ensuring processes and requirements are people centred
Taking a community focus	<ul style="list-style-type: none"> • Maintaining and growing the capability of public health services to work with local communities and territorial authorities • Working to better integrate gambling prevention and harm minimisation services with other social and health services that are serving the same communities • Understanding communities' attitudes to gambling
Being collaborative	<ul style="list-style-type: none"> • Building strong relationship across government, the harm minimisation sector and the gambling industry • Being willing to learn from others
Being innovative	<ul style="list-style-type: none"> • Being willing to try new initiatives and ways of doing things • Creating spaces where it is safe to innovate • Using evidence and research to make change

Appendix 3: Key continuities

The new draft strategic framework re-frames and re-structures the previous framework, responding to environmental changes and lessons learnt over recent years. It is closely related to the previous strategic framework because the prevention and minimisation of gambling-related harm is a long-term activity. Like many areas of health promotion, prevention and early intervention, the activities in this space need to be continuous as there are always new cohorts of people coming through, as well as people having different needs at different times in their lives. All 11 strategic objectives of the current strategy can be addressed under the four new objectives.

Table 22: Relationship of previous strategic objectives to new objectives

New objectives	Create a full spectrum of services and supports	Shift cultural and social norms	Strengthen system leadership and accountability	Strengthen the health and healthy equity of Māori, Pacific peoples, Asian peoples and young people / rangatahi
Previous gambling harm strategic objectives	A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm (6)	People participate in decision-making about activities in their communities that prevent and minimise gambling harm (3)	There is a reduction in gambling-harm inequities between population groups (particularly Māori, Pacific peoples and Asian peoples, as the populations that are most vulnerable to gambling harm) (1)	Māori have healthier futures, through the prevention and minimisation of gambling harm (2)
	Services enhance people's mana and build life skills and resiliency to improve healthy choices that prevent and minimise gambling harm (7)	People understand and acknowledge the range of gambling harms that affect individuals, families, whānau and communities (5)		Healthy policy at the national, regional and local level prevents and minimises gambling harm (4)
	People access effective treatment and support services at the right time and place (10)	Gambling environments are designed to prevent and minimise gambling harm (8)		A programme of research and evaluation establishes an evidence base that underpins all activities to prevent and minimise gambling harm (11)
		Services raise awareness about the signs and range of gambling harms that affect individuals, families, whānau and communities, and how to respond (9)		

Service and research contracts initiated under the previous strategic framework and its objectives will continue but will be gradually shifted to the new framework as opportunities occur (for example, through contract renewal or tender processes).

List of abbreviations

AUT	Auckland University of Technology
CLIC	Client Information Collection
CYWS	Child and Youth Wellbeing Strategy
daapanz	Addiction Practitioners' Association Aotearoa New Zealand
DIA	Department of Internal Affairs
EGM	Electronic gaming machine
EMS	Electronic monitoring system
FTE	Full-time equivalent
GHAW	Gambling Harm Awareness Week
GMP	Gaming Machine Profits
HLS	Health and Lifestyles Survey
HRP	Host Responsibility Programme
IRD	Inland Revenue Department
MVE	Multi-venue exclusion
NCGM	Non-casino gaming machine
NCS	National Coordination Service
NGO	Non-governmental organisation
NGS	National Gambling Study
NZAC	New Zealand Association of Counsellors
NZQA	New Zealand Qualifications Authority
PGF	Problem Gambling Foundation of New Zealand
PGSI	Problem gambling severity index
PPGM	Primary problem gambling mode
TAB NZ	TAB New Zealand
WHO	World Health Organization