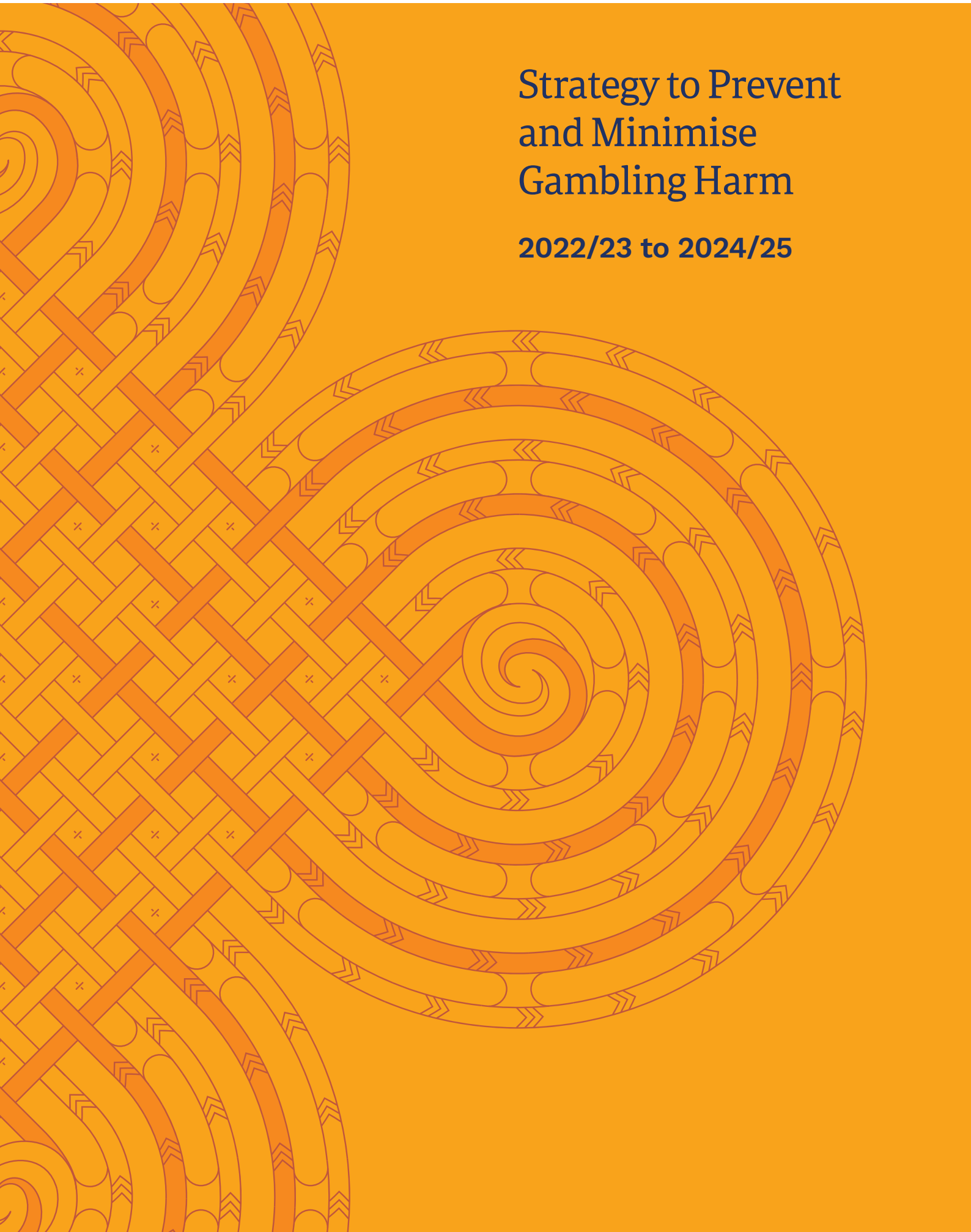




Strategy to Prevent and Minimise Gambling Harm

2022/23 to 2024/25





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Strategy to Prevent and Minimise Gambling Harm

2022/23 to 2024/25



Foreword

The Gambling Act 2003 sets out requirements for an ‘integrated problem gambling strategy focused on public health’. The Ministry of Health (the Ministry) is responsible for developing and refreshing this strategy every three years, as well as for implementing it. The Act specifies consultation requirements for developing the strategy and the levy rates.

This *Strategy to Prevent and Minimise Gambling Harm 2022/23 to 2024/25* (the strategy) is the integrated problem gambling strategy required in the Act. This strategy sets out the Ministry’s response to prevent and minimise gambling harm, after considering the:

- › submissions on the consultation document and the Allen + Clarke analysis of submissions
- › *Gambling Harm Needs Assessment 2021* (Malatest International)
- › Gambling Commission’s report to responsible Ministers and the independent report prepared for the Commission about the Ministry’s revised strategy proposals document and associated problem gambling levy rates (Gambling Commission 2022).



The Ministry acknowledges that the different views it received on gambling and minimising gambling harm during the consultation process represented the wide range of perspectives and different life experiences of those who made submissions. While these views sometimes differed, we recognise that the goals and outcomes of the strategy matter to all submitters, and they share the common goal of wanting to prevent and minimise gambling harm.

The strategy sets out a new direction for change that will address health inequities and barriers to services, incorporating learning from people with lived experience. It also describes a range of new and more relevant services to support the needs of people affected by gambling harm.

The strategy aligns strongly with the changes to the health and disability system outlined in the Pae Ora (Healthy Futures) Act 2022, and changes to mental health set out in *Kia Manawanui Aotearoa – Long-term pathway to mental wellbeing* and *Whakamaua: Māori Health Action Plan 2020–2025*. For example, they recognise the importance of placing people at the centre of a service, using service co-design and people with lived experience, expanding the range and choice of services to be more holistic and culturally appropriate, and strengthening the mix of peer, cultural, support and clinical workforces, communities, tāngata whai ora and whānau.

The Ministry is grateful for the passion and compassion evident in submissions from people who frankly shared their experiences of gambling harm and drew on these experiences to constructively contribute to the consultation. While it is impossible for the strategy to reflect every individual's point of view, the Ministry hopes that those who participated can see themselves in this revised strategy.



Executive Summary

Gambling harm is a significant social and economic issue. About one in five people in New Zealand will experience harm in their lifetime due to their own or someone else's gambling. It is also an equity issue, given that Māori, Pacific peoples, some Asian communities, young people/rangatahi, and people on lower incomes are disproportionately affected.

The Gambling Act 2003 prioritises the prevention and minimisation of gambling harm through multiple channels, including by mandating an integrated problem gambling strategy focused on public health (the strategy). The strategy must include public health and intervention services to prevent and minimise gambling harm, which are funded by a problem gambling levy on the gambling industry. This means the strategy will be fiscally neutral to the Crown over time. The levy is set in regulation and the levy formula is contained in the Act. The current levy regulations expire on 30 June 2022.

The Ministry of Health (the Ministry) is responsible for developing and implementing the strategy.



This strategy provides for a greater focus on equity. It aims to reduce health inequities attributable to gambling harm for priority populations (Māori, Pacific peoples, Asian peoples and young people/rangatahi), and to better meet their needs, by strengthening:

- › access to a range of more targeted, culturally responsive services and supports, developed in collaboration with affected communities and people with lived experience of gambling harm
- › public health initiatives to increase awareness and engagement by those at risk, with a greater focus on targeted initiatives developed in collaboration with priority populations, including addressing stigma and education in schools
- › enablers that support the above, including:
 - the gambling harm workforce capacity and capability
 - addressing cultural and language barriers
 - developing digital services and supports
 - action-oriented research, and evaluation to learn what works best and how to improve services.

The total cost for the Ministry to implement the strategy for 2022/23 to 2024/25 is \$76.123 million, an increase of \$15.784 million from the last levy period (2019/20 to 2021/22). This cost is recouped by a levy on the main types of gambling funded by main gambling operators.

This increase is the most significant investment to address gambling harm in 20 years, and the enhanced service programme reflects the government's commitment to addressing gambling harm and associated health inequities.

The Ministry thanks all those who shared their experiences of gambling harm and contributed to the revised strategy, which drew comments from a wide range of industry, health service and community stakeholders, including people with lived experience of gambling harm, Māori, Pacific, Asian and young people/rangatahi.

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1

Introduction

Role of the Ministry of Health

Since 1 July 2004, the Ministry has been responsible for developing and implementing the ‘integrated problem gambling strategy focused on public health’ described in section 317 of the Gambling Act 2003 (the Act). The Act states that the strategy must include:

- › measures to promote public health by preventing and minimising the harm from gambling (harm is defined below)
- › services to treat and assist problem gamblers and their families and whānau
- › independent scientific research associated with gambling, including such as (for example) longitudinal research on the social and economic impacts of gambling, particularly the impacts of gambling on different cultural groups
- › evaluation.

The Act defines a ‘problem gambler’ as a person whose gambling causes or may cause harm. It states that ‘harm’:

- › means 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.

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 paid by the main gambling operators.

Structure of this document

This document meets the Act's requirements for an integrated problem gambling strategy. It comprises a strategic plan and service plan that together describe the Ministry's approach to prevent and minimise gambling harm, and the range of activities it plans to provide for the three years to 30 June 2025.

The document is divided into sections.

- › **Section 2: Strategic overview** provides 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.
- › **Section 3: The strategic plan** outlines the long-term strategic framework that guides the Ministry's approach to the prevention and minimisation of gambling harm, including high-level objectives and priorities for action. It forms the strategic context for the three-year service plan.
- › **Section 4: The service plan 2022/23 to 2024/25** sets out the Ministry's service priorities to prevent and minimise gambling harm, and the costs of these services, from 1 July 2022 to 30 June 2025.
- › **Section 5: The levy rates for 2022/23 to 2024/25** sets out the levy rate that applies to each of the four gambling industry sectors required to pay the levy: non-casino gaming machine (NCGM) operators, casinos, TAB New Zealand (TAB NZ, formerly the New Zealand Racing Board) and New Zealand Lotteries Commission (Lotto NZ). It also describes the process used to calculate the levy rates.

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

Alignment with health sector reforms

The strategy contributes to the government’s priority of wellbeing for all New Zealanders. Gambling is a source of inequity and harm, especially to Māori and Pacific peoples.

Changes have been made to align the strategy with the broader reforms currently underway across the health and disability system. The strategy is closely aligned with the goals, principles and objectives of *Kia Manawanui Aotearoa – Long-term pathway to mental wellbeing (Kia Manawanui)* and *Whakamaua: Māori Health Action Plan 2020–2025 (Whakamaua)*.

While some details are not available at the time of publication, the strategy also aligns with the aims of the broader health and disability sector changes developed in response to the *Health and Disability System Review / Hauora Manaaki Ki Aotearoa Whānui* and reflected in the Pae Ora (Healthy Futures) Act. These changes will transform health and disability services to create a more equitable, accessible, cohesive and people-centred system that will improve the health and wellbeing of all New Zealanders.

For example, the strategy draws from the above and is positioned to achieve pae ora – healthy futures, recognising the importance of Te Tiriti o Waitangi (Te Tiriti), placing people at the centre, using service co-design and the voice of people with lived experience. This will expand the range and choice of services to be more holistic and culturally appropriate, and strengthen the mix of peer, cultural, support and clinical workforces, communities, tāngata whai ora and whānau to improve mental wellbeing.

2

Strategic overview

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

The gambling environment

Participation in gambling

Most New Zealanders gamble at least occasionally. Estimates suggest that in 2020,¹ 69.3 percent (about 2.8 million New Zealanders aged 16 and older) had participated in some form of gambling in the previous 12 months.

The most popular forms of gambling in 2020 were Lotto NZ products (59.1 percent), followed by informal gambling such as playing cards with friends² (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).

1. Te Hīringa Hauora and Kupe. 2020. *Health and Lifestyles Survey Gambling Harm*. URL: <https://kupe.hpa.org.nz/#!/gambling/gambling-harm>.

2. Informal gambling activities as defined by the Health and Lifestyles Survey include casino fundraising events, sweepstakes and monetary bets with friends or family.

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 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 and website, at raceways, and through TAB NZ venues (some TAB NZ venues also operate NCGMs)
- › a range of lottery products provided by Lotto NZ, including the national lottery, Keno, Instant Kiwi (scratch) tickets and MyLotto online games on their mobile app and website.

Gambling outlets

Historically, gambling required participation at a venue or retail outlet, but this has changed 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.

Department of Internal Affairs (DIA) reports that, as at 30 June 2021, there were 1,059 active licensed NCGM venues, operating 14,704 machines. This reflects a decreasing trend 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 NZ’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 the 2020 Health and Lifestyles Survey (HLS) shows 23.5 percent of New Zealand adults had bought one of Instant Kiwi, Lotto, Strike, Powerball, Keno or Bullseye online, or by using the MyLotto mobile app in the previous 12 months. This is a significant increase from 9 percent in 2018.

In the 12 months to 28 February 2021, TAB NZ reported 205,000 active TAB NZ customers and 560 retail TAB outlets. Of these outlets, 44 hosted gaming machines in the previous 12 months.³ Analysis from the 2020 HLS 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 previous 12 months.

There are six casinos in New Zealand: one each in Auckland, Hamilton, Christchurch and Dunedin, and two in Queenstown. Analysis from the 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.

3. Correspondence with TAB NZ.

Online gambling

An increasing number of New Zealanders purchased Lotto NZ products or placed bets on TAB NZ products online in 2020. According to analysis from the 2020 HLS, over 1,093,000 (26.7 percent) New Zealand adults (aged 16 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.

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 (described below), particularly in terms of the potential impact on vulnerable groups including Māori, Pacific peoples and young people/rangatahi. People using overseas gambling websites are much more likely to be at risk of experiencing harm.⁴

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 writing 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, such as virtual reality-enabled Instant Kiwi tickets (such forms of gambling are also an example of continuous gambling,⁵ which research shows poses an increased risk of harm⁶)
- › 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'.

4. Online gambling in New Zealand: Results from the 2018 Health and Lifestyles Survey <https://www.hpa.org.nz/research-library/research-publications/online-gambling-in-new-zealand-results-from-the-2018-health-and-lifestyles-survey>

5. 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).

6. 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.

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.

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.⁷

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 COVID 19 lockdown restrictions. Expenditure for the 2020/21 year shows that there has been a substantial recovery across most sectors.

Total gambling expenditure in 2020/21 was \$2.624 billion for NCGMs, Lotto NZ, TAB NZ and casinos combined. This is the highest-ever recorded annual total.

Expenditure on NCGMs increased annually from a low of \$806 million in 2013/14, to \$924 million in 2018/19. 2019/20 saw a fall to \$802 million, which can be primarily attributed to the COVID 19 restrictions. However, it quickly recovered and for 2020/21 was \$987 million, the highest since records began in 2007.

Expenditure on Lotto NZ products in 2019/20 increased significantly to \$631 million – over \$100 million more than the 2018/19 year – making it Lotto NZ's highest turnover up to that point. This increased again to \$694 million in 2020/21. This growth is partly attributed to more New Zealanders using the MyLotto online platform, which was not affected by COVID-19 restrictions. It is also important to 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. For 2020/21, expenditure was \$385 million, their highest year on record.

Annual expenditure on casinos in 2019/20 was \$504 million, a significant decrease compared with previous years. In 2020/21, expenditure increased to \$559 million, although this is still lower than for 2018/19. Again, a key contributing factor 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.

7. Malatest International. *Gambling Harm Needs Assessment 2021*.

The nature of gambling harm

The Act provides a broad definition of gambling harm that includes harm or distress of any kind arising from, or caused or exacerbated by, a person's gambling; including personal, social or economic harm suffered by the person; or by their spouse, partner, family, whānau, or wider community including in the workplace or by society at large.

Harm may include damage to relationships, emotional and psychological distress, disruptions to work or study, loss of income, the financial cost of gambling, and 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).⁸ 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, 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 its lowest 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.⁹

However, while gambling harm rates have not changed significantly, the adult population has grown. This means that the actual number of people who are experiencing gambling-related harm has increased.¹⁰

The 2020 HLS estimates that in 2020, some 65,000 people aged 16 years or older were at either moderate risk or high risk (problem gamblers) of harm from gambling. 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.¹¹

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

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

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

11. 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 in 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 participate in low-risk gambling is very significant, with one study finding nearly 50 percent of all gambling harm is experienced by these people.¹² This is because many more people experience low levels of harm or burden of disease than high levels.

Research shows that one in five New Zealand adults (22 percent) are affected at some time in their lives by their own or others' gambling.¹³

► **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 small number of people¹⁴ who play gaming machines. Most people accessing gambling-harm intervention services cite pub or club pokies as the primary problem gambling mode.

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 the total (estimated) electronic gaming machine (EGM) expenditure in 2015

12. 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).

13. Thimasarn-Anwar T, Squire H, Trowland H, et al. 2017. *Gambling Report: Results from the 2016 Health and Lifestyles Survey*. Wellington: Te Hiringa 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).

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

(moderate-risk and problem gamblers 28 percent; low-risk gamblers 24 percent).¹⁵ Similarly, analysis from the 2020 HLS shows 50.3 percent of those who played EGMs in pubs or clubs at least once a month experienced some level of gambling harm.¹⁶

Who is bearing the burden of gambling harm?

While many New Zealanders who gamble do so without experiencing harm, a significant minority will cause harm through their gambling, to themselves and/or harm others. Harm may include damage to relationships, emotional and psychological distress (including stress and anxiety), disruptions to work or study, loss of income, the financial cost of gambling, and 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.¹⁷

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

Analysis from the 2020 HLS provides two clear themes.

- › Māori were 3.13 times more likely to be moderate-risk or problem gamblers than non-Māori and non-Pacific peoples. In the Māori adult population, approximately 3.7 percent were moderate-risk or 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 or 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. They are also more likely to have other risk factors for gambling harm, such as low incomes and living in low socioeconomic communities where some forms of gambling, particularly NCGMs, are more accessible.

After adjusting for deprivation level, the 2020 HLS 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 peoples. Pacific peoples were 2.67 times more likely to report these harms than non-Pacific peoples and non-Māori.

Past HLS 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.

15. 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. URL: <https://www.health.govt.nz/publication/new-zealand-national-gambling-study-wave-4-2015>.

16. Te Hirainga Hauora. 2021. *Results from the Health and Lifestyles Survey 2020*.

17. 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).

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

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

According to 2020 HLS 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 moderate- and high-risk gamblers (1.6 percent of all adults or 65,000 people).

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 suggests some parallels between problem gaming and problem gambling behaviour.¹⁸ This research found that 28 percent of Pacific survey respondents spend more than \$20 per month on loot boxes,¹⁹ and Pacific young people in the study drew parallels between problem gaming and problem gambling.

Similarly, a Norwegian longitudinal study 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.²⁰

Recent research into New Zealand secondary school students’ gambling found that about one in three had participated in gambling at some point in their lives. Of this subgroup, 13 percent wanted to reduce their gambling, and 11 percent were worried about their own gambling. These two groups were both more likely to be in low-decile schools (deciles 1–3) than in high-decile schools (deciles 8–10).²¹

This study found 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, students who experience greater levels of disadvantage are more likely to express concern about their gambling and be exposed to greater levels of harm, than those who experience less disadvantage.

There are growing concerns about access to online gambling and gaming convergence and the impacts of these on the wellbeing of children and young people/rangatahi. The Gambling Harm Needs Assessment 2021 reported an increase in parents asking for support for young people who were ‘addicted’ to gaming.

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

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

20. 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. URL: <https://link.springer.com/article/10.1007/s10899-018-9781-z#Abs1>.

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

Anecdotally, there are concerns that unregulated online gambling may be particularly harmful for disabled people. Almost one in four New Zealanders identify as disabled, but 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.²² Disabled people on average have lower incomes, which may exacerbate their experience of gambling harm.

There is limited information about gambling among the disabled community in New Zealand, but an American study found that one-quarter of recipients of disability benefits were experiencing harm from gambling.²³ Recent small-scale Australian research found people with intellectual disabilities are engaging with gambling in the same ways as the general public.²⁴

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 sociocultural 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 to 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.²⁵

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.²⁶

Research shows that older people are less likely to be experiencing gambling harms.

Analysis from the 2020 HLS shows that:

- › older people (65 and over) are less likely to gamble and report gambling-related harms than the average New Zealander
- › about 1% of New Zealanders aged 65 and over were moderate-risk or problem gamblers compared to 1.6% of the total population
- › those aged 65 and over were significantly less likely to report experiencing household-level gambling harm.

22. 2013 *New Zealand Disability Survey*. Statistics New Zealand. URL: www.stats.govt.nz/information-releases/disability-survey-2013.

23. 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.

24. 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.

25. 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. URL: www.health.govt.nz/publication/mixed-methods-analysis-gambling-harm-women-new-zealand (accessed 18 July 2021).

26. 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. URL: www.health.govt.nz/publication/pacific-islands-families-study-2014-mother-and-youth-gambling-report (accessed 18 July 2021).

However, research indicates older people may be vulnerable to gambling harm and that retirement was a factor for transition into moderate risk or problem gambling.²⁷ For example, persons aged 65 and over were likely to spend more money and time gambling on EGM per session.²⁸

Gambling harm and other health problems

Harmful gambling typically presents with other 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. Having coexisting health issues (comorbidity) is an indication that a person may require holistic health services.²⁹

Some 23 percent of clients screened by Ministry-funded health services for coexisting problematic alcohol or drug use in 2020/21 reported wanting to cut down their use of prescription or other drugs, and 31 percent reported 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 research³⁰ suggests that between 5 and 10 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.³¹ 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.³²

It is also useful to consider the broader impacts on society from the large amount of expenditure currently going into gambling. New Zealanders lose around \$2.6 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 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

27. Bellringer, M.E., Lowe, G., Paavonen, A-M., Palmer du Preez, K., Garrett, N., & Abbott, M. (2019). New Zealand National Gambling Study: Qualitative phase. NGS Series Report number 8. Auckland: Auckland University of Technology, Gambling and Addictions Research Centre. URL: www.health.govt.nz/publication/new-zealand-national-gambling-qualitative-phase

28. Palmer du Preez, K., Landon, J., Garret, N., Bellringer, M.E., Page, A., Coomarasamy, C., Abbott, M. (2014). Investigation into the effects of gambling game characteristics, PIDs and pop-up technology on gambling and problem gambling behaviour in New Zealand. Auckland: Auckland University of Technology, Gambling and Addictions Research Centre. URL: www.health.govt.nz/publication/investigation-effects-gambling-game-characteristics-pids-and-pop-technology-gambling-and-problem

29. 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.

30. 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).

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

32. 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. URL: [www.ajpmonline.org/article/S0749-3797\(17\)30163-0/fulltext](http://www.ajpmonline.org/article/S0749-3797(17)30163-0/fulltext).

equivalent jobs worth approximately \$50 million in wages and salaries.³³ The tax impacts would be nearly \$60 million in increased GST collected and \$7 million in income tax on workers. This research assumed that all spending would switch to retail and not to other forms of gambling. Even if it is assumed that only half of the spending was switched, it could have a significant economic impact.

Spending on gambling, especially NCGMs, is not spread evenly across our communities. This is at least partly due to accessibility, with over 60 percent of NCGM venues (the source of the highest risk of harmful gambling activity) located in the most socioeconomically deprived areas (that is, the poorest areas of the country).³⁴ People in these areas spend up to three times as much on NCGMs than people in the least-deprived areas.³⁵ While it is possible that people may gamble outside their neighbourhoods, there are significant associations between gambling behaviour and neighbourhood access to gambling venues. Problem gambling is significantly associated with living closer to a gambling venue.³⁶

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.³⁷ This is a small proportion of the 45,000 to 92,000 people estimated to be experiencing moderate to significant harms from their own gambling, from analysis of the 2020 HLS. 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 2020/21 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 1 shows, there has been a general decrease in people accessing Ministry-funded services (excluding clients who received only brief interventions).³⁸ The Ministry's suggestions for ways to address this decline in requests and improve access are described in this strategy.

33. 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).

34. 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).

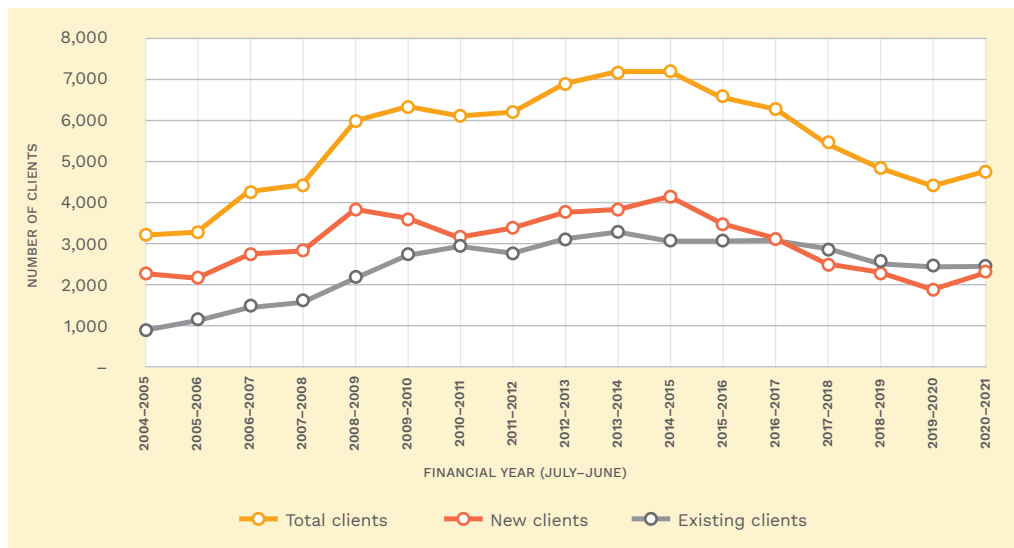
35. Ward AD, McIvor JT, Bracewell P. 2020. The geographic distribution of gaming machine proceeds in New Zealand. *Kōtuitui: New Zealand Journal of Social Sciences Online* 15 (1): 54–74. URL: <https://doi.org/10.1080/1177083X.2019.1640752> (accessed 18 July 2021).

36. Ministry of Health. 2008. *Raising the Odds? Gambling behaviour and neighbourhood access to gambling venues in New Zealand*. Wellington: Ministry of Health. URL: <https://www.health.govt.nz/publication/raising-odds-gambling-behaviour-and-neighbourhood-access-gambling-venues-new-zealand>

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

38. Intervention client data www.health.govt.nz/our-work/mental-health-and-addictions/gambling/service-user-data/intervention-client-data

Figure 1: Clients accessing Ministry-funded services (excluding brief interventions)



Gambling harm services environment

COVID 19 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 (by phone or online meetings). While this shift highlighted the adaptability of health service providers, it also exacerbated the negative impacts of the COVID-19 restrictions on people without ready access to digital services.

In addition to COVID 19, there were other 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 enable gamblers to self-exclude from multiple venues without having to visit each individual site. MVE is now available across the country. An electronic gambling exclusions database was also procured and is being trialled to support the exclusion application process and collect the exclusion data.
- › Two new ways of working (service pilots) were introduced in the Waikato region: a preventing and minimising gambling harm (PMGH) service for Māori and one for Pacific peoples. Both services are based in Hamilton and are within 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 is an increase 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 2019/20 to 2021/22

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 | Health Promotion Agency'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 Gambling 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 gamblers seeking treatment continues to decline, 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 was 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 have been relatively stable for several years.³⁹

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

Analysis of the 10,946 people who experienced harm from their own or someone else's gambling and received help shows that:

- › 35 percent identified as European/Other
- › 32 percent identified as Māori
- › 17 percent identified as Pacific peoples
- › 16 percent identified as Asian
- › 49 percent identified as female, 51 percent male
- › 9 percent were 65 or older
- › 9 percent were 24 or younger.

Of the 2,798 people who were screened for coexisting problematic alcohol or drug use, 43 percent were identified as having a coexisting issue.

The 6,605 people seeking help for their own gambling is substantively lower than expected, representing only 10 percent of the 65,000 New Zealanders estimated to be affected by moderate to severe gambling harm.⁴⁰

It is important to note that these statistics are population prevalence rates, and although they are static, the actual number of people affected 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 (ie, 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 some PMGH 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 systemic barriers to access based on ethnicity or socioeconomic status.

Early intervention

It is apparent that a number of New Zealanders who would benefit from gambling harm intervention are not seeking help. Likely causes for this (identified in submissions to this consultation from health and service providers) are the high level of stigma associated with gambling harm, and societal attitudes towards gambling, as well as cultural, language and other barriers.

40. This level of service use equates to approximately 10% of those in the moderate-risk and problem gambling categories. The number of problem gamblers and moderate-risk gamblers (1.6%) in the total New Zealand population aged over 16 is estimated at approximately 65,000 people (2020 HLS).

While it is necessary to address the needs of those who have already developed a serious gambling problem and who need specialist help, earlier prevention-focused interventions would help individuals and their families, whānau and communities to avoid developing harmful gambling behaviours and associated higher risks of harm.

Early intervention approaches align closely with public health programmes in the mental health and addictions areas of alcohol, tobacco and drug use, and family, whānau and partner violence prevention.

Conclusions

The key issues underpinning the strategy include:

- › disproportionate levels of harm experienced by Māori and Pacific peoples, and by some segments of the Asian population
- › higher levels of exposure to gambling products and disproportionate levels of harm experienced by people living in areas with high social deprivation scores
- › high rates of comorbidities among at-risk gamblers, and low levels of treatment uptake and screening to minimise and prevent gambling harm
- › harm experienced by children and the involvement of younger people in gambling, including long-term impacts of exposure to gambling harm
- › the possibility of a significant increase in online gambling.

Gambling Harm Needs Assessment

The Gambling Harm Needs Assessment 2021 (the needs assessment) is an independent report commissioned 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.⁴¹ These were the key findings.

- › 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 affects 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.

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

- › The enablers and barriers to seeking help have not changed significantly since the last needs assessment.

The needs assessment also considered progress towards the strategic objectives of the previous strategy. 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 this strategy.

Focusing on public health

The Act sets out requirements for an integrated problem gambling strategy focused on public health. Public health measures are an integral part of preventing and minimising gambling harm, providing early intervention and 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.

1. Both promotion and prevention activities are included.
2. Promotional and preventative activities are applied collectively.
3. The health of the whole population is the goal.

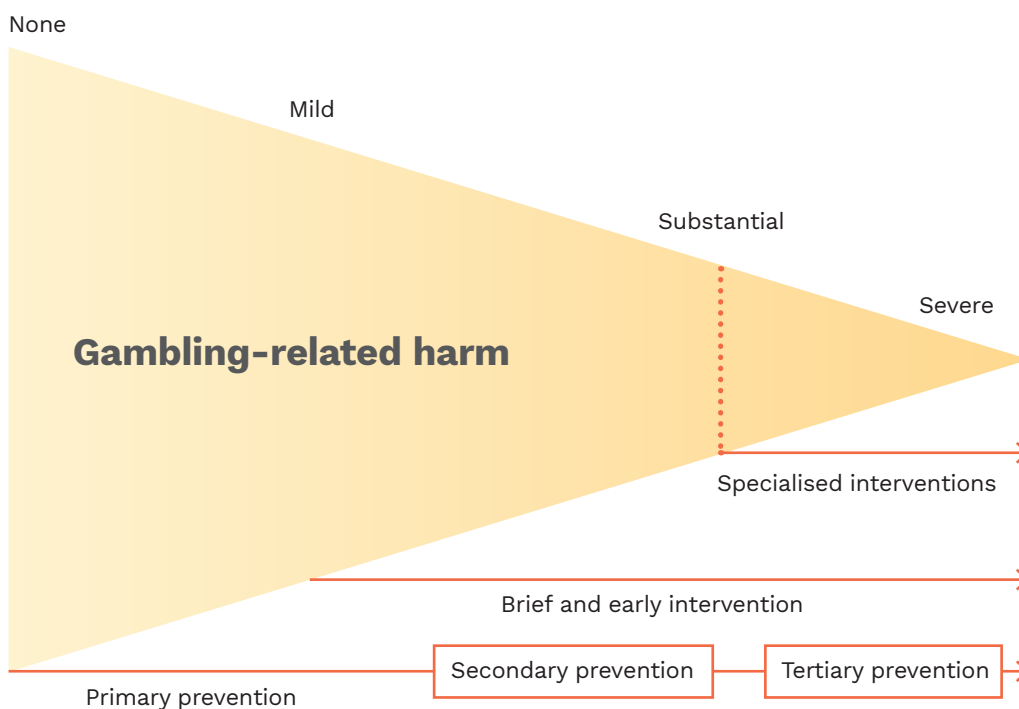
In the context of gambling, this includes raising awareness of the signs of harmful gambling, encouraging at-risk people to check whether their gambling is under control before harm escalates in severity, and motivating those who are at risk to engage in self-help changes or get help early.

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 2** 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 2: Continuum of gambling behaviour and responses



Gambling harm as an equity issue

Equity recognises that 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 much greater burden of harm than other groups.

These strongly patterned outcomes have a systemic cause. For example, we know that NCGMs – the most harmful form of gambling – are not distributed randomly across our communities but are concentrated in areas defined by lower socioeconomic status and high deprivation measures, which are also more likely to be areas where Māori and Pacific peoples live. We also know the services and supports that are in place to prevent and minimise gambling harm are underutilised, and one reason for this may be that they are not considered acceptable or culturally appropriate⁴³ by all potential service users.

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.

43. See preference to use cultural safety rather than cultural competence. URL: <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1082-3>.

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.”

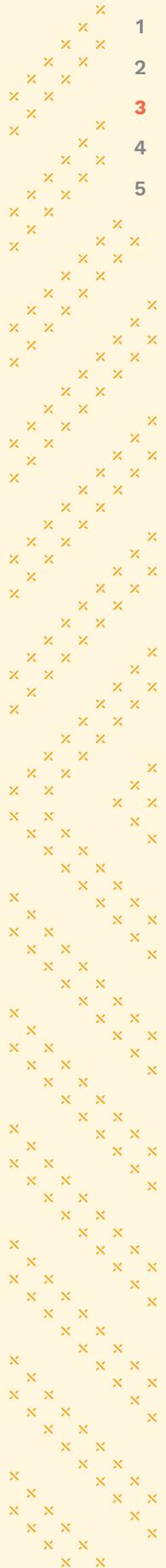
This definition of equity was signed off by Director-General of Health Dr Ashley Bloomfield in March 2019.⁴⁴

We usually refer to the differences in health experience that occur between population groups as 'health inequalities'. A health inequality can be attributed 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 <https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity>

3



The strategic plan

The strategic plan section describes the strategic framework to guide the strategy and service plan. The strategic framework provides for long-term goals and objectives to achieve healthy futures and wellbeing as a population outcome. This sets the direction for change over the medium to long term, so the strategic goals and objectives are not expected to change as long as they remain fit for purpose and provide the framework for the activities described in the service plan section.

The framework takes into account the submissions on the consultation document, the needs assessment findings, an analysis of the most current research and other evidence available, including emerging issues, to ensure it remains fit for purpose. Relevant research has been described in earlier sections and is not repeated here.

The strategic environment

The Gambling Act 2003

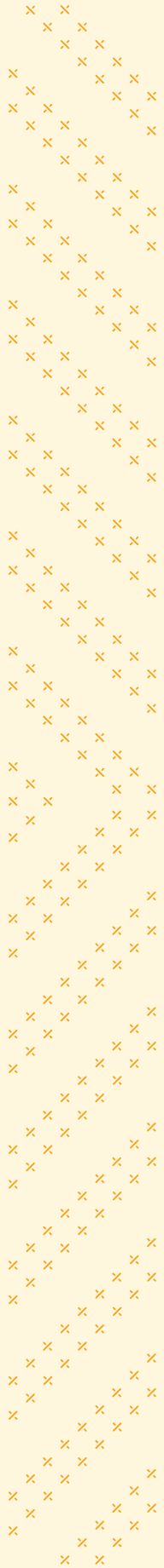
The Act recognises that gambling harm is a significant issue and requires the development and implementation of an integrated problem gambling strategy focused on public health. The Act specifies that this strategy must be informed by a needs assessment and include measures to promote public health,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

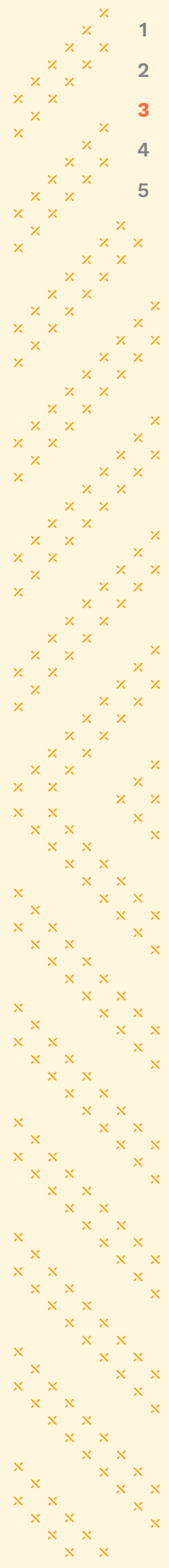
The strategy also reflects the Ministry's public health approach to minimising gambling harm and its relationship to the complementary responsibilities of DIA in regulating gambling activities and the other agencies who also play a role in addressing gambling harm.

The Ministry of Health

The Ministry is responsible for developing the strategy, and funding and implementing the services mandated by the strategy. The annual and three-year funding requirements to deliver the strategy are outlined in the service plan, and these cost estimates are used to calculate the problem gambling levy.

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: NCGMs, casinos, TAB NZ and Lotto NZ.





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 law, for example inspecting gambling venues to assess whether the harm minimisation provisions are being implemented
- › working with the gambling industry sector to encourage best practice
- › 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.

Territorial authorities

Under the Gambling Act 2003 and the Racing Industry Act 2020, territorial authorities are required to develop, review and apply policies on NCGM venues and TAB venues in their area.⁴⁵

Gambling Commission

The Gambling Commission also hears casino licensing applications (which include harm minimisation plans)⁴⁶ 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.

Te Hiringa Hauora – Health Promotion Agency

While Te Hiringa Hauora does not have a statutory role in gambling prevention and harm minimisation under the Act, it plays a key role as its mandate is to promote health and wellbeing and encourage healthy lifestyles. Te Hiringa Hauora is funded under the 2019/20 to 2021/22 strategy to deliver an education and awareness work programme to prevent and minimise gambling harm. Te Hiringa Hauora works closely with the Ministry in this area, which complements many other activities in both agencies.

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

46. The Gambling Commission approves a 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. DIA may also provide input into the HRP when it is periodically reviewed by the Gambling Commission.

Health sector changes underway

The strategy has been refreshed at a time when the entire health system in New Zealand is undergoing major transformation of not only mental health and addiction but also wider health and disability services. These transformations are driven by common themes and principles, which also form the foundations for the strategy, for example to provide services that are more equitable, accessible, cohesive and people-centred.

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 (Healthy 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 (Healthy Futures) Act, describes the high-level purpose of building towards pae ora and a series of health system principles. It also outlines key roles, including 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.⁴⁷

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

Kia Manawanui is a whole-of-government action plan for the long-term transformation of the mental health and addiction sector. 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 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 EGMs.

47. URL: www.futureofhealth.govt.nz/ (accessed 9 February 2022).

► **Whakamaua: Māori Health Action Plan 2020–2025**⁴⁸

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.

► **DIA’s new strategic focus on gambling**

In 2020, DIA announced its strategic focus on gambling would be ‘Delivering community wellbeing through reducing gambling-related harms’.⁴⁹ 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 aligned with this strategy, such as *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025 (Ola Manuia)*.

The Waitangi Tribunal is currently hearing WAI 2575 – the Health Services and Outcomes Inquiry, which may affect how we approach services for Māori in the future. This inquiry will hear all claims concerning grievances about health services and outcomes which are of national significance. The Tribunal has commissioned a number of related reports into issues such as Māori mental health, and alcohol, tobacco and substance abuse for Māori.

Te Tiriti o Waitangi in the health and disability system

This strategy draws on the principles of Te Tiriti to inform its strategic framework, and positions gambling harm 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)* as follows.^{50 51}

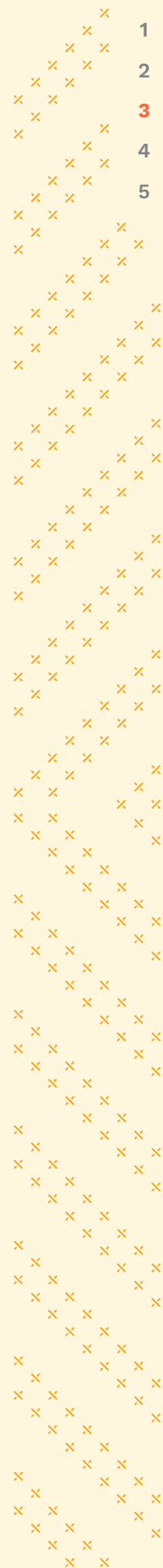
- › Tino rangatiratanga underpins the principles identified in Te Tiriti. It is often translated as ‘self-determination’ or ‘sovereignty’. It means that Māori are guaranteed self-determination and mana motuhake (the right to be Māori and to live on Māori terms in accordance with Māori philosophies, values and practices) in the design, delivery and monitoring of health and disability services.


48. 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.

49. DIA Gambling Group Strategic Direction 2020–2023 – Purpose Statement. URL: [https://www.dia.govt.nz/diawebsite.nsf/Files/Gambling-Group-Strategic-Direction/\\$file/Gambling-Group-Strategic-Direction-2020-2023-Purpose-Statement.pdf](https://www.dia.govt.nz/diawebsite.nsf/Files/Gambling-Group-Strategic-Direction/$file/Gambling-Group-Strategic-Direction-2020-2023-Purpose-Statement.pdf)

50. 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).

51. www.health.govt.nz/our-work/populations/maori-health/te-tiriti-o-waitangi.



- 
- › ‘Partnership’ is recognised as a relationship between the Crown and Māori, in which the two parties act with respect towards each other, work together and are flexible about different structures if organisations are not meeting one another’s needs. Partnership requires the Crown and Māori to collaborate in the governance, design, delivery 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.

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

The strategy also maintains and builds on existing momentum from preceding strategies to prevent and minimise gambling harm. For example, the strategy for 2019/20 to 2021/22 (the previous strategy) had begun to implement changes to service elements set out 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. Appendix 3 shows how the current strategic objectives align with those from past strategies.

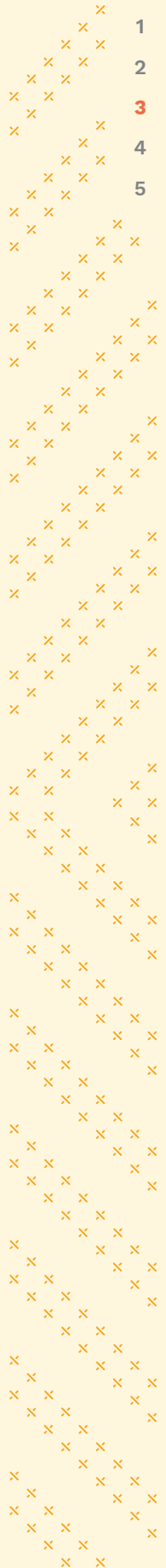
While the strategy includes changes to services, the momentum for change is balanced against providing continuity for long-term activities such as health education, harm prevention and early intervention required to meet the needs of new cohorts of people coming through, as well as for people having different needs at different times in their lives.

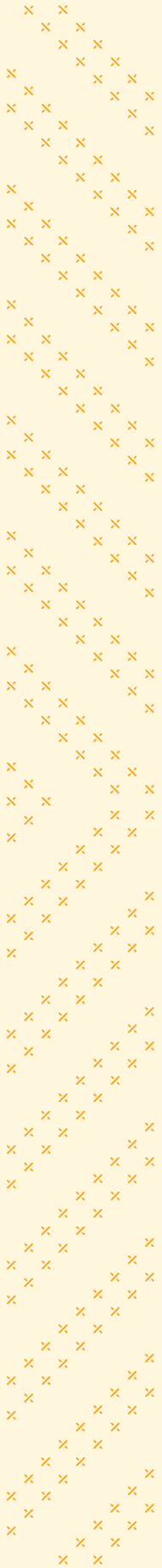
Key changes

Based on the above, the key areas of change from the previous strategy to this strategy are to:

- › strengthen the focus on equity and public health approaches, including addressing the stigma associated with gambling and gambling harm that prevents people from seeking help
- › 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 gambling operators
- › strengthen collaboration and opportunities to engage and support Māori and Pacific peoples, Asian communities, young people/rangatahi, people with lived experience and the gambling operators
- › empower affected communities and priority populations and people with 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 key shifts in focus are reflected in the strategic framework and service plan that follow. Together with the principle to ‘put people and communities at the centre’, these shifts will enable us to better address inequities for priority populations.





The new strategic framework

Taken together, in the context of the Ministry's existing approach to Te Tiriti, the strategic framework reflects 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, with a new set of objectives based on *Whakamaua*
- › aligning with *Kia Manawanui* and *Whakamaua* through outcomes and principles derived from those strategies
- › affirming gambling 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.

The elements of the new strategic framework are described below, and summarised in Figure 3.

OBJECTIVE

1

Create a full spectrum of services and supports

OUTCOME

The health and disability system and wider system to prevent and minimise gambling harm addresses racism and discrimination in all their forms.

OBJECTIVE

2

Shift cultural and social norms

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

OUTCOME

Māori and all communities in Aotearoa New Zealand can exercise their authority to improve their health and wellbeing.

OUTCOME

The inclusion and protection of mātauranga Māori throughout the health and disability system.

OBJECTIVE

3

Strengthen leadership and accountability to achieve equity

OUTCOME

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.

OBJECTIVE

4

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

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 or organisation.



The population outcome for the strategy is **Pae ora – healthy futures for Māori and all New Zealanders**, which is drawn from *Kia Manawanui*.⁵²

While the concept was developed as a vision for Māori wellbeing, *Kia Manawanui* applies this to Māori and all New Zealanders. This acknowledges that 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 and communities, and within 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.

⁵² Pae ora is also the driving outcome for *He Korowai Oranga: Māori Health Strategy* (He Korowai Oranga) and *Whakamaua*, which both precede *Kia Manawanui*.

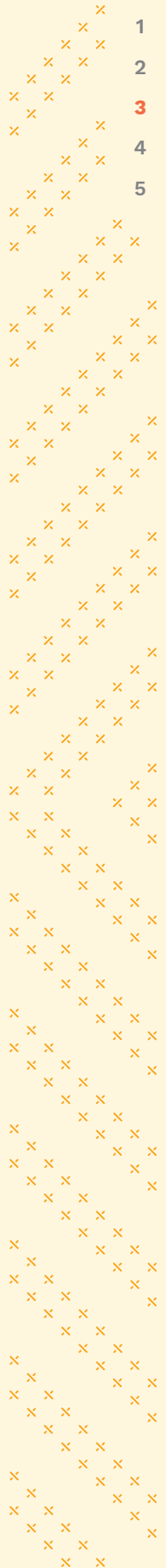
Strategic goal

The strategic goal is **to promote equity and wellbeing by preventing and minimising 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.
- › 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) of 'Delivering community wellbeing through reducing gambling-related harms'.

This 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*⁵³ and *Whakamaua*, to 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.

53. *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 that 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.

▶ **Innovation⁵⁴**

This principle is about encouraging new approaches to achieve mental wellbeing. Innovation includes changing the way we deliver and design 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 the activities we plan, but also the way we deliver them. **Appendix 2** shows how these principles align with preventing and minimising gambling harm.

54. *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 strategy as it has limited relevance to gambling prevention and harm minimisation.

Outcomes

The 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.



OUTCOME

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.

OUTCOME

Māori and all communities in Aotearoa New Zealand can exercise their authority to improve their health and wellbeing.

OUTCOME

Mātauranga Māori is included and protected throughout the health and disability system.

OUTCOME

The health and disability system and wider system to prevent and minimise gambling harm addresses racism and discrimination in all their forms.

Objectives

Set out below are four objectives to shape our strategic approach and service plan.

These objectives provide a framework that guides our actions to prevent and minimise gambling harm. Appendix 3 shows how these objectives align with those in the previous strategy.

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 preventing and minimising gambling harm.

1

OBJECTIVE 1

► Create a full spectrum of services and supports

This objective acknowledges the importance of 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.

This objective will maintain momentum 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.

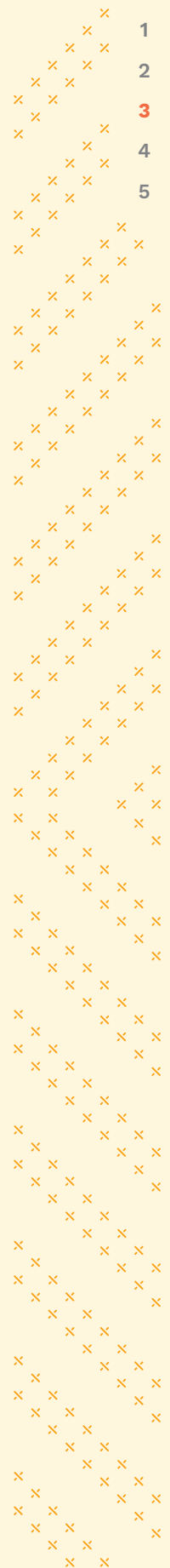
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OBJECTIVE 2

► Shift cultural and social norms

This reflects a key objective of *Whakamaua* that is directly relevant to preventing and minimising gambling harm, 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 objective will support activities to increase public awareness about the nature of harmful gambling and how to provide support for those with gambling problems, including de-stigmatisation.



3

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. This system to prevent and minimise gambling harm is itself 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.

This objective will support the Ministry playing a stronger leadership role in preventing and minimising gambling harm, by engaging with gambling harm services, gambling operators, researchers and communities, and developing mutually respectful partnerships and relationships.

4

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, as it has for some time (compared with European/Other New Zealanders. It is derived from and supports *Whakamaua*, *Ola Manuia*,⁵⁵ and the *Child and Youth Wellbeing Strategy*.⁵⁶ The 2020 HLS results indicated that Māori were 3.13 times 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 HLS surveys across several years, accounting for ethnicity, gender and socioeconomic deprivation, found that compared with European/Other New Zealanders, of those who gamble the Asian group's risk factor is 9.5 times higher.

The 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.

55. 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.

56. Discussed further 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 strategies, and are have a rolling six-year timeframe.

The priority action areas also reflect the contributions of other agencies that have a role to address gambling harm. For example, DIA and Te Hiringa Hauora activities in the gambling arena will also affect whether the strategy will achieve its goal. The priority action areas are as follows.

1

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).

These actions align with the *Hauora* principles of equity and options, and support the four *Whakamaua* outcomes, as well as *pae ora*, to be realised in preventing and minimising 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.

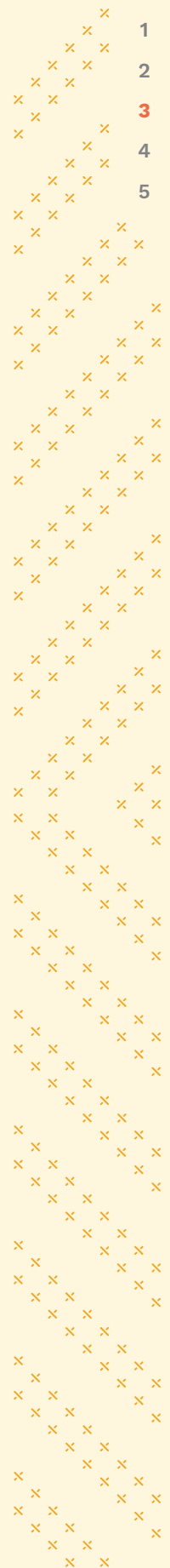
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ACTION AREAS FOR OBJECTIVE 2

► 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 communities⁵⁷ (Ministry of Health, DIA, territorial authorities).

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





2

- › Reduce the stigma attached to gambling harm that prevents people from accessing services and supports (Ministry of Health, Te Hīringa Hauora).

These actions align with the *Hauora* principles of active protection, equity and partnership to be realised in preventing and minimising gambling harm. Key strategy principles that will be activated are upholding Te Tiriti, equity, people and whānau at the centre, and community focus.

3

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, 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).

These actions align with the *Hauora* principles of tino rangatiratanga, active protection and equity, and enable them to be realised in preventing and minimising 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.

In addition to the strategy, several related complementary activities are also planned or underway, to effect changes to the broader gambling policy, legislative or regulatory frameworks. For example, as noted above, the Government has also committed in *Kia Manawanui* to review the Gambling Act, with a particular focus on reducing harm from online gambling and pokies.

4

ACTION AREAS FOR OBJECTIVE 4

▶ Strengthen the health and health equity of Māori, Pacific peoples, Asian peoples and young people / rangatahi

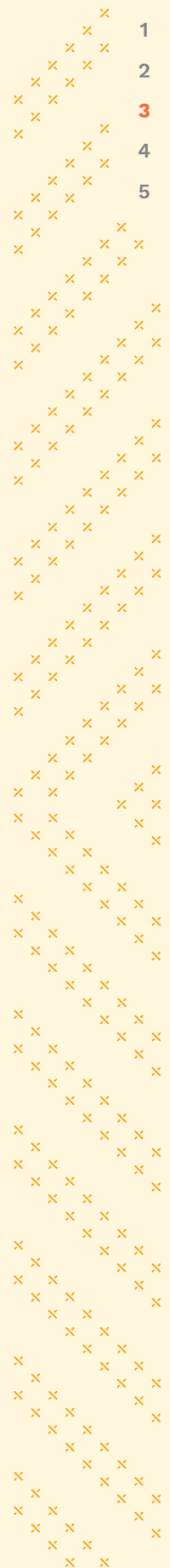
- › Collaborate and co-design with iwi and other Māori organisations, Pacific and Asian communities, young people/rangatahi, and people with lived experience of gambling harm to prevent and minimise gambling harm (Ministry of Health).
- › Enable the development of kaupapa Māori and gambling-harm prevention 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).

These actions align with the *Hauora* principles of tino rangatiratanga, partnership, active protection, options and equity, and enable them to be realised in preventing and minimising 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.

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

At the time of preparing this strategy the impact of the health sector transformations, including the roles of the Māori Health Authority and local iwi-Māori partnership boards, was unknown. The Ministry will develop action plans for each priority population and will incorporate the new roles after the enabling legislation is finalised and details are known, as the strategy is implemented.

The strategic framework shown in **Figure 3** illustrates the complementary action areas, led by the Ministry of Health, DIA and Te Hiringa Hauora, according to each agency’s core mandate. It also shows priority action areas that are delivered jointly. This collaborative and coordinated approach is essential to effectively preventing and minimising gambling harm.



Priority populations

The priority populations identified for the strategy are Māori, Pacific peoples, Asian peoples and young people/rangatahi.

The first three groups were priority populations for the previous strategy, and their risk of gambling harm has not reduced to a level that would suggest a population-neutral or universal approach should be taken.

The strategy acknowledges the risks to young people/rangatahi and the importance of engaging with and including them⁵⁸ to address a gap in public health and early intervention services, with an emphasis on education and the risks from online gambling. 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).

These population groups are not homogenous. There is diversity within each of them and also significant crossover, 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.

It is recognised that other groups are also vulnerable to gambling harm, for example people with disabilities, older people, and families on low incomes. The Ministry expects all funded services to be accessible and responsive to address the gambling harm-related needs of anyone who needs them.

58. In this strategy, young people / rangatahi relates to people aged under 25, as set out in the CYWS (see <https://childyouthwellbeing.govt.nz/resources/child-and-youth-wellbeing-strategy>).

Figure 3: Strategic framework outcomes and objectives

KEY

- Ministry of Health
- Ministry of Health and DIA
- Ministry of Health and Te Hīringa Hauora
- DIA

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

WHAKAMAUA HEALTH AND DISABILITY SYSTEM OUTCOMES [ADAPTED FOR GAMBLING HARM]

OBJECTIVES FOR THE PMGH STRATEGY

		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	

How we will measure progress

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.

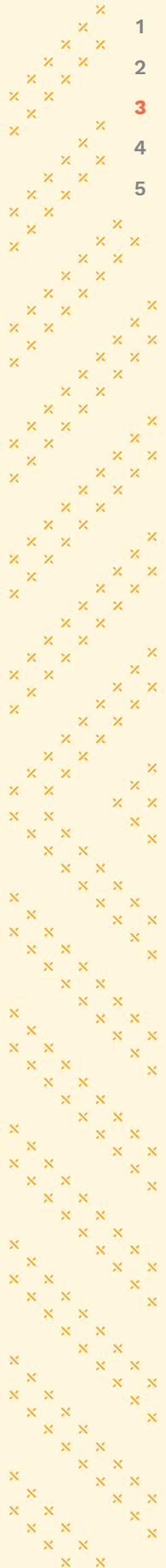
We will measure and report on progress in two main ways.

- › We will publish 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 website.⁵⁹
- › We will commission and publish a needs assessment every three years. The next needs assessment, due to be commissioned in 2023, will consider the impact of the strategy.

Research and service data is published on the Ministry website and updated regularly. DIA also provides detailed information about the gambling industry on its website.

The Ministry will also explore the development of a set of service- and system-level indicators for gambling harm. 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 into account work currently being done by the Ministry and Mental Health and Wellbeing Commission, as well as the transformation of the health and disability system. We will consult with interested stakeholders as we develop these long-term indicators.

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



4

The service plan 2022/23 to 2024/25

Purpose of the service plan

The service plan 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 we will deliver the strategic goals, outcomes, objectives and priority action areas outlined in the strategic plan.

The Ministry is 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 of harmful gambling on individuals, their families and whānau, and affected others.

Change in focus

The service plan has been informed by research evaluation and service data, the needs assessment and submissions received.

Gambling harm inequities continue to significantly affect priority populations (Māori and Pacific peoples, Asian peoples and young people/rangatahi). To address this, the service plan includes the following service and investment priorities (see Table 1):

- › strengthen system leadership and collaboration to reduce longstanding inequities in gambling harm
- › strengthen our public health approach, improve access to services and supports, and reverse the trend of client interventions declining while numbers experiencing gambling harm increase with population growth
- › invest in new and enhanced activities to enable more effective system-wide leadership and responses to prevent and minimise gambling harm
- › enable priority populations and people with lived experience to have greater involvement in service design, evaluation and research
- › develop and deliver services and supports that are innovative and respond effectively to this diversity.

Table 1: Summary of service and investment priorities

Service and investment priorities	Summary of service plan commitments
Strengthen our public health approach, including prevention	Invest in public health services and initiatives to build 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	<p>Commission public health and clinical intervention services. This will include kaupapa Māori services and services based on Pacific and Asian world views.</p> <p>Increase FTE rates for gambling harm clinical services to align with clinical rates for the mental health and addiction sector.</p> <p>Develop and evaluate innovative service models and approaches.</p>
Invest in digital services and supports	Develop and expand 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	<p>Collaborate with Māori and other priority populations, service providers, agencies, the research and evaluation sector, and the gambling industry.</p> <p>Commission and work with services to enable sector and community leadership. We will invest in coordination of services and the International Gambling Conference and Think Tank.</p>
Sustain funding in research and evaluation	Fund research and evaluation, including research into youth and online gambling, to better inform our understanding of gambling behaviour and service efficacy. This will be informed by greater engagement with affected communities.
Invest in developing a skilled, enabled, culturally safe and responsive workforce	<p>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 developing gambling-harm content for New Zealand Qualification Authority (NZQA) Level 7 and lower-level qualifications, and peer workforce qualifications.</p> <p>Invest in workforce development for the contracted public health and clinical gambling harm workforce.</p>
Invest in stronger Ministry leadership and delivery	Increase the Ministry’s operating capability to strengthen its leadership function and ability to deliver an expanded work programme.

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How the service plan aligns with the strategic framework

The service plan provides for a broader scope and mix of services, more focused research priorities and, importantly, additional investments to:

- › address health inequities, including young people/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
- › continue developing technological and service innovations.

Many of the strategic objectives and priority actions described in Section 3 are reflected throughout the service plan activities to varying degrees. For example, the strategic objectives to address equity issues and to provide a spectrum of services and support necessarily require services to place people at the centre and identify and respond to the needs of Māori, Pacific, Asian and young people/rangatahi (the priority populations). This will be reflected by activities that:

- › provide for 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 – which 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 make positive behaviour and lifestyle changes, and enable supportive conversations to challenge stigma and enhance mana
- › foster 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.

Overall, the service plan aligns with the key elements in the strategic framework through:

- › placing people at the centre, including those with 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 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 to enter the workforce
- › better sharing of information and evidence from research and evaluations to enable robust, evidence-based decisions about services and policies.

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Appendix 4 shows how the activities in the service plan align with the strategic objectives that they are most likely to affect. The services described below include additional investments to address identified gaps and priorities that will help achieve this change. However, the degree of change is also 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 of promoting equity and wellbeing by preventing and minimising gambling-related harm, will take time to appear in 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 strategic framework provides a set of long-term goals and objectives and to develop long-term indicators to measure progress towards improving health equity and wellbeing in relation to gambling harm.

Budget for 2022/23 to 2024/25

The service plan outlines the activities that the Ministry considers are required, and the estimated costs of providing those activities, for the 2022/23 to 2024/25 (current) levy period.

The total costs are \$76.123 million over three years, which is an increase of \$15.784 million from the last levy period (2019/20 to 2021/22). These costs cover the four nominal budget areas, plus a line item for new services and innovation:

- › public health services (preventing and minimising gambling harm)
- › clinical intervention and support services
- › research and evaluation
- › new services and innovation
- › Ministry operating costs.

Table 2 shows the three-year budget for the current levy period. These totals include costs incurred from activities that were planned for the last levy period but delayed due to impacts from the response to COVID 19 and will be completed in the current levy period. These delays contributed to a forecast underspend of approximately \$6.700 million, which is carried forward. This underspend is included in the total costs for the current levy period.

Table 2: Budget to prevent and minimise gambling harm (GST-exclusive), 2022/23 to 2024/25

Service area	2022/23	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.

Changes in investment

Table 3 shows the changes in funding by service area compared with the budget for the previous strategy.

Table 3: Budget changes compared with the last 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

Public health services (harm prevention and minimisation)

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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.

Table 4: Summary of public health services (harm prevention and minimisation) key actions

Investment area	Actions
Develop quality gambling harm minimisation services and supports	<ul style="list-style-type: none"> › Primary prevention (public health services) will empower people and communities to take control of their health and wellbeing to reduce gambling-related harm. › Standardise funding rates for workers in gambling harm public health services across service providers. Enable and embed 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"> › Primary prevention (public health services) will empower people and communities to take control of their health and wellbeing to reduce gambling-related harm.
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"> › Educate people about the signs and risks of harmful gambling and how they can respond and seek help through an awareness and education programme. › Develop and promote gambling harm material in schools 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"> › A de-stigmatisation initiative focused on priority populations will 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"> › Enable collaboration and leadership across the gambling sector by coordinating services and supporting an international gambling conference and think tank. › Fund an MVE database and administration service to support people who have opted to avoid gambling venues. › Enable and embed lived experience representation and input through the Gambling Harm Lived Experience Advisory Group.

The strategy includes investing in and developing services that better meet the needs of priority populations and engage with those with lived experience and affected communities in the design and delivery of health promotion, prevention and early intervention services and supports, for example as indicated in the actions shown in Table 4.

We will also explore developing content for host responsibility training, as an action that aligns with the strategic objective to support leadership to prevent and minimise gambling harm. This is not included as a funded activity in the strategy, because this training development work is administered by Toi Mai, as the relevant Workforce Development Council.

Table 5: Public health services (harm prevention and minimisations) 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
Public Health in Schools (young people / rangatahi)	0.200	0.200	0.250	0.650
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
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 in public health services described below include:

- › de-stigmatisation initiative, with support to engage with priority populations
- › young people/rangatahi as a new priority population
- › additional support for an MVE administration service and database.

Primary prevention (public health services)

The Ministry will:

- › commission services aligning with the current levy period
- › standardise the funding rates for the public health workforce across providers of public health gambling harm services.

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 and are available to service providers,⁶⁰ to enable the public health workforce to assess their competency levels as well as training and development needs.

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

- › policy development and implementation
- › safe gambling environments
- › supportive communities
- › aware and motivated communities
- › effective screening environments.

Training will include an emphasis on understanding different world views through cultural competence training, including developing the capability to work with Māori, Pacific and Asian communities and young people/rangatahi.

Awareness and education programme

The Ministry will continue to invest in an awareness and education 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 previous strategy.

The focus on young people/rangatahi is new for this levy period and additional resources to develop appropriate supports.

Key priorities for the current levy period include:

- › improving awareness of gambling harm among 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

60. See www.hetaumata.co.nz/public-health/pou-toru-core-competencies

- › promoting helpline and web-based services, face-to-face services and delivering a national gambling campaign (by building on work being delivered under the previous strategy)
- › developing digital self-help tools to improve access to information, help and online support
- › improving the safety of gambling environments and host responsibilities through online, training and gambling host resources, including translations into te reo Māori, Pacific and Asian languages.
- › listening to people with lived experience of gambling harm, to help identify barriers to service access and inform the design of better access for those seeking help.

Public health in schools (young people / rangatahi)

Public health in schools is a new initiative to prevent and minimise gambling harm for young people/rangatahi. For rangatahi, gambling is often associated with other harms including from substance abuse. We intend to maximise opportunities to address gambling harm by working with a mental health and addiction initiative operating in education settings.

De-stigmatisation initiative

The Ministry will 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 to enhance mana. This initiative will build on and align with the public health messaging of the awareness and education programme. It provides additional resourcing to ensure that effective and appropriate messaging is developed for different priority populations to challenge stigmas related to gambling harm as they affect each of their communities.

Stigmas related to gambling harm have many components and encompass a wide range of perspectives and cultural differences that deter people from seeking help or accessing services and support. Stigma can be experienced at an individual, community or institutional level, or by association. It can include a feeling of shame, losing face, low self-esteem, negative stereotyping or discriminatory behaviours. Family and friends may experience stigma by association or from the reaction of others.

This initiative will be developed in a way that meets the expectations of priority populations and people with lived experience for more agile messaging that is relevant and appropriate to specific communities. Funding will cover market research and engagement with affected communities to inform a second phase of participatory 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.

National coordination service

National coordination of services ensures all service providers know about significant developments, facilitates training opportunities, and provides regular updates.

Communication and engagement can strengthen partnerships and leadership among stakeholders. The national coordination of services will be a key mechanism for enabling this.

Gambling Harm Lived Experience Advisory Group

The Ministry's Mental Health and Addiction Directorate is committed to encouraging lived-experience participation and strengthen their networks, reach and influence.

The Ministry will continue to fund the Gambling Harm Lived Experience Advisory Group (previously called the 'consumer network') to inform service design, research and evaluation, and the education and awareness campaign through engagement with the Ministry and other agencies.

Multi-venue exclusion administration service and database

A national MVE administration service and database enables an individual to self-exclude from multiple gambling venues. The administration service component is essential for the MVE process to work. It maintains relationships with MVE stakeholders (including NCGM societies and venues, the supplier of the gambling exclusion electronic database, gambling harm service providers and DIA).

The Ministry will fund an MVE service and an electronic database to serve as a central repository for all venue exclusions.

Conference support

The Ministry contributes part of the funding for a biennial international gambling conference and an associated international think tank held in Aotearoa New Zealand. The next event is planned for 2024.

Holding international conferences and think tanks on gambling harm promotes New Zealand 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, and provides opportunities to strengthen leadership, communication and collaboration.

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Clinical interventions and support services

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

The indicative budget for these services is \$34.213 million for the current levy period. Indicative priority areas 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 funding for the clinical workforce delivering clinical interventions for gambling harm, to align with other Ministry-funded mental health and addiction clinical services, subject to appropriate criteria
- › 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, detailed in the new services and innovation section, which will lead to improved clinical services. This will cover new service models to address inequities and gaps, develop the clinical and peer workforce, and improve cultural responsiveness.

Table 6: 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	9.256	9.256	9.256	27.768
Helpline and web-based services	1.100	1.100	1.100	3.300
Digital services and supports	–	1.000	1.500	2.500
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 in intervention services described below include:

- › increasing FTE funding rates for clinical workforce delivering intervention services
- › developing and expanding digital services and support (eg, helpline and web-based services).

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Clinical interventions

Clinical interventions, including support services, provide for a range of interventions delivered in a variety of settings (including prisons) to people who are experiencing gambling harm. These are provided to 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.

We fund general (whole population) services and dedicated Māori, Pacific and Asian services. All services are open to people experiencing gambling harm.

We acknowledge the needs assessment findings that services need to be more equitable and culturally responsive and will be taking actions to address this in the current levy period.

The increase in funding for costs associated with the clinical workforce is expected to help attract and retain the clinical workforce.

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

Helpline and web-based services

Helpline and web-based services provide:

- › information, including self-help and assessment guides
- › access to intervention services for people who are unable or do not wish to access face-to-face services
- › referral to other gambling harm services.

A gambling telehealth service should provide a free 24/7 service and be a first contact point for people in crisis as a result of harmful gambling. It will also provide 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.

Key considerations for a telehealth service for gambling harm are to:

- › deliver Te Āo Māori and culturally appropriate services, with bilingual and bicultural models of care using Māori and Pacific clinicians and specialists
- › work with the gambling-harm sector and providers to ensure referral pathways to community-based services, with improved continuity of care.

Digital services and supports

Additional funding is provided to expand and develop new digital tools, services and self-help supports available online. This will improve access to and a range of information, services and supports that address gambling harm.

Data collection and reporting

This funding is allocated to provide specialist technical support for the database and reporting system.

Workforce development (clinical)

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

A qualified and culturally competent clinical workforce is needed to deliver a culturally responsive service to reduce the harm for people affected by gambling, including families, whānau and others.

Service 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.

The budget for research and evaluation is \$5.658 million for the current levy period. This is \$0.971 million less than the last 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 past commitments that will be completed after 30 June 2022.

Table 7: 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 funding reflects a commitment to focus on:

- › research into young people's gambling and online gambling, two interrelated topics
- › research into coexisting conditions, for greater understanding of the barriers to preventing and minimising gambling harm
- › increasing action research and evaluation with affected communities.

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Strategic priorities for 2022/23 to 2024/25

The research and evaluation programme is designed to strengthen the evidence base that supports all our work, and inform 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
- › studying patterns and impacts of gambling on young people/rangatahi, and online gambling
- › 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 services and innovations.

The Ministry will work more closely with the gambling sector to make research and evaluation findings more accessible, to communicate findings to all stakeholders and affected communities, and support application of these learnings into gambling harm services.

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. These 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 services 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:

- › commitments under the previous strategy to be delivered after 30 June 2022
- › new budgets to strengthen and develop a skilled, diverse and culturally responsive workforce.

The previous strategy includes commitments to trial several new service models that address inequities related to public health and intervention services. These activities will be completed after 30 June 2022, and 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.

Table 8: 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 ways 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 service model and expansion	0.350	0.688	0.800	1.838
Developing NZQA gambling harm content	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.

► **New ways to address inequity (public health and intervention services)**

The Ministry committed under the previous 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 8 includes funding committed in the last levy period that will be spent to complete these activities over the first two years of the current levy period.

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

► **Technology-related innovation**

The previous strategy included 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 provides for funding to complete this work in the strategy period from 1 July 2022.

Additional funding for digital services and supports is provided under clinical 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.

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 might otherwise hinder their treatment and recovery.

Enabling a diverse, skilled, and responsive workforce

This provides funding to strengthen and diversify the gambling harm workforce to improve workforce capacity and capability. It recognises the unique 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 intend to develop a skilled, capable and culturally responsive gambling harm workforce by investing in expanding the peer workforce, developing NZQA content specific to gambling harm to support degree (Level 7) and lower-level training, which has been identified as a gap in the current education and training provision

► Developing NZQA gambling harm content

Health practitioners working in gambling harm need to understand the specific interventions available, the specific pathways to problem gambling, and the ways in which families, whānau and others can identify if someone has a gambling problem.

The current qualifications available to those wanting to enter the workforce do not include a focus on preventing and minimising gambling harm.

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, with additional support available for priority populations and those with lived experience (see 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 undertake tertiary study that will help them enter the gambling-harm workforce.

The scholarships will include funding for the following.

- › An NZQA Level 7 addiction qualification, alongside support for professional development and practicum placements with providers. Scholarship recipients will be expected to include relevant gambling-harm content if it is available.
- › To study a lower-level NZQA qualification relevant to gambling and/or 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

The Ministry has increased its operating costs to enhance its leadership function and capacity to deliver on the expanded work programme and commitments outlined above.

The Ministry operating costs (departmental expenditure) enable the Ministry to deliver its responsibilities under the Act for developing and implementing this strategy. This includes leadership, service commissioning, and cross-government strategies and policies to prevent and minimise gambling harm.

This would include aligning with the new health and disability system.

Table 9: 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



Levy rates for 2022/23 to 2024/25

Section 319(2) of 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 current levy period is from 1 July 2022 to 30 June 2025 and aligns with the 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 NZ. There is no change to the levy paying sectors for the period covered by this strategy.

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 (sections 318–320). As part of this process, the Ministry consulted extensively on its estimated annual funding requirements, and four alternative sets of estimated levy rates. After considering submissions, the Ministry revised its consultation document and submitted these proposals to the Gambling Commission and responsible Ministers.

The Gambling Commission obtained its own advice and convened a consultation meeting on 27 January 2022. It submitted its report to responsible Ministers on 11 February 2022.

After considering the Gambling Commission report, the responsible Ministers recommended new problem gambling levy rates and regulations to the Governor-General.

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:

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

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 previous levy periods⁶¹

W1 and **W2** are weights, the sum of which is 1.

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 as defined in section 320(3) of the Act. Each sector’s 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.

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

Estimated current player expenditure (A)

The formula in the Act requires the levy rate calculation to take into account the latest, most reliable and most appropriate sources of information. The figures used are DIA estimates of player expenditure for each sector for 2021/22. The Ministry will use actual reported expenditure for 2020/21 and earlier years.

DIA has estimated current player expenditure using a variety of information sources, including its NCGM electronic monitoring system, gambling operators' annual and half-yearly reports, and information from Inland Revenue.⁶² Other data on gambling expenditure is available on DIA's website (www.dia.govt.nz).

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 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 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, this is not covered here but can be provided on request.

Table 9 shows each gambling sector's share of player expenditure and presentations.

The funding requirement (C)

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

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

⁶² Inland Revenue provides gaming duty and problem gambling levy data to DIA. The Tax Administration Act 1994 requires Inland Revenue 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.

Forecast player expenditure (D)

The amounts represented by *D* in the formula are sector-by-sector forecasts of the amounts that DIA expects to be spent on the gambling products of the four levy-paying gambling sectors in the new levy 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 electronic monitoring system, gambling operators' annual and half-yearly reports, and information from Inland Revenue. The reasoning behind the DIA forecast for each sector is set out below.

There may be changes in gambling expenditure as a result of future changes to the Act or regulations. However, it is not possible to forecast the likely impact of any changes until the nature of any legislative or policy changes becomes clear.

► Non-casino gaming machines

The number of NCGMs declined from 25,221 in 2003 to 14,704 at 30 June 2021 (in 1,059 active venues).⁶³ 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 \$924 million in 2018/19 before decreasing to \$802 million in 2019/20, reflecting the impacts of COVID 19 restrictions that closed NCGM venues. That said, expenditure for 2020/21 increased to \$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.

In the NCGM sector, club expenditure continues to decrease while non-club expenditure increases. In 2019/20 club expenditure accounted for only 10 percent of total NCGM expenditure.⁶⁴

► Casinos

Over the last few years, spending on casino gambling has fluctuated. DIA figures show expenditure of \$578 million in 2017/18, \$616 million in 2018/19, \$504 million in 2019/20 and \$559 million in 2020/21. Casino expenditure is affected by variations in international tourist numbers, including VIP (high-stakes) gamblers. This was most noticeable in the 2019/20 and 2020/21 years given the COVID 19 restrictions, which are ongoing at the time of preparing this document. DIA anticipates some slow growth in expenditure for 2021/22 to 2024/25, but its forecast is relatively conservative.

63. Data taken from the Gaming machine profits (GMP dashboard) page on the DIA website. URL: www.dia.govt.nz/gambling-statistics-gmp-dashboard (accessed 9 November 2021).

64. Data taken from the Key performance indicators page on the DIA website. URL: www.dia.govt.nz/gambling-statistics-key-performance-indicators (accessed 1 February 2022).

► TAB NZ

Spending on TAB NZ products was relatively flat for some years. 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. 2020/21 saw a shift against this trend with an expenditure of \$385 million, their highest year on record.

DIA anticipates flat to modest expenditure growth in the next three-year period.

Potential increases in expenditure brought about by technical innovations and product developments may be affected by competition in the racing and sports betting market from offshore betting agencies.

► Lotto NZ

Spending growth on Lotto NZ products has been relatively high, but volatile, since 2005/06. This volatility appears to correspond with the number of large jackpots in a year. Strong growth has continued over recent years. DIA noted player expenditure of \$561 million in 2017/18, \$530 million in 2018/19, \$631 million in 2019/20 and \$694 million in 2020/21. The significant increase in 2019/20 has been attributed to the rare occurrence of a Powerball Must-be-Won draw in February 2020, and Lotto NZ's ability to continue operating during the COVID 19 lockdowns.⁶⁵ Expenditure growth continued into 2020/21 with another Must-Be-Won draw in August 2020.⁶⁶

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

DIA expenditure forecasts by year and sector are shown in Table 10. DIA forecasts that Lotto NZ will experience stronger expenditure growth but that the other three sectors will experience steadier expenditure growth over the same period.

Table 10: Forecast expenditure by sector (GST-inclusive), 2022/23 to 2024/25

Forecast expenditure	NCGMs	Casinos	TAB NZ	Lotto NZ
2022/23 (\$m)	1051.51	601.95	376.25	784.14
2023/24 (\$m)	1076.44	611.50	383.77	833.51
2024/25 (\$m)	1105.91	621.04	391.28	885.98

Note: These forecasts are based on best estimates at this time, after the actuals for 2020/21 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.

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

66. Lotto New Zealand Integrated Report 2020/21. URL: <https://assets.mylotto.co.nz/assets/uploads/f9fd2390-509d-11ec-b7e0-455213321d7c.pdf>.

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.

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.^{67 68} This approach is considered 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 amounts to the actual spending recorded for the levy period for each previous year between 2004/05 and 2014/15.

This totals \$314.789 million, which becomes the target recovery amount from the four levy-paying gambling sectors. We estimate the levy payments received by Inland Revenue will total \$320.116 million by 30 June 2022. We calculated this by adding actual payments from each sector up to 30 June 2021 and 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 11 shows the values of *R* calculated. Overpayment amounts are deducted from (credited to) the next levy period amounts required from each sector, while any underpayments are added.

67. This takes account of any underspend for a previous levy period.

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

Table 11: Estimated underpayment or overpayment of problem gambling levy, 2004/05 to 2021/22, by sector

Sector	\$m (GST exclusive)
NCGMs	-3.758
Casinos	0.211
TAB NZ	-0.014
Lotto NZ	-1.765
Net difference (total)	-5.327

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

The weightings (W1 and W2)

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

Table 12 shows the proportion of expenditure (*A*) and presentations (*B*) attributed to each levy-paying sector for 2020/21, the most recent year for which comparative data is available for all four sectors.

Table 12: Share of expenditure and presentations by sector, 2020/21

NCGMs		Casinos		TAB NZ		Lotto NZ	
Expenditure	Presentations	Expenditure	Presentations	Expenditure	Presentations	Expenditure	Presentations
0.376	0.567	0.213	0.206	0.147	0.103	0.265	0.125

The top line of the levy formula determines the amount each sector will 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.

Levy Rates

Table 13 sets out each sector's levy rate for 2022/23 to 2024/25, expected payment amounts, and percent shares for the 30/70 weighting. The 30/70 weighting reflects changing patterns of player expenditure and presentations, and 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 top row of the table shows the levy rate for each sector, as the percentage of player expenditure it must pay as a levy. For example, a rate of 0.85 means that the sector must pay 0.85 cents for each dollar of player expenditure (as defined in Section 320(3) of the Act) from 1 July 2022 to 30 June 2025. The second row shows the expected levy amount each sector would pay if actual player expenditure matches the forecasts. The third row shows this amount as a percentage of the total expected in levy payments (having adjusted for R). The last row shows each sector's share of the total cost to fund the strategy over the levy period.

Table 13: Levy rates per sector: 30/70 weighting (all figures GST-exclusive)

	NCGMs	Casinos	TAB NZ*	NZLC
Levy rate (% of player net expenditure)	1.08	0.87	0.76	0.44
Expected levy amount (\$m)	34.926	15.960	8.750	11.016
Share of total expected levy amount (%)	49.43	22.59	12.38	15.59
Share of budget (%)	50.91	20.73	11.54	16.82

Appendices

Appendix 1: Aligning with other strategic documents

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

Whakamaua: Māori Health Action Plan 2020–2025

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
- › reduce health inequities and health loss for Māori.

We have adopted the latter three as objectives in this strategy, 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 is the key overarching document for improving health outcomes for Pacific peoples in Aotearoa New Zealand. 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 Pacific peoples 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 this strategy. *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 peoples. It also has a strong focus on workforce development across the health and disability sector. This strategy includes service and workforce plans that will help achieve these goals.

Pacific Aotearoa 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 and are reflected in this strategy.

- › 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.

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 14 shows how the principles of this strategy have been expressed in the strategic framework and service plan.

Table 14: Expressing the principles through the strategic framework and service plan

Principle	As expressed in the 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 mapped to each of the principles, and these links are explained in more detail in the 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 objectives and approaches. The service plan includes 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	Preventing and minimising gambling harm is supported not only by the strategy but also by requirements under the 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 assess 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 with this type of proposal. The majority of gambling-harm prevention and minimisation services are delivered by 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 service plan continues the recent focus on innovation and expands it from a focus on technology to a focus on new ways of delivering services, such as online options, and new ways of commissioning services, for example, through kōrero Māori.

Table 15 works through the practical implications for the Ministry and its service providers of applying 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 15: Applying 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"> › Recognising that 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 (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 with other social and health agencies in the same communities to better integrate services to prevent and minimise gambling harm › 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 changes

Appendix 3: Key continuities

This strategy reframes and restructures the previous one, responding to environmental changes and lessons learnt over recent years. 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. Table 16 shows the continuity between the four objectives of this strategy and the 11 strategic objectives of the previous strategy.

Table 16: 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 health 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 policies at national, regional and local levels prevent and minimise 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)		

Appendix 4: Strategic objectives by service plan activity

Table 17: 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 services (harm prevention and minimisation)				
Primary prevention (public health services)	✓	✓	✓	✓
Workforce development (public health)	✓	✓	✓	✓
Awareness and education programme	✓	✓		✓
Public Health in Schools (young people / rangatahi)	✓	✓		✓
De-stigmatisation initiative		✓		✓
National coordination service			✓	✓
Gambling Harm Lived Experience Advisory Group	✓	✓	✓	✓
MVE administration service and database	✓			✓
Conference support			✓	
Clinical intervention and support services				
Clinical interventions	✓	✓		✓

Appendices

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
Helpline and web based services	✓	✓		✓
Digital services and supports	✓	✓		✓
Data collection and reporting			✓	✓
Workforce development (clinical)	✓	✓	✓	✓
Research / evaluation				
Research	✓	✓	✓	✓
Evaluation (including outcomes reporting)	✓	✓	✓	✓
New services and innovation				
New ways to address inequity (public health and intervention services)	✓	✓		✓
Technology-related innovation	✓	✓	✓	✓
Intensive support	✓			✓
Peer workforce and expansion	✓	✓		✓
Developing NZQA gambling harm content	✓		✓	✓
Gambling harm scholarships	✓		✓	✓
Ministry operating costs				
Total operating costs	✓	✓	✓	✓

List of abbreviations

CYWS	Child and Youth Wellbeing Strategy
DIA	Department of Internal Affairs
EGM	Electronic gaming machine
FTE	Full-time equivalent
HLS	Health and Lifestyles Survey
MVE	Multi-venue exclusion
NCGM	Non-casino gaming machine
NGO	Non-governmental organisation
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

