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Draft Strategy to Prevent and Minimise Gambling Harm 2025/26 to 2027/28

Summary of Submissions

22 November 2024

Acknowledgements

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Glossary

Term	Description
The Act	Gambling Act 2003
AI	Artificial intelligence
AOD	Alcohol and other drugs
CLIC	Client Information Collection database, used for collecting clinical gambling harm intervention data
CS	Submission received through the Citizen Space submissions portal
CONCERN database	National venue exclusion database, serves as a central repository for all venue exclusion information
Continuous gambling	Gambling where a person can immediately reinvest winnings in further gambling, for example, gaming machines (within or separate from a casino), casino table games, 'scratchies' (Instant Kiwi) and sports or race betting
DIA	Department of Internal Affairs
The draft Strategy	The draft <i>Strategy to Prevent and Minimise Gambling Harm 2025/26 to 2027/28</i>
E	Submission received via the Ministry of Health's gambling harm email address
FRT	Facial Recognition Technology
Gamblification	The intentional insertion of gambling or gambling-related content into contexts in which it is not naturally present (i.e. within online games)
The Gambling Commission	New Zealand Gambling Commission
HLS	Health and Lifestyles Survey - the main source of information about individuals' gambling risk in Aotearoa New Zealand
HNZ	Health New Zealand Te Whatu Ora
Levy rates	The problem gambling levies paid by the regulated gambling sector operators
Lived experience	Within the context of this document, lived experience refers to the knowledge and wisdom that comes about from the direct impacts of experiencing mental distress from gambling harm and addiction
Loot box	In video gaming, a virtual container or prize crate (like a lucky dip) that players buy in a game with real or in-game money and which holds a random virtual item that players can use in the game, such as a special ability to add to a player's avatar or equipment like weapons or armour

Term	Description
The Ministry	Ministry of Health Manatū Hauora
Medical college	A membership-based organisation that supports and represents medical practitioners.
MVE	Multi-venue exclusion
NCGM	Non-casino gaming machine, also known as class 4 gambling or electronic 'pokie' machine
NZQA	New Zealand Qualifications Authority
Pae Ora	Pae Ora (Healthy Futures) Act 2022
PMGH	Prevention and minimisation of gambling harm
Regulated gambling sectors	Lotto New Zealand, TAB New Zealand, casinos, and non-casino gaming machine operators
TLA	Territorial local authority
Tāngata whaiora	People with lived experience of mental distress, including from gambling harm and addiction
Tūturu	School-focused programme created to help schools and health services better support all students to learn and be well, led by the New Zealand Drug Foundation

Executive summary

Sixty-four submissions were received

Sixty-four submissions were received on the Ministry of Health (the Ministry) draft *Strategy to Prevent and Minimise Gambling Harm 2025/26 to 2027/28* (the draft Strategy) consultation document. This is the same as the number of submissions (64) received during the 2021 consultation and less than the number of submissions (82) received during the 2018 consultation. Submissions were received from:

- twenty-five **gambling industry** representatives¹
- eleven **service providers** including clinical treatment providers, public health providers, and advisory groups
- thirteen **individuals**
- nine **health** representatives including health providers, medical colleges, and not-for-profit health organisations
- two **local government** organisations
- one **researcher**
- one **lived experience group**
- two **others**.

¹ Including 16 that utilised a [form submission](#) developed by the NCGM industry.

Learnings and recommendations from lived experience of gambling harm

Some hui participants and submitters provided specific examples of their own lived experience of gambling harm, or gambling-related harm experienced by their friends, family, whānau or clients.

- These experiences highlighted the impact gambling harm has had on all aspects of a person's life when they are struggling with gambling harm including the **risks to their own (and others) safety that they take to obtain funds to gamble**.
- **International students** were seen as a population that is at risk of considerable harm but **are underrepresented in harm reduction priority groups**. A few stakeholders with lived experience observed gambling harm impacts on international students. These stakeholders highlighted the compounding impacts of isolation from support networks, being in a foreign country, easy access to gambling, and language barriers for international students. One stakeholder noted on more than one occasion the high number of international students they witnessed lose hundreds of thousands of dollars in casinos.
- The effect on children living in households impacted by gambling harm made up some of the most sobering stories. Primary school aged children (and sometimes younger) have had to advocate on behalf of themselves and their whānau and encountered roadblocks to accessing services. This was seen as being a result of **service provision for youth only being funded from 14 years and up**. Hui participants who had been in this position as children urged the Ministry to fund support service to children aged under 14 years.
- We heard stories of financial harm when someone can access funds or acquire debt against a shared bank account to fund their gambling. These stakeholders shared stories of **devastating financial loss and hardship that was a direct result of someone else's gambling**. These stakeholders urged greater regulatory controls around joint bank accounts.
- We heard stories about the efficacy of existing harm reduction measures. Those with lived experience of gambling harm noted that **intervention processes designed to mitigate continuous gambling is not always executed effectively**, if at all. Stakeholders suggested that this is a result of poor training and support for venue staff.
- Lived experience stakeholders emphasised that **gambling harm does not occur in a vacuum**, and that other mental health, addiction, and socio-economic considerations are important co-morbidities to gambling harm. However, due to the funding parameters of the current health system, those seeking help are unable to be treated for multiple harm factors at the same time or by the same provider. This has resulted in a lack of continuity of care across the mental health and addiction sector.

Key themes from written submissions

Strategic plan

Forty-six submissions commented on the strategic plan. Feedback was largely positive with some constructive recommendations. Some of the feedback on the strategic plan was broad, and much of it applies across the entire draft Strategy document:

Priority populations and cultural competence was a strong theme throughout

- Service providers highlighted that **te Tiriti was missing from the draft Strategy** which sent a strong message to readers.
- **There was broad support across submitter categories for the work to support priority populations.** Some submissions provided feedback on ways to better support priority populations, and suggestions to expand the list of priority populations to include older people.
- Service providers and health organisations noted that **cultural competence is important and requires ongoing focus.** Submitters noted efforts within this draft Strategy and previous Prevention and Minimisation of Gambling Harm (PMGH) strategies to raise the bar regarding cultural competence, but that there is still more work to be done in this regard.
- All categories of submitter spoke to **growing concerns for tamariki and rangatahi** as being at increasing risk of gambling harm. Specifically, submitters were concerned about the gamification of online gambling apps, the particularly vulnerable position international students were in, and the impact of second-hand harm on young children who have suffered negative impacts at home because of gambling harm.

Online gambling was an issue for many submitters

- **Online gambling was an area of focus across the consultation for all categories of submitter,** from both a strategic and service delivery perspective. Submitters across the spectrum were concerned about the impacts of online gambling.

Submitters were concerned for the health and wellbeing of those impacted by gambling harm

- Service providers and those with direct and second-hand lived experience asked for **more support for families, communities, and the workforce.** Through stories of lived experience, submitters highlighted the impacts of gambling harm on whānau and communities.
- Health organisations suggested **there is room to better align the draft Strategy with other mental health priorities.** Submitters acknowledged the Ministry's work to align the draft Strategy to mental health priorities, but submitters felt that more could be done to align the actions of the draft Strategy to other mental health and addictions work, including Pae Ora, and representation for gambling harm within the Mental Health Act 1992.

Service plan

Forty-three submissions commented on the service plan. There was support in some areas, such as for the proposed new services and investments, as well as for the research priorities. Other proposals such as the type and mix of services was less popular with submitters. The key areas of feedback across the service plan are summarised below:

Accessibility was a key concern for many submitters who commented on the draft service plan

- **Lack of afterhours service support** was seen as a failing of the service plan. Many submitters noted that afterhours services were key, as people seeking help might only reach out one time. Submitters were concerned that if these people are missed, there is a strong possibility they will then fall through the cracks and not engage with service providers.
- Similarly, **support for geographically isolated communities** was raised in many submissions, with an emphasis on the lack of face-to-face support. Some submitters acknowledged the difficulty in providing face-to-face support and suggested an outreach or hybrid programme be established to reach rural and regional communities.
- There was a strong desire to see **culturally appropriate services for priority populations**. Submitters were pleased to see that work is being done to expand the peer support workforce in this regard, and that the availability of additional NZQA qualifications would engage those with lived experience to enter the sector or upskill those working in non-counselling roles. Submitters reinforced the importance of funding a diverse range of service providers to culturally and linguistically diverse communities.

Some submitters felt the service plan does not place enough weight on prevention

- Prevention and early intervention were not seen as having enough prominence within the draft strategic plan. Many submitters noted that **prevention should be prioritised**, if necessary, over treatment. Several submitters wanted to see funding allocated to prevention and minimisation of gambling, rather than focusing on the 'ambulance at the bottom of the hill'.

Submitters broadly valued the investment in research, monitoring, and evaluation

- There was **general agreement with the research and evaluation priorities proposed**, and submissions highlighted the importance of commissioning independent evaluation of the approach to preventing and minimising gambling harm in Aotearoa New Zealand.
- Gambling industry submissions that agreed with research priorities suggested **including sector feedback in regular, national research and evaluation activity**.

- Service providers were **concerned by the decrease in the research budget** and recommended investing in collaborative, long-term research capacity.
- Submissions that disagreed with research priorities called for **more culturally appropriate and methodologically robust evaluation and research approaches** and greater clarity of funding and procurement processes.
- Some gambling industry submitters wanted to see **greater accountability** for the Ministry and service delivery partners and proposed including service delivery targets with key performance indicators that could be monitored and reported on to levy payers and the public.

Technology and self-exclusion were considerations for all category of submitter

- There was a vocal collective of gambling industry submitters that opposed the **removal of a dedicated technology budget** from the draft service plan. These submitters highlighted the fact that there was a dedicated technology budget in the previous strategy.
- There was widespread **support in principle for self-exclusion functions**, though there were also concerns about the funding for MVE and for a new online self-exclusion database. Submitters who discussed this topic almost universally recommended that the **CONCERN database be used for online self-exclusion** as well as MVE. Additionally, some gambling industry submissions opposed Hauora Māori services being funded for MVE while others were not, particularly given the amount set aside for this proposal.

Levy

Forty-one submissions commented on the draft levy, with the gambling industry being the largest group of contributors. Key themes from feedback on the levy included:

Levy payers did not agree on proposed weightings

- Most submissions that commented on the levy **did not agree that the player expenditure forecasts are realistic** and particularly, that online gambling operators were not paying a fair share of the levy. These submissions were mostly made by NCGM submitters.
- There was a distribution of preferences for levy weightings, with **30/70 being the most popular of the weightings** from the consultation document, and 50/50 being a popular new weighting. The **suggested 50/50 weighting** is part of a collection of gambling industry submitters citing a form submission written by the NCGM gambling sector (see 1.4.2 for more on this).

Strategy development process

Twenty-four submissions commented on one or both of the two additional questions posed by the Ministry regarding the strategy development process. The Ministry sought feedback from key stakeholders on whether the strategy update process should be conducted every

five years instead of every three; and whether the Ministry and Gambling Commission consultation processes should be combined and streamlined.

Keeping the status quo was generally the preference across all submitter categories

- Most submissions **did not want the strategy development process to extend to five years**, with most preferring to stick with the status quo. Submitters considered it was important that they be given the opportunity to consult every three years, particularly if they were levy payers.
- Similarly, as technology and the market are changing at a rapid pace, a five-yearly cycle was considered too long.
- A few individual submissions however agreed that a five-yearly review cycle was preferable to mitigate the administrative and cost burdens associated with a three-yearly cycle.
- Submissions were **divided on support for simplifying consultation requirements** from two phases to one. Some submitters stated it was important that the Gambling Commission maintain independence within the review and consultation process, while others considered it would be more cost-effective and pragmatic to merge the two review processes.
- Some submitters called for a **review of the overall strategy development process**. Gambling industry submissions in particular called for an overhaul of the strategy development process, noting the Gambling Commission feedback on this topic in 2019 and 2022. Additionally, some submitters called for an overhaul of the Gambling Act, citing that it was now out of date and no longer fit for purpose.

Key themes at consultation hui

In the consultation hui, discussions around the strategic and service plan focused on reducing stigma for those with lived experience, aligning the draft Strategy with other mental health priorities and documents, and the absence of te reo Māori.

There is more work to be done to connect with priority populations

- Hui participants were disappointed that the draft Strategy **did not include meaningful use of te reo Māori or reference to te ao Māori worldviews**. This was seen as a big step backwards for the provision of healthcare services in Aotearoa New Zealand, particularly given the proportion of Māori with complex relationships to gambling.
- The role of stigma in reaching out for help was a significant topic in hui, particularly at hui with lived experienced representatives attending. Some submitters stressed the impact of stigma on some populations (particularly Asian and other ethnic minorities). These participants emphasised the **ongoing need for stigma reduction in the draft Strategy**.
- Following on from personal experience, some hui participants wanted to see an expansion of **harm reduction programmes to reach a wider range of whānau** affected by gambling harm beyond the directly impacted individual/s. This includes funding services for children under the age of 14 years.

Lack of accessibility to services was concerning for some

- Participants from across demographic categories noted that **accessibility to services** was potentially missing from the service plan, specifically regarding **afterhours and rural and regional service provision**. These participants noted that afterhours availability is particularly important, as those who need help might only reach out once. Service providers wanted to ensure there is someone for those people to connect with regardless of the time of day.

Alignment of health services is critical for continuity of care

- Service providers and those with lived experience raised the **need for greater interconnectedness at a strategic level between gambling and other mental health, addiction, and social service provision**. For example, a few service providers noted that service users rarely present *only* with gambling harm requirements. Co-morbidities could include a wide range of health, social, and welfare considerations. Service providers wanted to see greater alignment across provision of services at both a strategic and operational level.
- Service providers noted the importance of **alignment at the operational level between the provision of related services**. Participants noted these other services are likely to include mental health, welfare, and alcohol and other drug (AOD) services. Some participants discussed continuity of care across service provision.

Other key themes

- Some participants raised questions about **MVE and facial recognition programmes**. Some participants with lived experience of gambling harm were critical of MVE as a process and stated that the reliance on venue staff to engage gamblers experiencing harm was sometimes unreliable.
- **Strengthening the peer support workforce** was noted in most hui as a core component of the delivery of gambling harm services. Service delivery and lived experience participants in particular noted that adequate workforce development (as noted in the Needs Assessment, strategic plan, and service plan) is key to recruiting and retaining a workforce with the best skills and experience. Lived experience and service provider participants highlighted the value of peer support workers specifically.

Levy

Most of the comments regarding the levy in consultation hui came from gambling industry levy payers. Key themes included:

- Some participants raised concerns that **online gambling sites, particularly those based overseas, were not paying a fair share of the levy**. These participants wanted clarity before the 2026 regulations came into force over how these sites would be taxed and how they would be assessed regarding the levy weighting.
- A few participants **queried whether, despite the intention of the full cost-recovery model, the levy funds were sufficient to provide funding for the growing needs of gambling harm service users**. Some service providers highlighted the often interlinked and complex requirements that service users can present with, some of which cannot be disentangled from gambling harm. These providers queried where the responsibility and thus funding should lie regarding intersectional and interlinked harm.
- One industry participant queried whether the levy options provided for consultation should take the (current) **70/30 weighting as the midpoint option**, rather than the lowest end option.

How to navigate this report

This report has been drafted and arranged thematically, based on the structure of the Ministry's consultation document.

This report contains eight sections and three appendices.

1. **Section 1** outlines the purpose and structure of the report, describes the methodology, and provides an overview of submissions received.
2. **Section 2** summarises recommendations from **lived experience** stakeholders.
3. **Section 3** describes the comments from submissions regarding the **draft strategic plan** including commentary about each of the four objectives, changes in the gambling environment, and priority populations.
4. **Section 4** describes comments from stakeholders regarding the **draft service plan** including the proposed funding allocation and the key initiatives or programmes planned for 2025/6 to 2027/8.
5. **Section 5** describes comments from stakeholders regarding on the **gambling levy** rates including the levy weightings and the method for calculating levy rates.
6. **Section 6** describes comments regarding the **future Strategy development process** including two specific proposals that the Ministry sought feedback on.
7. **Section 7** provides a **thematic analysis by sector**
8. **Section 8** summarises out of scope issues that were raised frequently by stakeholders.

Appendix A provides a list of the questions outlined in the consultation document.

Appendix B provides a list of the specific recommendations made by submitters.

Appendix C identifies submitter organisations (individuals have been anonymised).

1 Introduction

1.1 Background

About one in five people in Aotearoa New Zealand experience harm because of their own or someone else's gambling. This harm is not experienced evenly across communities, with Māori, Pacific, Asian, and young people being at greater risk of gambling-related harm. While the number of people spending money on gambling is relatively small, for the first time in 2022/23, New Zealanders lost over \$1b on non-casino gaming machines (NCGMs). NCGMs are disproportionately located in higher deprivation areas.

Gambling in Aotearoa New Zealand is regulated by the Gambling Act 2003 (the Act). This legislation has a range of purposes including to prevent and minimise harm from gambling and problem gambling (section 318(3)(b) refers). The Ministry is required to prepare an integrated gambling harm strategy focused on public health under the Act. The draft *Strategy to Prevent and Minimise Gambling Harm 2025/26 to 2027/28* (the draft Strategy) sets out the approach and budget for funding and coordinating services to prevent and minimise gambling harm. It includes a problem definition and Needs Assessment, the proposed strategic plan, the proposed service plan, and the proposed levy rates and weighting options for the next three years.

The proposed three-year strategic plan drives towards four outcomes:

1. There is a spectrum of effective services and supports to prevent and minimise gambling harm – from prevention to early intervention to specialist support.
2. Social and cultural norms prevent and minimise harm from gambling.
3. Strong leadership and accountability of the gambling harm prevention system support decision-making as close to communities as possible.
4. The system focuses on those who are most at risk of harm from gambling.

1.2 Purpose

The Ministry commissioned *Allen + Clarke* to support public consultation on the draft Strategy by supporting two information sessions, facilitating 13 virtual and in-person consultation hui, and providing independent analysis of the feedback received through the public consultation hui and the 64 written submissions (received via email or the Ministry's consultation hub). Some hui were general in theme, and some had focus areas geared towards priority populations including Māori, Pacific peoples, Asian, youth, and lived experience. Other hui were designed to reach industry and service provider viewpoints, as well as the general public.

This report provides the Ministry with a summary of all feedback collected through the public consultation and via submissions made on the draft Strategy. It includes analysis from 13 consultation hui and the 64 submissions received during the formal consultation process undertaken from 23 August to 6 October 2024. This report summarises views submitted on the draft Strategy by both thematic area and by category of submitter. It includes analysis of submissions by submitter category (individual, service provider, gambling industry etc).

Evidence provided by submissions is also described where relevant. The contents of this report will inform the Ministry's development of an updated Prevention and Minimisation of Gambling Harm Strategy, which will take effect from 1 July 2025 and cover the period 2025/26 to 2027/28.

1.3 Methodology

1.3.1 Consultation hui

Thirteen consultation hui were conducted in-person and online (via Zoom) between September 4th and 30th 2024. Different stakeholder and interest groups were encouraged to attend and share feedback. The purpose of the two-hour hui was to facilitate discussion about the draft Strategy, answer questions from stakeholders, and provide advice about preparing written submissions. During each hui, Ministry officials delivered a 20 to 30-minute presentation of technical information relating to the draft Strategy and the consultation process, with supporting detail provided in a slide deck. *Allen + Clarke* representatives facilitated an open conversation to engage stakeholders and gather feedback on the consultation document.

Stakeholders were recruited for hui via email, the Ministry's website, and social media. As well as Ministry and *Allen + Clarke* attendance, officials from Health New Zealand (HNZ) and the Department of Internal Affairs (DIA) also attended most hui to help answer questions relating to their gambling harm minimisation work programmes. Written notes of the verbal feedback received during the hui were taken by *Allen + Clarke*. Themes from the hui are included under the relevant heading throughout the report.

1.3.2 Submissions

Written submissions were received by the Ministry via Citizen Space, a web-based consultation software, and by direct email submission, according to submitter preference. The list of consultation questions is provided in **Appendix A**. Submitters were asked to identify if they were submitting on behalf of an organisation (and if so, what type of organisation) or as an individual. Submitters were also asked which perspectives their submission represents, with a standard set of possible options to select from. This categorisation was supplemented by a Ministry assessment if the submission type was not clear or not provided OR to determine a primary classification if the submission had nominated multiple types. All submissions were collated and allocated a unique identifier before being provided to *Allen + Clarke* in electronic format.

1.3.3 Information sessions

To support participants engaging in consultation hui and written submissions, *Allen + Clarke* assisted the Ministry to deliver two online information sessions. The Ministry hosted these sessions on Tuesday 27 and Thursday 29 August to outline the purpose of the consultation and the ways in which stakeholders were invited to engage. The Ministry developed and delivered the content and published a recording of this material online.

1.3.4 Analysis

Allen + Clarke analysed the consultation hui notes and submissions through NVivo, a qualitative data analysis software tool. All data was organised and analysed against a coding framework that aimed to extract key themes relevant to the consultation process. This coding framework was informed by the consultation questions and the outputs from consultation hui. It was developed collaboratively between *Allen + Clarke* and the Ministry.

1.3.5 Reporting

Following completion of the analysis, *Allen + Clarke* developed a summary of submissions report (this document). This report provides a descriptive analysis of all commentary provided including a table summary of the yes/no questions by category, section, question, submission characteristics, and a thematic analysis of the free text responses to consultation questions. Each comment has been attributed to a submission, using a unique identification code.

When reporting on themes and sub-themes throughout the report, numbers and/or submitter types have been provided.

Additionally, the strength of support/opposition of themes is indicated within the level three storyline headings throughout this report for succinctness and clarity. The terminology below has been used to indicate the strength of support/opposition is as follows:

Description	Approximate proportion of submitters
Few	Fewer than 5 percent
Some	5 to 25 percent
Quarter	25 percent
Many	25 to 50 percent
Half	50 percent
Three-quarters	75 percent
Most	50 to 90 percent
Almost all	90 percent or more
All	100 percent

When determining answers to yes/no questions, submissions made via Citizen Space were straightforward as most questions required a yes/no answer. For email submissions, analysis determined the sentiment of the submission based on the narrative feedback provided, and submissions were categorised manually. In the rare instance that a submitter did not indicate support/opposition to the themes they were discussing, analysts coded this content to an 'other' code and included the content in the thematic analysis, but not in the numeric breakdown.

1.4 Summary of stakeholders

1.4.1 Number and type of submitters

A total of 64 written submissions were received:

- 51 submissions from organisations
- 13 submissions from individuals.

The primary classification of the number of submissions for each are described in **Table 1** **Error! Reference source not found.**

- ‘Gambling industry’ includes gambling-associated organisations such as NCGM societies, clubs, sector representatives, and technology providers.
- ‘Service provider’ includes organisations that offer treatment to people who are experiencing harm from gambling.
- ‘Health’ includes organisations such as other health providers, medical colleges, and social services organisations.
- ‘Local government’ includes territorial local authorities (TLAs).
- ‘Researcher’ includes academics and researchers.
- ‘Lived experience’ includes individuals and groups of individuals with direct lived experience of mental distress caused by gambling harm.
- ‘Individual’ is the category of submissions received from private individuals.
- ‘Other’ is the category of submissions received from organisations or individual that do not fit under any of the other classifications.

Table 1: Submissions by primary classification

Primary classification	Number of submissions received
Gambling industry	25 submissions ²
Individual	13 submissions ³
Service provider	11 submissions ⁴
Health	9 submissions ⁵
Local government	2 submissions ⁶

² CS12, CS14, E1, E5, E6, E9, E10, E11, E20, E22, E25, E26, E27, E28, E29, E30, E31, E32, E34, E36, E37, E38, E41, E46, E47.

³ CS1, CS2, CS3, CS5, CS6, CS7, CS8, CS9, CS10, CS11, CS13, E2, E8.

⁴ CS4, CS15, E4, E12, E16, E21, E23, E39, E42, E45, E49.

⁵ E13, E14, E17, E19, E33, E40, E43, E44, E48.

⁶ E2, E24.

Primary classification	Number of submissions received
Researcher	1 submission ⁷
Lived experience	1 submission ⁸
Other	2 submissions ⁹
Total	64 submissions

As well as the ability to self-identify from a range of different classification types, submitters could identify one or more perspective/s. Submitters who **self-identified into priority perspectives** are described in **Table 2**. Please note that the perspectives have been collected where provided, but **not all submitters provided details of specific perspectives that they represented. Additionally, some submitters provided more than one perspective.** As such, these have not been added to provide a total number, as the perspectives are decoupled from the number of submitters. We also acknowledge that there are other perspectives held by those who interact with gambling harm, but these are the most frequently cited perspectives by submitters. For instance, some submitters identified as individuals, and were classified accordingly in Error! Reference source not found., and also self-identified with one or more different perspectives, as noted below in **Table 2**.

Table 2: Number of submissions by perspective

Perspective	Number of submissions identifying with this perspective
Gambling industry (levy payer)	26 ¹⁰
Service provider	10 ¹¹
Health	10 ¹²
Lived experience/tāngata whaiora	11 ¹³
Māori	5 ¹⁴
Family/whānau	2 ¹⁵
Researcher	2 ¹⁶

⁷ E7.

⁸ E15.

⁹ E18, E35.

¹⁰ CS7, CS12, CS14, E1, E5, E6, E9, E10, E11, E20, E22, E25, E26, E27, E28, E29, E30, E31, E32, E34, E36, E37, E38, E41, E46, E47.

¹¹ CS1, CS4, CS15, E4, E12, E16, E21, E23, E45, E49.

¹² CS3, E13, E14, E17, E19, E33, E40, E43, E44, E48.

¹³ CS1, CS2, CS4, CS6, CS8, CS9, CS10, CS11, CS15, E8, E15.

¹⁴ CS4, CS15, E4, E12, E45.

¹⁵ CS3, CS11.

¹⁶ CS1, E7.

Perspective	Number of submissions identifying with this perspective
Pacific	2 ¹⁷
Asian	4 ¹⁸
Local government	2 ¹⁹
Disability	2 ²⁰
Children/young people	1 ²¹

1.4.2 Form submissions

Most submissions were unique, but 16 NCGM gambling industry submitters drew on the submission drafted by a NCGM gambling industry leader, at least in part and sometimes substantially, to develop their own submission. This has been noted in sections of the report where content from this submission type has been dominant in the analysis as ‘NCGM form submission’. This group largely comment on service delivery and the gambling levy.

1.4.3 Summary of consultation hui participants

Table 3: Number of participations by hui

Date of hui	Focus of hui (if applicable)	Number of participants
4 September 2024	General (online)	11
5 September 2024	Industry (online)	8
9 September 2024	Lived experience (Wellington)	8
10 September 2024	Lived experience (online)	3
11 September 2024	Service provider (online)	17
12 September 2024	Lived experience (Christchurch)	4
16 September 2024	Pacific peoples (Auckland)	37
16 September 2024	Lived experience (Auckland)	1
17 September 2024	Asian and other ethnic communities (Auckland)	21

¹⁷ E2, E49.

¹⁸ CS11, E8, E15, E16.

¹⁹ E3, E24.

²⁰ CS1, E14.

²¹ CS6.

Date of hui	Focus of hui (if applicable)	Number of participants
18 September 2024	Youth (online)	2
19 September 2024	Māori (online)	11
28 September 2024	Lived experience, Asian (online)	11
30 September 2024	General (online)	13
	Total	147

1.5 Limitations

This report should be considered in context of the consultation approach and reporting timeframes:

Consultation questions 13 and 14 on the future Strategy development process under the Act were published part-way through the six-week formal consultation period. These additions were made on Friday 13 September when submissions had already been open for three weeks. Six submissions were received before 13 September and did not have the opportunity to respond to these two questions. At less than 10 percent of the total number of submissions, this number is not consequential to the overall findings of the report or of Q13 and Q14.

This report is the product of a rapid review of submissions. Submission closed on 6 October and all (except one) submissions were received by close of business 7 October. The draft Summary of Submission report was provided to the Ministry on 16 October, and final report (this document) provided on 15 November.

2 Lived experience of gambling harm

The content in this section discusses lived experiences of mental distress caused by gambling harm, including emotional, financial, and psychological impacts, which may be distressing for some readers. Please only read this section if you feel safe to do so.

If you or someone you know has been impacted by gambling harm, you can contact [Gambling Helpline Aotearoa](#).

2.1 Those with lived experience suggested changes to the strategic design and service delivery of gambling harm reduction measures

Submitters and hui participants (collectively referred to in this section as stakeholders) with lived experience of gambling harm provided valuable insights, expertise, and knowledge to this consultation. Some stakeholders provided explicit suggestions for change to improve outcomes for those affected by gambling harm.

Additionally, some stakeholders with lived experience of gambling harm detailed their experiences and wisdom as part of this consultation, but did not always provide explicit recommendations for changes to the draft Strategy. In these instances, we have noted where any recommendations have been drawn out from our analysis and are not verbatim recommendations from the lived experience community. These have been indicated with an asterix*

We have also included recommendations and personal experiences from family and whānau of those who have direct experience of gambling harm.

2.1.1 Recommendations made by the Gambling Harm Lived Experience Advisory Group

The Gambling Harm Lived Experience Advisory Group (the Advisory Group) was established in 2020 by the Ministry, and now sits with HNZ. The group currently consists of 11 expert advisors who all have lived experience of gambling harm. The purpose of this group is to advise a range of agencies and services including the Ministry and HNZ on issues relating to gambling harm, from a lived experience perspective.

The Advisory Group recommended that player cards limiting the amount of time spent gambling be introduced as part of the self-exclusion system.

Accounts from stakeholders with lived experience of gambling harm reinforced the need for greater controls around time spent engaging in gambling. For example, some stakeholders detailed experiences of spending long hours engaging in continuous gambling without ever being questioned by venue staff (as per their responsibilities as gambling operators).

The Advisory Group recommended that chairs and other seating should be removed from NCGM venues to make the spaces less conducive to long periods of gambling.

The Advisory Group considered it was important to ensure gambling venues were not enabling long periods of continuous gambling by making the spaces too comfortable. They advised that these spaces should be actively uncomfortable as a way to mitigate longer, uninterrupted, periods of harmful gambling.

The Advisory Group considered it problematic that there were no gambling harm reduction programmes in prison.

The Advisory group considered it was critical to provide gambling specific services in prisons, and noted that they were aware of instances where people who had experienced gambling addiction were seeking help from AOD services such as Alcoholics Anonymous in prison.

The Advisory Group suggested ATM withdrawal limits should be enforced more routinely.

The Advisory Group highlighted the positive impact of restricting the amount of money that can be withdrawn from ATMs within gambling venues. The group emphasised this was, in their personal experiences, a highly effective policy, but that it wasn't routinely enforced.

2.1.2 Recommendations drawn from lived experiences of gambling harm*²²

Gambling venues should not be able to capitalise on cultural traditions and holidays*

Some stakeholders with lived experience of gambling harm detailed experiences and knowledge of gambling venues capitalising on cultural traditions and holidays to promote gambling.

For example, one stakeholder described how a casino in a major Aotearoa New Zealand city had capitalised on cultural traditions and holidays celebrated by Asian communities. For years, this casino had targeted Asian patrons by hosting festivities, especially during the Lunar New Year, which is the most significant holiday in many Asian cultures. At this time, it is tradition for families to play games like mahjong as a way to test one's luck and forecast the upcoming year's fortunes. The casino leveraged this cultural practice, creating a festive atmosphere with decorations and activities that evoked a sense of belonging. The casino also distributed red packets to visitors, which are traditionally given by elders to younger family members, and contain money, symbolising good luck and prosperity. These red packets distributed by the casino contained gambling vouchers.

Additionally, a few stakeholders noted concerns that housie (similar to bingo) can be considered a form of low-risk gambling, especially in Pacific communities. Stakeholders noted that while housie is primarily played to connect, have fun, and socialise, there are a few participants who develop harmful habits such as needing to play daily, for prolonged periods, and spending significant amounts of money while playing.

²² These recommendations have been made by the authors of this report based on the information provided by stakeholders with lived experience of gambling harm and informed by the authors contextual knowledge of gambling harm through this consultation.

Investment is required to better understand and address the needs of those gambling due to social isolation*

Some stakeholders with lived experience of gambling harm expressed strong concern for those who were socially isolated and looking for connection through gambling. Many stakeholders (both with and without lived experience) highlighted the social nature of some forms of gambling, and how people without strong support networks were at risk of gambling addiction and gambling harm.

Accounts of immigrant experiences (specifically international students) suggested that living in a foreign country, separated from loved ones and support networks, and (sometimes) novel and unrestricted access to money, created a 'perfect storm' to engage in harmful gambling.

The impacts for this demographic can be significant, with some stating they felt suicidal during periods of harmful gambling, others recalling experiences of students they knew who had to return to their home country without finishing their qualification, having lost all their savings to gambling.

Experiences of rural and regional New Zealanders were also raised during this consultation, with social isolation cited as a similarly insidious contributor to gambling harm in these communities. One such individual detailed how the social isolation they experienced led them to connect with others via online gambling (via a legal online gambling provider in Aotearoa New Zealand). This online gambling provider enticed this individual with a \$50 credit to open an account, which led to tens of thousands of dollars of losses.

Guidelines for healthcare practitioners could be updated to enable better understanding of the connection between mental distress from gambling harm to other health conditions*

A few stakeholders with lived experience of gambling harm noted they've had disappointing interactions with the health sector, and emphasised the key role general practitioners specifically can play in accessing harm reduction services. One stakeholder specified that it was only during an assessment with a gambling harm counsellor that they realised their years of anxiety were directly connected to the gambling harm they had experienced, ranging from financial loss to relationship strain. Although their general practitioner had diagnosed them with anxiety, the connection between their gambling experience and mental health issues had never been made.

More robust training is required for gambling venue staff to better equip them to identify harmful gambling, interact with continuous gamblers, and support those experiencing mental distress to connect with gambling harm support*

A range of stakeholders and lived experience accounts of gambling harm reinforced the need for better intervention training for gambling venue staff. For example, one stakeholder detailed how they had been asked by casino staff to take a break from gambling, but they never explained what the reason was (such as the fact that they were exhibiting signs of gambling harm). As a result, these breaks were not immediately effective in reducing gambling behaviour.

2.1.3 Recommendations made by family and whanau of those experiencing gambling harm

More needs to be done to support the children of harmful gamblers.

Several hui participants were children of parents who were impacted by harmful gambling. These individuals detailed experiences such as being left unattended at home or in the car while their parents gambled. They discussed the constant fear and worry they experienced about their family's financial situation – whether there would be enough food on the table or if their parents had gambled away their earnings – which created deep insecurity.

One participant shared that the profound emotional impact of their parents' gambling included financial stress leading to frequent arguments and heightened tensions at home. They were often uncertain about how bills would be paid, which, compounded by the emotional strain of watching their parent struggle with losses, had lasting effects on their wellbeing. The persistent stress led to an anxiety diagnosis and depression as a teenager. Despite this, they never disclosed the struggle to their parents, carrying the emotional burden alone.

Gambling addiction, or gambling disorder, should be officially recognised as a mental health condition.

One hui participant and one medical college made this suggestion. The hui participant suggested this in the context of their spouse engaging in harmful gambling and taking on large amounts of debt in both their names via joint accounts. This was devastating as this individual had no recourse to close the joint account on their own, or seek medical intervention for their partner (without the partner's consent). With an official mental illness diagnosis, there may be more options available to the loved ones of harmful gamblers to limit the harm experienced by the wider family and whānau.

The medical college noted in their submission (see **section 3.1.6**) that recognising gambling disorder as a mental illness would broaden potential treatment options.

3 Draft strategic plan

The consultation document set out the draft strategic plan for the draft Strategy and the aim for gambling harm minimisation. It specified four priorities for the mental health and addiction sector over the next three years, as part of a framework for preventing and minimising gambling harm with 12 action areas and four strategic outcomes. This section outlines the commentary from submissions on the draft strategic plan. It covers:

- agreement (or otherwise) with the proposed strategic goal, objectives and priority action areas
- discussion of whether the draft strategic plan adequately reflected changes in the gambling environment
- comments on priority populations.

Three questions were asked, all of which included ‘Yes/No’ responses. **Table 4** below shows the wording of those questions and the number of submissions who responded, by response.

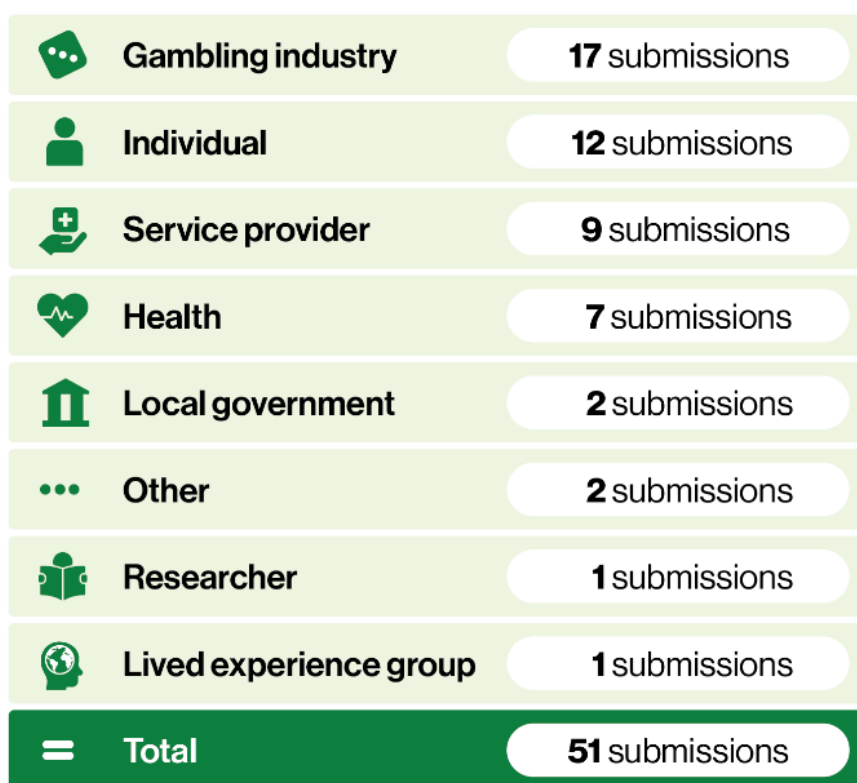
Responses were received from across the seven sector groups, as detailed in **Figure 1**.

Table 4: Responses to questions about the draft strategic plan

Question	Yes	Qualified support	No	Other comments	Total
1. Do you agree with the proposed strategic goal, outcomes, actions, and system priorities?	15	9	18	6	48
2. Does the draft strategic plan adequately reflect changes in the gambling environment?	5	3	24	1	33
3. Do you have any comments to make on the work to support priority populations?	N/A				29

Fifty-one submissions provided feedback on the draft strategic plan (17 gambling industry submissions, 12 individuals, nine service providers, seven health submissions, two local government submissions, two other submissions, one researcher, one lived experience group).

Figure 1: Number of submissions, by classification, that commented on the draft strategic plan



Key themes on the draft strategic plan:

Overarching feedback on the Draft Strategy

- There was moderate support for the strategic goal, outcomes, actions, and system priorities.
- Te Tiriti o Waitangi was missing from the draft Strategy.
- The draft Strategy could align better with other mental health priorities and strategies.
- Clarity was sought on the public health approach to harm minimisation.
- More funding was requested for facial recognition software and AI.

Online gambling

- More needs to be done to manage the impacts of online gambling.
- 2026 online gambling regulations should align with land-based gambling regulations.

Cultural competency and priority populations

- There was broad support for the work to support priority populations.

- Priority populations should remain a focus within the draft Strategy.
- Rangatahi are at increasing risk of gambling harm.
- Older people should be included as a priority population.
- Rainbow and disability recognition is missing from the draft Strategy.

Workforce and community support

- More support is required for families and communities.
- More support is required for the service provider workforce.

3.1 Strategic goal, outcomes, actions, and system priorities

3.1.1 Over half of the submissions supported the proposed strategic direction

Twenty-four submissions broadly agreed with the proposed strategic goal, outcomes, actions and system priorities (six gambling industry submissions, four service providers, six health submissions, two local government submissions, five individuals, one other submission).

One health submission emphasised the significance of the draft Strategy given the harms from gambling are substantial, diverse, and wide-ranging, referring to negative impacts such as psychological distress, relationship disruption, and criminal activity. They welcomed the proposed Strategy and commended the Ministry for the work it has done to develop it. Similarly, another health submission reflected on the importance of the draft Strategy given the pervasive issues related to gambling harm, such as health and financial consequences.

One medical college noted that because problem gambling is associated with other public health risk factors such as drinking, smoking, and substance abuse they, support the Strategy's aim of expanding funding for support services for affected people.

These comorbidities have been echoed in Australia with over half of problem gamblers experiencing substance use disorders, and higher rates of psychological disorders than the general populations. Indications show that increased public health funding correlates with reduced risk of problem gambling, especially for youth gambling.

One service provider peak body welcomed the government's mental health and addiction priorities being a pivotal link to the Strategy and the desired strategic outcomes.

3.1.2 Public health, te Tiriti o Waitangi, and the draft Strategy budget were key areas for feedback

Eighteen submissions (seven individuals, six from the gambling industry, four service providers, and one researcher) provided constructive feedback on the proposed strategic goal, outcomes, actions, and system priorities.

Submitters sought greater clarity around the public health, regulatory, and policy approach to managing gambling harm reduction

Six submissions (two health submissions, two service providers, one researcher, and one individual) expressed a desire for a clearer, stronger, more specific, public health approach that recognises the complexities of the gambling environment and outlines various measures to address the range of contributing factors to harm.

One individual considered that the proposed system priorities are focused on individual-level interventions and lacked a broader **public health approach**. They also suggested a greater emphasis on improving the gambling environment, by restricting access and marketing. Similarly, one researcher considered that the draft Strategy does not embody a true public health approach, given that the gambling environment is omitted, while tertiary prevention (treatment services) appears to be a key focus. They recommended understanding and responding to the provision of gambling and the behaviours of the gambling industry (the gambling environment) through, for example, investigating industry behaviours such as push notifications to continue or resume gambling and the effects of gambling advertising.

One medical college considered the draft Strategy could strengthen public health measures to address harmful gambling behaviours at the root, through population-wide education and regulation of gambling venues.

A health organisation submission advised combining upstream and downstream approaches to shape a healthier environment and protect population health with established methods such as “*restricting access, availability, and advertising, and denormalisation and evidence-based counter-marketing*”.

One service provider suggested that the strategy allocate funding to advance **public policy and regulation initiatives** which restrict access, availability and advertising of gambling products. They also reiterated that more needs to be done to ensure communities are not saturated with harmful gambling products and opportunities to gamble, noting that this requires cross-sector collaboration between central government agencies involved in prevention and minimisation.

This service provider suggested including clear strategic outcomes regarding a strengthened regulatory framework to drive gambling harm prevention and minimisation. In addition, a health organisation advised greater emphasis on reviewing and tightening gambling regulation and improving policy to control the availability and promotion of all types of gambling, to reduce gambling-related harm:

Pre-commitment is a highly effective preventive gambling harm intervention, requiring gamblers to set predetermined limits on how much they can spend – sometimes with a statutory upper limit in place... This approach is part of a comprehensive package of proposals to address gambling-related harm in

Australia... and Tasmania plans to introduce a universal pre-commitment system for electronic gambling machines by 2025.

One medical college considered that policy development, advocacy and awareness-raising activities must address social determinants of harmful gambling and focus on these priority populations. They highlighted that policy development and public health measures must be separated from the influences of the gambling industry.

Te Tiriti o Waitangi was missing from the draft Strategy

Five service providers and one other submission expressed **concern at the absence of te Tiriti o Waitangi in the draft Strategy** and the implications of this omission.

One service provider considered that the proposed strategic framework does not adequately reflect critical insights from Māori practitioners and communities, whose voices and needs are central to ensuring the health service design and delivery process is effective and contributes to improved outcomes. Another service provider expressed strong concerns that the omission of te Tiriti o Waitangi, the Pae Ora (Healthy Futures) Act 2022, and Whakamaua: Māori Health Action Plan 2020-2025 from the draft Strategy is a “*failure of the Government to uphold its obligations to uphold its obligations to whānau Māori who continue to experience inequitable harms from gambling*”. They called for comprehensive reform to dismantle the systemic perpetuation of harm, ensuring that the actions taken going forward actively reduce harm, rather than inadvertently enabling it.

Another service provider urged the Ministry to **include a clear statement on the role of te Tiriti o Waitangi in the draft Strategy** and provide context for the strategic framework in guiding the health and disability sector. They advised that the draft Strategy and service plan should be grounded in te Tiriti o Waitangi, with the articles of te Tiriti o Waitangi clearly reflected in the strategic components.

One service provider recommended that the **problem definition should clearly stipulate the historical context of colonisation**, the targeting of Māori by the gambling industry, and the oppressive systems that have shaped the current gambling landscape in Aotearoa New Zealand. This submitter noted that this will ensure the draft Strategy is focused on engaging with the complexities of inequity and gambling harm.

Comments from hui participants

Participants at the Māori hui noted that people can engage in gambling behaviour due to **environmental and financial pressures**. They recommended a greater focus on **prevention**. They suggested **honouring te Tiriti o Waitangi and including te reo Māori in the draft Strategy**, as the lack of te reo kupu sets a tone and sends a message that despite being listed as a priority population, Māori worldviews have not been prioritised in the development of the draft Strategy.

Greater clarity was sought regarding the CLIC database and the practicalities of increasing access to support

Five submission including two service providers and three gambling industry submissions proposed improvements to the CLIC database, such as including functionality for key performance metrics to be recorded and published.

These submissions called for the modernised CLIC database to:

include functionality that allows for key performance metrics such as wait time, client appraisal of the service received, and client outcome, to be recorded and published in an anonymised format.

One individual requested clarity of where **access to services and support will be offered in regional and rural areas** including the availability of workforce members that are specifically experienced and trained in gambling harm. One gambling industry submission recommended including specific, evidence-based intervention programmes with descriptions of therapies, counselling methods, or community programmes to provide clearer guidance on implementation in terms of increasing access to support and expanding services.

3.1.3 Some submitters commented on the overall budget of the draft Strategy

Twelve submissions (nine NCGM gambling industry submissions, one health organisation, one service provider, one other gambling industry) made comments about the overall budget of the strategy. Other submitters made specific points about the budget relating to service areas which are included in the Service Plan chapter.

NCGM submitters opposed the increase in budget

Nine NCGM submitters (utilising the NCGM form submission in whole or in part) highlighted that the Gambling Commission's funding approval for 2022/25 came with a significant caveat that future funding would not be endorsed if there was not a fresh approach, a reset, based on sound data. Considering this caveat, these submitters opposed the \$11.595m increase in funding sought by the Ministry. These submitters were concerned that as the Ministry had not undertaken a strategic review of the strategy process, the increase in budget was unjustified.

One of these gambling industry submitters, suggested that the technology budget be increased to \$10m but that the increased funding can occur without increasing the overall budget of the strategy.

Health and service delivery submitters did not think the budget had increased enough

One medical college supports the focus on growing and retaining clinical and peer support workers, but did not believe the aspirations of this priority were reflected in the proposed budget:

As noted in the Ministry of Health's review documents, there is a strong association between gambling harm and substance use and increasing difficulty in accessing clinical support. We advocate that specific funding to be provided for sub-specialty training in addiction psychiatry to ensure that the demand for services can be met within the context of ongoing psychiatry workforce shortages.

Additionally, this submitter recommended allocating additional funding for research focused on reducing gambling harm in Aotearoa New Zealand, to ensure more effective evidence-based measures can be introduced in the future.

One service provider suggested that the overall budget for the strategy be increased from \$87.72m to \$93.32M (3.38% of total annual expenditure on gambling activities) to address service gaps. They noted that this increase is relative to the increase in total annual expenditure on gambling activities. One service provider also suggested prioritising investment to ensure decision making and actions are as close to communities and priority populations as possible.

3.1.4 There was a desire to restrict the availability of NCGMs, particularly in areas of higher deprivation

Four submitters (two service providers, two health submissions) commented that the availability of **NCGMs should be restricted**, particularly in areas of higher deprivation.

Two service providers requested the addition of highly addictive modes of gambling, particularly **NCGMs, to be included within the problem definition**. These submissions noted that the intentional placement and operation of gambling venues in communities of medium-to-high deprivation is problematic. They suggested that these realities need to be explicitly recognised, otherwise the draft Strategy cannot effectively address harm or the issue in its entirety. Similarly, a health submission pointed to the disproportionate harms experienced by Māori and Pacific peoples and advised that restricting the availability and concentration of gambling venues is a key preventative measure (which the draft Strategy fails to identify). Another health submission suggested that changes to address the inequitable distribution of gambling venues and gambling harm across communities, as recognised in the Needs Assessment, would make a meaningful difference to better and more equitable outcomes.

The location of gambling venues in lower socioeconomic areas places underserved communities at greater risk of experiencing harm; this placement not only increases accessibility but also entrenches patterns of harm and inequity.

While gambling participation is declining, overall harm may have increased and is concentrated among fewer people

One service provider suggested that the draft Strategy needs to address the fact that per capita **gambling losses, adjusted for inflation, increased in 2023**. While acknowledging that gambling participation is lower than ten years ago and is declining, this submission noted that it appears fewer people are betting more frequently and losing more money, suggesting overall gambling harm may have increased, but is concentrated among fewer people. This submitter recognised that measures to enable communities to reduce the number of NCGMs in their localities have been successful in continuing to reduce the number of machines. This included reducing the unequal distribution of machines in more deprived communities. This submission agreed with the conclusions reached in the Gambling Harm Needs Assessment 2024, that the prevalence of harmful gambling has not changed significantly since 2012.

Seven submissions (six gambling industry, one service provider) considered that the findings of the Gambling Harm **Needs Assessment 2024 demonstrated that the current Strategy has not reduced the prevalence of problem gambling**, despite the increased funding approved for the 2022/23 to 2024/24 period.

There was a desire to empower community and government leadership

Two service providers expressed a desire for **stronger leadership and coordination including collaborating across sectors** to address the complexities of gambling harm and updating the current legislative system, specifically amending the Act. They recommended:

- limiting access to all modes of gambling
- removing NCGMs situated in mid-to-high deprivation areas
- transferring power back to people to make decisions about gambling venues in their communities
- ensuring robust online gambling regulations
- banning advertising
- applying pre-commitment limits on game time and spend
- no longer utilising revenue from gambling as part of a government and community funding model.

The proposed strategy should aim to restore decision-making power to communities, empowering them with the autonomy to contribute to gambling regulation. Creating opportunities for communities to engage in discussions and engage in the development of gambling policies is essential, as these policies have the most significant impact on their environments.

One service provider suggested that the strategic plan prioritise investment to ensure decision making and actions are as close to communities and priority populations as possible.

3.1.5 There was mixed support for system priorities

More support is required for families and communities

Three submissions (one gambling industry submission, one health submission, one local government submission) provided comments on the support required for families and communities.

One gambling industry submission recommended expanding programmes that provide **comprehensive support to families and communities affected by gambling harm** – including community rebuilding initiatives and offering financial counselling, debt management services, and assistance programmes for individuals struggling with gambling-related debt.

One health submission recommended prioritising prevention, removing barriers to early access, and growing the peer support workforce at all levels. They specifically suggested **adding the word “accessible” to strategic outcome one** when describing the spectrum of services and supports, to ensure alignment with the access-related priority.

One local government submission queried how the strategic goal will be implemented within the proposed timeframes, particularly after services were disrupted when previous contracts ended, and sought information about how capacity and capability will be redeveloped.

Proactive education and awareness should be a focus within the system priorities

Four submissions (one gambling industry submission, one service provider, two individuals) highlighted the importance of system priority three but recommended that it should include improving community awareness and educating young people from an earlier age.

One individual considered that community awareness of problem gambling needs to be addressed in a more proactive manner, for example, increasing general practitioner clinic and staff **awareness of the significance of problem gambling and where to source help**. Another individual reiterated the importance of preventative support. One gambling industry submission advocated for more dedicated and targeted early intervention for young people, such as the Tūturu programme and resources for educational and school leavers.

Early Intervention must focus on education from an early age and should be part of the education curriculum to give youth the best possible opportunity to understand and be educated of the risks and probabilities of [land-based gambling] Online Gambling and Gaming.

Two service providers suggested stronger action regarding health promotion

One service provider suggested strengthening the system priorities by collaborating across multiple government agencies to address the root causes and co-related factors that contribute to reducing gambling harm. They also called for the provision of resources for the **development and evaluation of community health promotion initiatives** focused on awareness, prevention, and education specifically for the Pacific population. This includes Pacific-centric school-based programmes, noting that many services are currently not equipped to support primary school-aged children experiencing harm from gambling.

One service provider suggested the Ministry develop a **10-year health promotion strategy** including a review of the role of Health New Zealand's health promotion team and align the Service Plan accordingly. Enhance the resourcing of community and priority population initiatives.

Other comments about the system priorities are discussed within **Section 4** service plan.

Comments from hui participants

- Participants at the Pacific peoples' hui expressed support for the workforce priority. They noted that **gambling-specific and cultural expertise** exists in the sector, and suggested this should be drawn on when developing and delivering training content. They also expressed support for the recognition of **peer support** but highlighted that the **clinical supervision** required is time- and resource-intensive.
- Participants at a lived experience hui expressed support for the **balance of promotion, early intervention, and service provision** within the draft Strategy. They were also supportive of the focus on **culturally appropriate and peer support services** to ensure helpfulness and relevance, and suggested the workforce-related system priority include distributing **training or development to peer support services** (not only clinical services).

3.1.6 There is room to better align the draft Strategy with other mental health priorities

Four submissions (two service providers, two health submissions) recommended **greater alignment with other relevant mental health and population-based health strategies**.

One health submission recommended alignment and integration with other key policies through clear connections to other key mental health and addiction plans, policies, and frameworks such as *Kia Manawanui Aotearoa: the long-term pathway* and the *Oranga Hinengaro System and Service Framework*. Specifically, they suggested that the draft Strategy should integrate the collaborative and innovative funding mechanisms promoted by the *Oranga Hinengaro framework*, which would emphasise **collective accountability** and support for Māori and those most impacted by gambling harm. One service provider called for the draft Strategy to align with the Pae Ora strategies.

One medical college recommended that **'gambling disorder' be recognised as a mental illness** and treatment options broadened to include evidence-based interventions provided by specialist services in addition to relevant peer-led and other psychosocial interventions. This submitter noted that the most recent version of the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5), and the International Classification of Diseases 11th Revision (ICD-11) describe gambling disorder as a clinical condition under the broad category of substance and addictive disorders.

Comments from hui participants

- Participants at the Māori hui recommended **ensuring the draft Strategy aligns with other health strategies**, such as the six population-based Pae Ora Strategies (New Zealand Health Strategy, Pae Tū: Hauora Māori Strategy, Te Mana Ola: The Pacific Health Strategy, Health of Disabled People Strategy, Rural Health Strategy, Women's Health Strategy), including reflecting the drivers in those existing strategies. Participants at the service provider hui also raised the need for **greater integration at both a strategic and operational level between gambling and other mental health, addiction, and social service provision**. They noted that service users rarely present only with gambling harm, and co-morbidities include a wide range of health, social, and welfare considerations.
- Participants at a lived experience hui requested that the draft Strategy more clearly seek to address the **culture of normalising gambling** in Aotearoa New Zealand society. They noted that this can be a barrier to priority groups engaging in help-seeking behaviour, particularly if they also have (systemic) mistrust in government-led services. They also considered it important to emphasise the **role of destigmatisation** in the draft Strategy as it links to the first and third mental health and addiction system priorities.

3.1.7 More can be done to mitigate the impact of online gambling

Within the context of feedback on the Strategic plan, four submissions (one health organisation, one service provider, and two individuals) provided feedback regarding online gambling. More comments on online gambling as it related to the service plan and gambling levy are in **sections 3 and 4** respectively.

One service provider suggested the **draft Strategy address the rising impact of online gambling**, with a clear strategic approach to addressing the likely increase in harm. They specified that this should include additional actions including the development of online gambling harm prevention initiatives and intervention services that meet the needs of tāngata whaiora who are engaging in the online environment. Two individuals suggested that more needs to be done to mitigate online gambling harm. One of these individuals expressed support for the recognition of the increasing impact of online gambling but advocated for a plan to address the operation of offshore gambling sites.

The health organisation (a medical college) advocated for the regulation of online gambling:

We recommend the introduction of legislation to regulate online gambling services, particularly overseas gambling activities which are currently not subject to levies. We acknowledge the difficulties of creating effective legislation to regulate online gambling but with fast-paced advances of online gambling activities, we must act before harm is caused.

This medical college noted that Aotearoa New Zealand is lagging behind overseas jurisdictions in regard to online gambling regulations. For example, in Australia, it is illegal for offshore gambling services to offer real money gambling to individuals accessing the internet.

One gambling industry submission requested that a previous strategic objective (advocating for technological and/or environmental changes to gambling environments that are likely to have a positive effect on reducing harmful gambling behaviour) be reinstated and elevated.

3.1.8 Some submitters commented on the Needs Assessment

There were conflicting views on the degree to which the needs assessment should influence the draft Strategy

One gambling industry submission expressed support for the Ministry's utilisation of the latest information from the Needs Assessment to inform its priorities.

However, one researcher expressed concerns with the findings from the Needs Assessment due to the **“incomplete and inadequate academic literature search”**. They considered that the Needs Assessment did not comprehensively access contemporary, relevant, and robust gambling-related research, meaning that the draft Strategy was not as well-informed as it should be. This submission advised that public health, health promotion and general addictions-focused journals should have been included in the search methodology, along with gambling-specific journals.

The Needs Assessment found that the current Strategy has not reduced the prevalence of problem gambling

Seven submissions (six gambling industry, one service provider) considered that the findings of the Gambling Harm **Needs Assessment 2024 demonstrated that the current Strategy**

has not reduced the prevalence of problem gambling, despite the increased funding approved for the 2022/23 to 2024/24 period.

Two of these submissions considered the shift toward online gambling is disrupting the gambling levy setting arrangements. One gambling industry submission noted its agreement with the finding that, for most people, gambling issues are symptomatic of broader addiction issues and should be treated accordingly.

Comments from hui participants

- Research participants noted that the Needs Assessment is based on **limited data**, due to the limited use or lack of journals and relevant research included. Participants at the Asian and other ethnic communities hui also highlighted challenges with both the Gambling Harm Needs Assessment 2024 and the Health and Lifestyles Survey (HLS) data. They expressed concern that the Needs Assessment was undertaken “last minute” and did not capture **gambling harm among the Asian population** or reflect the needs of Asian communities.
- Participants at the service provider hui noted that the findings of the Needs Assessment clearly highlight the challenges of the gambling environment being an enabling factor that contributes to the constant presence and behaviour of gambling among growing populations. They raised that this extends to the challenge of constant **advertisements, and community organisations and clubs receiving funding from the industry**, which further breeds and normalises the enabling environment.
- Participants at the Pacific peoples’ hui reflected on the finding from the Needs Assessment that the **sector is becoming isolated** and needs to be brought together.
- Participants at the service provider hui expressed concern at the commentary in the Needs Assessment about the “drop-off in youth” and hoped that this would not mean that there is any change in focus. They considered that **youth were not visible in the draft Strategy and the numbers do not capture growing harm**, even though the funding is similar.
- Participants at a general hui expressed surprise at Drug and Alcohol Practitioners’ Association Aotearoa New Zealand (DAPAANZ) not featuring in the Needs Assessment and considered this a missed opportunity given this stakeholder is a key player. They suggested it would be useful to have a **workforce breakdown** including workforce development underspend and clinical service provider engagement.
- Participants at a lived experience hui suggested that the findings of the Needs Assessment point to a formal opportunity for sector input around **AOD services for tāngata whaiora within treatment centres**.
- Participants at the industry hui noted the **emphasis on equity and priority populations** in the Needs Assessment but queried if this is also true for the draft Strategy.

3.2 Changes in the gambling environment

3.2.1 Most submitters did not consider the that the draft strategic plan adequately reflects changes in the gambling environment

A quarter of the submissions that answered question two agree that the draft strategic plan adequately reflects changes in the gambling environment

The eight submissions that considered that the draft strategic plan adequately reflects changes in the gambling environment include responses from four individuals, two health organisations, one gambling industry submission, and one service provider. Associated commentary from these submissions included:

- appreciation for the recognition of the rapidly changing gambling environment and the impact this has on gambling harm services
- the growth of offshore-based online gambling sites, particularly with the ease of access to online gambling, which may lead to increased harm among people with existing gambling addictions and a rise in people gambling for the first time
- the current economic climate which may also mean that more people resort to different types of gambling more frequently, increasing overall harm
- support for the clear distinction made between the unregulated online gambling market and the regulated domestic market, including noting the growth of the offshore online gambling in the past decade and the Government's upcoming plans to regulate this.

Of the submissions that generally considered the draft strategic plan to reflect changes in the gambling environment, the following feedback from one health submission and one other submission was provided for further consideration by the Ministry:

- The need to strengthen the strategic plan to emphasise the growing social media aspects of gambling, for example, to consider this as a fifth sector.
- The opportunity to strengthen mitigation of the growing incidence and burden of online gambling harm, especially for rangatahi/young people (for example, referencing online gambling in prevention and early intervention measures).
- The need to provide online safety guidance and regulations for caregivers and family/whānau, promotion and prevention that involves communities and schools, and regulating online channels particularly given that video game problems and betting on game enhancements may lead to, or indicate a risk for, problem gambling later.

For three-quarters of submissions that answered question two, the draft strategic plan does not adequately reflect changes in the gambling environment

Twenty-four submissions (of the 32 that answered question two) considered that the draft strategic plan does not adequately reflect changes in the gambling environment. This

included responses from ten gambling industry submissions, four service providers, one researcher, eight individuals, and one other submission.

3.2.2 Greater visibility and accountability of online gambling is required

Seven submissions (three gambling industry submissions, one service provider, one researcher, one individual, one other submission) advocated for greater visibility and accountability of online gambling, including offshore gambling, in the draft Strategy.

One service provider and one gambling industry submission considered that **online gambling is insufficiently referenced in the draft Strategy**, noting that, within the lifetime of the draft Strategy, online gambling licences will take effect. They recommended that the draft Strategy include approaches to address online gambling and the potential increase in harm that this brings. Another service provider advised a stronger focus on harm prevention and minimisation in line with the findings of the 'Online Gambling Position Paper', and another individual advocated for a greater focus on online gambling and offshore sites.

One researcher expressed concern that the upcoming regulated online casino environment is absent from research priorities, so this major change in the gambling environment is not adequately considered. They stated that:

The proposed strategy barely considers online casino regulations expected to be in place in 2026, which is well within the scope of the three year strategy period. Whilst acknowledging that the online casino regulations are not yet in place and the timeframe might change, it would be prudent to have some identified strategies should the regulations, in fact, materialise as expected with regulated online casino gambling becoming easily accessible to all adult New Zealanders. The only consideration currently in the proposed strategy appears to be for the development of a national system allowing people to block themselves from accessing online casinos.

One other submission expressed support for the focus on addressing the evolving risks of online gambling, particularly as platforms are increasingly using new, and often covert methods to engage users. They noted that the integration of gambling into more casual forms of digital entertainment (such as in-game rewards and prize-based mechanics), poses a particular challenge. These features can blur the line between traditional gambling and other online activities and the financial risks can potentially become less visible to users.

The strategy must, therefore, be broad and capable of addressing not only current gambling practices but also the future innovations that online platforms will likely employ to target users.

One gambling industry submission called for a greater focus on unregulated online gambling, given the rapid growth in offshore gambling operators. Another gambling industry submission suggested a stronger regulatory environment is required for all forms of online wagering, given the significant growth in use of offshore Wagering Service Providers.

One service provider suggested the service plan address changes in the regulatory environment for online gambling by allocating funding for tailored online gambling harm prevention initiatives.

The 2026 gambling regulations should align with land-based gambling measures

Seven submissions (four gambling industry, three individuals) called for upcoming online gambling regulations to align with land-based gambling measures with a focus on harm minimisation, such as mechanisms for self-exclusion.

One gambling industry submission advised that **harm minimisation standards established by the regulator for online casino licenses should be flexible to evolve with technology**, research, and emerging best practice. This submitter also requested that new regulations are aligned to existing harm minimisation measures. This might include voluntary pre-commitment mechanisms, time-out, self-exclusion, real-time monitoring and alerting, and making use of advanced data, AI, and technology available in the online environment. Further suggestions from gambling industry submissions included:

- innovative approaches to video signage in NCGM venues, casinos, TAB and Lotto outlets, greater service promotion, and a 24/7 gambling support offering
- expand the CONCERN database to include online gambling and offer options for exclusion that are in plain language and easy to comprehend
- enable an online multilingual multi-venue exclusion (MVE) application process for land-based gambling and combine this with exclusion from online gambling.

One individual recommended that NCGMs should have an automatic time limit on continual use, with a 20-minute pause in play every three hours to enable a forced break, rest, and consideration of alternatives, and for staff to talk to patrons. Two other individuals advocated for overseas gambling sites to be held accountable to the same standards as domestic operators including paying a levy, and for all gambling to be regulated similarly.

3.2.3 A few submissions requested greater funding for facial recognition technology (FRT) and artificial intelligence (AI)

Four submissions (three gambling industry submissions and one service provider) suggested the inclusion of funding for, and greater application of, technology such as **AI, FRT, and telehealth** services.

One gambling industry submission suggested that there should be funding for the use of technology, such as FRT, to support with harm reduction. Another gambling industry submission expressed concern that the venue-based technology-related innovation funding appeared to have been removed from the draft Strategy. It requested that this be restored and increased to \$10 million.

Incorporating advanced technologies such as artificial intelligence (AI) to detect and intervene in problematic gambling behaviours in real-time, mobile applications for

self-help, and data analytics to identify trends could significantly enhance prevention and support efforts.

One service provider considered that the draft Strategy overlooked the increasing operational costs needed to maintain the information technology infrastructure of a modern gambling harm prevention system, particularly with digital platforms and multilingual telehealth services. More generally, they also raised that there is unequal distribution of resources among community-based organisations in terms of infrastructure funding. This limits the ability of providers to expand services to those who need specific support.

Currently, funding gaps hinder [service provider] from addressing the rising demand for Asian-focused services, particularly for populations disproportionately impacted by gambling harm, such as Chinese, South Asian, and Korean communities.

A few submissions wanted greater restrictions on advertising and marketing of gambling

Two individuals advocated for restrictions to limit gambling advertising, including online marketing of gambling websites and television-based marketing of other forms of gambling.

One individual highlighted that the significant increase in offshore online gaming is not visible and suggested strengthening public awareness of the challenges. They recommended providing support to enable effective blocks to be installed on devices referring to *Gamban* as an example of a blocker that cannot be bypassed but is considered relatively expensive to set up. They raised that young people who engage in online gaming that allows the purchase of loot boxes are a risk of addiction. This harm is not always visible. Another individual called for geo-blocking of offshore online gambling websites.

3.3 There was broad agreement with the work to support priority populations

Twenty-nine submissions (eight individuals, seven service providers, six gambling industry submissions, four health submissions, one local government submission, one researcher, one lived experience group, and one other submission) commented on the work to support priority populations.

3.3.1 Supporting priority populations was a key theme

Eight submissions (three service providers, two gambling industry submissions, one health submission, one individual, one other submission) explicitly expressed support for a focus on priority groups who experience disproportionate gambling harm. These submissions expressed **support for the intention in the fourth strategic outcome, to address the disproportionate gambling harm experienced by Māori, Pacific peoples, Asian people, and young people**. They noted that these population groups should remain a priority.

... we agree that population groups who experience inequitable outcomes should have continued focus, moreover these groups need increased access to culturally safe and effective kanohi ki te kanohi; face to face support within their community.

Māori face greater inequities than non-Māori

Five submissions (four service providers and one health submission) discussed the disproportionate gambling harm and inequities faced by Māori, with **calls for greater funding for kaupapa Māori services and stronger workforce cultural competency**.

One service provider noted that Māori experience disproportionately high rates of gambling harm, compounded by significant socio-economic and health disparities, including elevated suicide rates, the interrelated factors of gambling harm, co-existing health challenges, and poverty and deprivation disparities among Māori. Furthermore, Māori are overrepresented in high deprivation areas, where access to health services is limited and the availability of gambling outlets is higher. Poverty is a significant driver of gambling behavior in these communities, where it is often seen as a means to alleviate financial stress. This service provider considered that the draft Strategy proposes more targeted measures to address the broader health disparities that contribute to elevated suicide rates among Māori who gamble, including the focus on workforce development, suicide prevention, and integration of services. They made the following recommendations pertaining to Māori:

- expand funding for kaupapa Māori services, given their success in addressing both gambling harm and co-existing issues like mental illness and suicide prevention
- develop specific interventions to address high rates of suicide among Māori affected by gambling harm, including specialised training for gambling harm practitioners in suicide prevention and enhanced screening for suicidal ideation in gambling harm services
- address poverty and financial insecurity, since gambling harm and financial stress are closely linked in Māori communities (for example, develop financial literacy programs and economic support for whānau struggling with poverty).

One service provider highlighted that Māori are over-exposed to commercial gambling and its aggressive and targeted product placement and marketing. One health submission suggested that the draft Strategy should direct resources to target gambling support services to communities with a high Māori population, and work with them to identify how to reduce access to gambling (particularly NCGMs) in these targeted areas.

One service provider advised that supporting priority populations requires a deep understanding of the unique needs and aspirations of iwi, hapū, marae, community, and whānau. They raised that it is essential to ensure cultural competency among staff who should whakapapa Māori and have a connection to iwi, hapū, marae, community, and whānau of that rohe in order to drive trusting and enduring relationships. They also recommended that funding for providers should take into account the infrastructure and services currently available in a community and be allocated accordingly, including consideration of gambling loss experienced by the community, socioeconomic factors, and deprivation levels. Another service provider advocated for a te ao Māori approach as that is effective for Māori.

The prevalence of gambling harm in certain populations can be linked to inequitable distribution of gambling opportunities

One researcher considered one of the major reasons for disproportionately high levels of gambling harm amongst certain populations is the inequitable distribution of gambling opportunities, with more availability and accessibility in areas of high deprivation than in areas of low deprivation.

Research has shown that availability and accessibility are risk factors for harmful gambling behaviours, and that people who are less financially well off have higher risk for experiencing gambling-related harms. Furthermore, accessible gambling venues can become refuges for people trying to escape stressors or violence at home.

This researcher further considered that incentives from gambling industries (e.g. advertising, marketing and push notifications) also encourage increased gambling levels. This submitter notes that while this is outside the remit of the Ministry of Health, whilst such issues continue to exist, the current inequities in gambling harm will be difficult to remove and the proposed goal of reducing inequities for these populations will continue from one strategy period to the next.

3.3.2 Rangatahi are at increasing risk of gambling harm

Five submissions (two service providers, two health submissions, one individual) highlighted the **growing gambling harm experienced by rangatahi**, particularly given the convergence of online gaming and gambling.

One individual highlighted the convergence of online gaming and gambling among youth. One health submission and one service provider noted that gambling services are accessible to people aged 14 years and older, despite younger children engaging in gambling behaviour. The service provider urged the Ministry to reconsider this cutoff age and make services available to younger children who show signs of distress as a result of family-related gambling harm. Another service provider raised a growing concern about young people, particularly males, regarding online casino gambling and sports betting. They recommended allocating funding to develop clinical support services tailored to meet the needs of young people, including both online and face-to-face support and self-help resources.

One health submission expressed support for the inclusion of young people as a priority population, particularly given the increased exposure to gambling products, advertising, and gamblification among youth. They encouraged greater resource to research and develop youth-centric service provision. They called for the workforce to be funded to provide appropriate clinical, peer, and public health approaches for youth across all priority groups and the general population. They also suggested a more cohesive approach between gambling harm prevention and minimisation, AOD, and the wider mental health sectors.

One service provider recommended incorporating gambling harm literacy into education systems, starting early in schools. They advised that a comprehensive public health approach should include materials that address both students and their parents, providing tools to recognise harmful behaviours, protect themselves, and seek help if needed.

Comments from hui participants

- Participants at two general hui and the service provider hui expressed support for the ongoing commitment to identify youth as a priority population but noted the **limited provision of clinical service delivery** for this group.
- Participants at a lived experience hui noted a **limited youth peer workforce** and suggested a holistic, whole-of-whānau approach with the right people in the right spaces.
- Participants at two lived experience hui expressed support for **reaching out to youth before they engage in gambling and stopping it early**, before lifelong habits develop.
- Participants at the Pacific peoples' hui expressed support for the components on **youth and technology** in the draft Strategy and suggested that this would require even greater focus given the impacts of technology on youth, which are likely to be understated.
- Participants at the lived experience advisory group hui noted that **young immigrants and international students** are specifically targeted by the gambling industry. They advised that there should be prevention and early intervention services for this demographic, which could be offered through universities, and greater understanding of the reasons behind the gambling behaviour. They also recommended better **education across platforms that youth engage with**, such as *TikTok*, and promotion of existing content.

Participants at the youth hui made the following points:

- *Youth19* survey data identifies **gambling as one of the first 'risky' activities that young people experiment with or try**, before alcohol, drugs and sex – this could come through more strongly in the draft Strategy
 - There is a **gap in focus on youth-centric professionals and services** in terms of workforce development and from a pastoral care or treatment perspective.
 - In terms of presentations and clinical treatment for traditional forms of gambling among adults, **help-seeking behaviour and self-referrals have historically been considerably low**, which also presents challenges for young people.
 - Tūturu needs to encourage buy-in from schools and teachers, some of whom are not aware of the challenges facing young people who engage with **in-app or in-game purchases, including loot boxes**, for items such as skins and weapons which can start with using fake currency but progress to using real currency.
 - There is a rise in **informal, low-risk and social forms of gambling**, such as sports betting, among young people, particularly males.

3.3.3 Older people should be included as a priority population

Four submissions (one service provider, two individuals, one other submission) called for older people to be included as a priority group in the draft Strategy, given the risk and impacts they face.

One individual noted that this is pertinent to older Pacific people, some of whom are immigrants and may not understand how the gambling environment is designed to target vulnerable people. The service provider highlighted that, while there is a lack of local research, data from Australia suggests loneliness, the need for social interaction, incentives and online access are triggering increases in gambling harm amongst older people. They also raised that older adults are less likely to seek treatment for problem gambling, which

may be due to lack of awareness of gambling as a problem and greater stigma toward mental illness or addictions. They recommended that funding is allocated to develop pilot programmes to raise awareness of gambling harm among older people and enhance screening for gambling harm when older people present for health services including when presenting with mental health concerns.

The other submission pointed to a 2008 Aotearoa New Zealand study into gambling and older adults, which found their motivation for gambling was typically to achieve rewards, boredom and the desire to socialise. Additionally, they noted that the Ministry has indicated that those aged 25 to 44 years and 45 to 64 years experience the most gambling harm, so as these cohorts continue to age, they are likely to take these patterns of gambling behaviour into older age, especially as digital literacy to engage with online gambling will be significant. This other submission also made the following recommendations pertaining to older people:

- undertake more research to determine the gambling harm caused to older people
- develop initiatives to raise awareness of gambling harm among older people
- increase screening for gambling harm when working with older clients in health and social services.

Suggestions to improve cultural competency and accessibility of services

Ten submissions (six gambling industry submission, one service provider, two individuals, one other submission) each offered various suggestions to **improve cultural and linguistic appropriateness of services** and support delivered to priority groups in a targeted way.

One service provider recommended reviewing the service plan to ensure adequate resourcing of culturally and linguistically appropriate services. They considered that gambling environments and prevention efforts also need to be further strengthened to address inequities and reduce negative impacts, for example, in high deprivation communities where Māori and Pacific peoples often reside. Additionally, This service provider suggested the service plan provide face-to-face service gaps and after-hours access along with solutions for support services that recognise the unique needs of youth, rainbow people, people with disabilities and older people.

Five NCGM submitters (utilising the NCGM form submission in whole or in part) advocated for a 'back-to-basics approach' including provision of face-to-face counselling services to all across all regions. These submitters further suggested that face-to-face counselling service need to be more flexible and more responsive. The service needs to be more mobile (counsellors need to be willing to travel to townships with no permanent service) and the service needs to be a prompt, on-call, 24/7 service. One of these industry submitters further notes that to achieve the target of having all people who want to obtain face-to-face counselling, having that counselling provided within 48 hours, in their own nearest township, the Ministry's requirements and funding need to change.

One individual suggested that early prevention support should be offered 24/7 with the option of either face-to-face or online delivery, and should target specific ethnic groups separately – including Māori, Pacific peoples, and Asian people.

One gambling industry submission advised developing marketing campaigns for priority populations to inform them that they are not alone. This could include profiling leaders or athletes from their communities as part of awareness-raising.

One other submission suggested a stronger emphasis on priority populations and communities, including significantly and speedily reducing the number of NCGMs in more deprived areas and providing increased culturally responsive problem gambling support services directly within these neighbourhoods.

One individual raised a need to provide more training to staff working in venues, such as bars and pubs, with a focus on harm minimisation and identifying people at risk. They noted that this is particularly important for venues that operate NCGMs.

Ensuring that all programs and services are culturally sensitive, inclusive, and tailored to the unique needs of diverse populations can enhance their effectiveness and acceptance within different communities.

One individual highlighted the need to consider equity (of funding and resource) in terms of workforce development when **ensuring the skills and experience of workforce members and service providers appropriately meet the needs of Pacific peoples**.

This individual raised that speaking a language relevant to Pacific peoples receiving support is a special skill that is not held by the entire workforce, so funding should be allocated to ensure effective solutions are in place to meet the needs of vulnerable groups. They suggested that there should be sufficient Pacific workforce including clinical FTEs, health promoters, cultural advisors, and qualified ethnic researchers who can appropriately support with addressing gambling harm among Pacific peoples. Specifically, this could involve creating language media plans, programmes, and activities with key messaging to encourage learning and understanding of the harms caused by gambling.

Priority populations should remain a focus within the draft Strategy

Three submissions (two service providers, one individual) reiterated desire for priority groups to be the core focus of the draft Strategy including consideration of projected population growth and other demographic change of those at-risk of, or affected by, gambling harm. For instance, Asian communities in Aotearoa New Zealand are a rapidly growing and diverse population, with some transient groups (such as international students), and Māori in certain localities (such as Northland) are disproportionately targeted and impacted by the prevalence of NCGMs.

3.3.4 Rainbow and disability recognition is missing from the draft Strategy

Three submissions (one service provider, one health submission, one researcher) called for **rainbow and disabled people to be recognised** and included as priority groups in the draft Strategy.

One researcher suggested that people of gender-diverse and rainbow communities should be considered in the draft Strategy. Similarly, a service provider highlighted that rainbow and disability communities who experience **intersectional impacts, including gambling harm**,

face significant challenges and require unique services. They noted that the Ministry does not collect or report on gender identity, sexual orientation, or disability data in relation to gambling harm, despite international evidence that suggests trans and gender diverse people experience higher and compounding levels of gambling harm compared to cisgender people. They made the following suggestions for rainbow and disabled people:

- Allocate funding to develop and pilot information, self-help resources, and services tailored to meet the needs of rainbow services including developing relationships and referral pathways with existing rainbow service providers and communities, and building capability across the sector to deliver appropriate services
- Review the Ministry's dataset to include gender identity and sexual orientation
- Allocate funding to undertake research on the gambling harms individuals and communities with disabilities are experiencing and co-design services to ensure best practice is established for marketing, outreach, and service delivery.

One health submission recommended that the disability community should be seen as an identified group which experiences inequitable outcomes and gambling harm. They noted that disabled people are proportionately low-income earners and live in poverty, which contributes to increased risk that results in some disabled people gambling disproportionately high amounts of their income. They raised that disabled people are also more likely to be harmful gamblers than non-disabled people. They also recognised that **disability is intersectional including tāngata whaikaha disabled Māori, disabled Pacific people, disabled Asian people and disabled younger people who are at even higher risk of gambling harm**. They also made the following recommendations pertaining to the disability community:

- Gambling harm services should tailor programmes and support to the diverse needs of individuals who are undergoing treatment for addictions.
- Gambling harm treatment services are responsive to the needs of disabled people.
- Disabled people are recruited and supported to work in the gambling harm intervention workforce.
- The gambling harm support workforce is trained in disability awareness and responsiveness.
- Information about gambling harm is available in accessible formats to disabled people.
- The Ministry, the DIA, and gambling sector stakeholders work collaboratively with disabled people and disability organisations to co-design policies and programmes around preventing harm within the disabled communities.

Comments from hui participants

- Participants at a general hui noted that youth and Māori are included as priority populations and queried whether **rainbow and disabled communities** will be included as priority populations in future. They highlighted that it can be difficult to focus research or funding on these groups if relevant data is not captured. Similarly, participants at the youth hui expressed concern at the lack of visibility for these communities. Participants at the Pacific

Comments from hui participants

peoples' hui also noted different layers of identities, including gender and sexuality, along with the **diversity of Pacific communities** (such as Cook Islands, Samoan and Tongan).

Advocacy for Asian communities

Two submissions (one service provider, one lived experience group) advocated for enhanced regulatory measures, greater cultural sensitivity, and more effective support systems for Asian communities.

These submitters (service provider and lived experience group) called for enhanced regulatory measures, greater cultural sensitivity, and more effective support systems to address and minimise gambling harm within Asian communities.

- The service provider recommended a national campaign and resource development that directly addresses the needs of Asian communities in culturally relevant ways. They noted a key issue being the limited reach of mainstream media within ethnic communities, so they considered it essential that campaigns utilise ethnic media platforms to reach diverse communities effectively.
- The service provider raised that simply translating mainstream resources into other languages is inadequate, and translations often fail to capture the cultural nuances required for effective communication, weakening the message's impact. They recommended that translations be co-designed with individuals who have lived experience, to ensure that language, tone, and terminology align with everyday speech that will resonate with the target audience.

Comments from hui participants

- Participants at the Asian and other ethnic communities hui highlighted **challenges faced by new migrants, such as language barriers** for people that do not speak English, which can contribute to the vulnerability and lack of visibility of gambling harm.

Questions on disproportionate gambling harm and implementation of peer support

Two submissions (one gambling industry submission, one local government submission) raised questions about the reasons behind population groups experiencing disproportionate harm and how peer support delivered by people with lived experience is implemented.

- One gambling industry submission raised that it would be helpful for them, from an industry perspective, to understand why Māori, Pacific peoples, and Asian people are disproportionately affected by gambling harm.
- One local government submission expressed support for the inclusion of people with lived experience and peer support as key parts of the draft service plan, but they sought detail around implementation, such as making connections with people with lived experience and how they could deliver peer support.

4 Draft service plan

This section outlines feedback from submissions on the draft service plan. It covers:

- satisfaction (or otherwise) with the direction and overall content of the service plan
- the proposed funding mix for services and support, and opinions about the proposed new services such as service promotion, workforce development and an online gambling exclusion system
- the priorities for research and evaluation.

Four questions were asked, all of which included ‘Yes/No’ responses. **Table 5** shows the wording of those questions and the number of submissions who responded, by response.

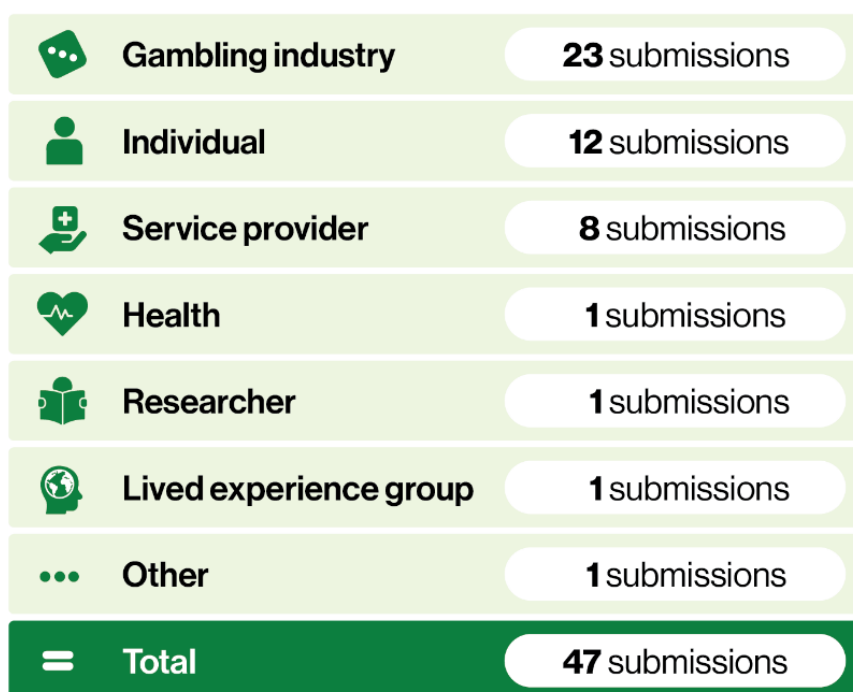
Responses were received from six of the seven sector groups, as detailed in **Figure 2** below.

Table 5: Responses to questions about the draft service plan

Question	Yes	Qualified support	No	Other comments	Total
4. Does the draft service plan adequately cover what it needs to cover, for example, does it include the right types of services and activities?	1	2	24	4	31
5. Do you consider the proposed funding levels, mix of services and service supports appropriate?	6	1	30	4	41
6. Do you agree with the proposed new services and investments?	11	13	12	3	39
7. Do you agree with the priorities for research and evaluation that have been outlined in the draft service plan?	6	11	16	5	38

Forty-seven submissions provided feedback on the draft service plan (23 gambling industry, 12 individuals, eight service providers, one health, one researcher, one lived experience group, one other submission).

Figure 2: Number of submissions, by classification, that provided feedback on the draft service plan



Key themes on the draft service plan were:

Alternative approaches to service delivery to increase accessibility, appropriateness, and safety of support

- Support for after-hours and face-to-face delivery, particularly for geographically isolated communities.
- More culturally appropriate services.
- Focus on prevention and early intervention (more than treatment).
- Widespread support in principle for self-exclusion functions.

Increased budget for services and the impact on levy payers

- Disagreement with the mix of services and supports.
- Budget for technology is missing from the draft service plan.

Accountability, including service delivery targets

- There was a suggestion to evaluate the gambling helpline.

Workforce development

- There was cross-sector support for a NZQA harm reduction qualification.

- Support to expand the peer support workforce.
- Clinical internships were seen as a positive initiative.
- There needs to be greater health promotion efforts among clinical services.

Evaluation and research

- There was recognition of the value of research and the importance of independent evaluation.
- There was a suggestion to include sector feedback in evaluation and research activity.
- There was concern with the decrease in budget.

4.1 Service and activity types

4.1.1 More work is required to make services accessible

Seven gambling industry submissions (that utilised the NCGM form submission in whole or in part) shared similar views about the need to ensure counselling services are available in every region, are flexible, and are responsive to client needs.

The face-to-face counselling service needs to be more flexible and more responsive. The service needs to be more mobile (counsellors need to be willing to travel to townships with no permanent service) and the service needs to be a prompt, on-call, 24/7 service.

Three of these gambling industry submissions noted major regional gaps in the provision of face-to-face counselling services – in areas such as Gisborne, Northland, and Timaru – which limits people to using the helpline only for support. These submissions advised that face-to-face counselling could better support mental health and addiction issues and lead to better outcomes. Three gambling industry submissions recommended that contracts for provision of treatment should include minimum response times and requirements to travel to the nearest township of clients, to ensure appropriate and timely services.

One service provider highlighted a critical need for services to include coverage of rural communities and for increased access to face-to-face appointments. This submission raised the importance of this approach for reaching Māori, particularly in more isolated areas such as Northland. One individual suggested that physical isolation could be addressed by face-to-face contact with social workers, staff, and other community supports.

Afterhours care was seen as a crucial element of service delivery

Four gambling industry submissions (that utilised the NCGM form submission in whole or in part) recommended that counselling services be available 24/7 to ensure they are client-centric, flexible, and responsive. Another gambling industry submission expressed concern that there is insufficient support at the right time and in the right place for people who are experiencing harm.

Why can't I get a counsellor at 10pm at night? Why can't I talk to a real person at 1am in the morning about how I feel after my gambling session?

One individual expressed a desire for more on-site provision of pastoral care that is delivered on a 24/7 basis. One lived experience group advocated for a 24/7 Asian helpline, noting that Asian Family Services (service provider) have previously called for this, as they often receive requests for support from clients when they are already experiencing substantial harm. One service provider emphasised that reducing barriers to accessing services should be a priority as it is an ongoing challenge, and requested greater funding to be allocated for service providers to extend both hours of face-to-face delivery and staff operating phones at peak times.

Comments from hui participants

- A few participants noted that **accessibility to services** was potentially missing from the service plan, specifically with **afterhours and rural/regional service provision**. They noted that afterhours availability is particularly important, as those who need help might only reach out once. Service providers wanted to ensure there is someone for those people to connect with regardless of the day or time.

Some submissions advocated for more culturally appropriate services

Two service providers suggested “*marae-based tautoko*” in which marae are central hubs for additional high-intensity support to enhance service provision and deliver support for Māori communities in familiar, trusted environments. One service provider also advocated for utilising mobile health units to improve access. Another service provider recommended culturally safe and effective, high-intensity support delivered in a by Māori for Māori model.

One individual called for more effective action to better represent and support the needs of Pacific communities in the service plan. This submission recommended strengthening the:

- cultural and clinical expertise of the sector (for example, increasing funding support for members of the workforce who have Pacific language capability)
- accessibility of support for priority populations, specifically increasing funding for service providers that are both equipped to deliver culturally safe and appropriate support and are physically located close to clients in need
- accessibility of services by offering Pacific online counselling.

One lived experience group suggested that culturally sensitive interventions should be included to support international students in the context of casino and online gambling, where professionals facilitate difficult conversations in a culturally appropriate manner.

4.1.2 Prevention and early intervention were not seen as having enough prominence within the draft strategic plan

Two NCGM submissions expressed support for gambling-related education, specifically Tūturu (a school-focused programme), the ‘Nan’s Song’ initiative, the ‘Let’s Kōrero’ series, national health promotion destigmatisation campaigns, and both Safer Gambling Aotearoa

and Gambling Host resources. Contrastingly, another gambling industry submission opposed further funding for training module development, as they had created their own content for this purpose. They suggested regularly refreshing video components of existing material and including lived experience perspectives. One service provider also considered that:

the funding and resourcing of host responsibility resources to support harm minimisation training and tools for in-venue use should not be included in the Strategy.

The Act attributes this requirement to gambling operators.

One individual recommended that the service plan should focus more on prevention and encouraging people who are experiencing gambling harm to reflect on their behaviour and seek help. One lived experience group advocated for primary healthcare providers to be supported to strengthen their ability to recognise and deliver brief, early interventions in a comprehensive way, including specific support for children affected by gambling harm. Another individual called for a significant increase in public awareness of gambling harm.

A few submissions considered the service plan should focus more on prevention and less on treatment

Three NCGM submissions expressed support for gambling education and promotion initiatives that are proven to be effective. They agreed with funding for the *Safer Gambling Aotearoa* website and NCGM venues resources produced. These submissions suggested that funding evidence-based data to assist with policy decision-making should be:

allocated to an independent agency to develop an objective and balanced summary of gambling in New Zealand, balancing costs and benefits.

One individual considered that the proposed funding levels, mix of services, and service supports focus too heavily on treatment, rather than prevention. Another individual recommended more public awareness and consistent application of restrictive measures to all gambling forms. Another individual sought greater visibility of pastoral care. Another individual suggested that funding should be allocated for primary care medical practitioners directly via specific contracts or via primary health organisations.

One other submission called for increased funding to be made available for effective prevention and support services, such as kaupapa Māori, Pacific, Asian and youth-focused services. This submission also called for increased funding in general:

We acknowledge that the funding to address gambling harm has increased under the Draft Strategy but consider that it is insufficient to meet the demand. Given the amount of profit made by gambling providers we would like to see the proportion reinvested into preventing gambling harm increased. Support agencies are typically non-government organisations, and we would like to see their workforce and services properly resourced and expanded.

4.1.3 Submissions wanted to see greater accountability and proposed including service delivery targets

Five gambling industry submissions (that utilised the NCGM form submission in whole or in part) considered that the current Strategy (2022/23 – 2024/25) lacks accountability and informed decision-making, and recommended setting specific, quantitative targets for treatment services to hold them to account. These submissions provided examples of specific targets that should be put in place, such as:

a 50% reduction in the relapse rate for persons who identify non-casino gaming machines as their primary gambling mode.

One gambling industry submission called for evaluation of tenders to consider whether a given treatment provider met targets, the development of a dashboard to track progress against targets, and the online publication of results:

... the Ministry needs to set clear targets that align with the Strategy period of three years, with yearly assessments to determine whether sufficient progress has been made toward achieving these targets.

One gambling industry submission considered that the system priorities and strategic outcomes outlined are broad, so they **suggested establishing key performance indicators** for each priority area to enable tracking against progress. One service provider expressed similar sentiments, calling for investment in leadership and accountability from a system coordination perspective to enable access to accurate and reliable data, support efficient data collection processes, and empower service providers to make decisions that are responsive to the needs of the people they serve.

We support the public health approach underpinning the strategic goal, outcomes, actions and system priorities. However, we are concerned that the [draft] Strategy is lacking or is not supported with population-level-measures against which the impact of the [draft] Strategy can be assessed and reported against. We suggest that in the life time of the [draft] Strategy there is inclusion of work to develop population level measure alongside obtaining prevalence data about gambling.

The same service provider submission recommended:

a clear accountability framework across these central agencies [the Ministry, HNZ, and the DIA] to ensure effective co-ordination and communication with the key players implement[ing] the various aspects of the service plan i.e. gambling harms service providers, lived experience leadership, priority population and communities, researchers, educators gambling harm operators and other stakeholders.

An evaluation of the gambling helpline might be required

One service provider suggested allocating funding to evaluate the efficacy and outcomes of the gambling helpline and investigating alternative models for provision of specialist gambling harm support at initial point of contact. This submission recommended providing access to peer support as an example of effectively alleviating help seekers' immediate concerns in another way.

One gambling industry submission requested that the gambling helpline have standard naming conventions for different modes of gambling when users identify where harm is being caused from their behaviour to ensure accuracy of statistics.

Alternative approaches to service delivery were suggested by some submissions

Nine submissions (seven gambling industry, two individuals) made comments and suggestions regarding alternative approaches for service delivery.

Seven gambling industry submissions (that utilised the NCGM form submission in whole or in part) called for a commitment to comprehensive and long-term engagement, specifically extending treatment beyond the immediate or initial intervention to ongoing monitoring and support, with a focus on preventing relapse. These submissions spoke to the need for an integrated, wrap-around approach that acknowledges how gambling issues can be symptomatic of broader addiction issues and should be treated accordingly. Two submissions considered that the Ministry should require service providers to “*take reasonable steps to maintain contact with their clients for a three-year period*”, including regular check-ins via visits to the client home, phone calls, and/or text messages.

One gambling industry submission recommended that the sector is best placed to deliver the proposed national system to allow individuals to block themselves from accessing regulated online or mobile gambling outlets. This submission suggested that the most effective harm minimisation approach would be to limit access to these sites in conjunction with a sector-run national order, rather than implementing such an order in isolation. Another gambling industry submission noted willingness to share insights on the development and implementation of *BetStop*, the Australian national self-exclusion register.

One individual requested that the role of general practitioners be emphasised in the identification of problem gambling harm (for example, as part of Needs Assessments and health improvement coaching).

One individual suggested that continuous gambling environments should be visited by local support providers who greet patrons and provide education on gambling harm. Venues should deliver educational presentations as part of a strategy to reduce harm.

4.2 Proposed funding levels and mix of services were not considered appropriate by most

Of the submissions that provided feedback on the funding levels and mix of services, most did not consider that the proposed funding levels, mix of services, and service supports are appropriate.

Of the seven submissions that considered the funding levels, mix of services, and service supports appropriate, six provided outright support and one supported it in-principle. The submission that provided qualified support was made by a disability advocacy group. This group was pleased to see the proposed funding increase of 16 percent to frontline gambling services, but it was concerned at the freeze in the operating costs provided to the Ministry and HNZ to cover their roles in developing and overseeing this strategy. This submission

considered that both agencies should play a continuing role in these areas and not be subjected to any funding cuts/freezes.

Almost half of submissions were concerned that a technology budget was absent

Twelve gambling industry submissions (that utilised the NCGM form submission in whole or in part) expressed concern that the technology budget had been removed from the draft Strategy. They noted that the sector has invested significantly in harm minimisation technology, such as FRT, which is proving useful for managing excluded persons and meeting the requirements of relevant regulations. These submissions suggested that technology such as FRT should be offered to more venues. One submission recommended that:

a contestable fund for technology initiatives should be established and be easy to access by the private sector.

Two gambling industry submissions highlighted that funding could be saved if technology was better utilised. They considered that venue-based technology has a major role to play in reducing gambling-related harm and that the funding of facial recognition technology is a fundamental and simple positive change that can and should be actioned immediately.

One gambling industry submission called for funding to be allocated for the development and testing of additional technology-based tools, such as a system that integrates player monitoring across all NCGM venues.

One service provider expressed concern at the lack of targeted investment for technology and infrastructure development and support for gambling harm providers to better position themselves to be sustainable and adapt to a changing gambling environment. Another service provider agreed with the strategic intent to invest in digital tools but considered that this investment needs to be targeted to filling gaps in existing services, and that responsibility for developing tools should lie with those with current and relevant expertise. This submission called for the Ministry to take the following actions:

- Remove the provision in the service plan for the ongoing development of the *Safer Gambling Test* – replace this with a provision for the central health promotion service to promote access to the revised *Gambling Harm Test* when it is available.
- Remove the provision in the service plan for the development of digital tools for financial literacy – reinvest the funding allocated into the development of financial capability expertise within service providers' clinical workforce.
- Include additional information with the rationale and plans for developing digital tools to promote harm minimisation messages, help-seeking, and site-blocking.

Some submissions raised concerns with the increased budget for services, and the impact this had on levy payers

Six gambling industry submissions (that utilised the NCGM form submission in whole or in part) opposed the increase in budget and considered that this was neither needed nor warranted. These submissions expressed concern that the Ministry has failed to collaborate effectively with gambling operators and has not adhered to the New Zealand Gambling

Commission's (the Gambling Commission's) 2019 and 2022 recommendations, evidenced by the \$3.412 million surplus and lack of evidence regarding the effectiveness of currently funded services and activities. One submission sought for funding to be "*diverted to programs that demonstrably prevent and minimise harm*".

Three gambling submissions expressed concern that the "*existing model of funding large non-profit non-government organisations to undertake clinical treatment has not worked*" and proposed that the procurement of clinical services should be simplified to become attractive for small private providers. These submissions suggested that the Ministry should move away from a siloed funding model and towards a wraparound approach to "*part-fund addiction agencies that can treat multiple addictions and provide other support*" in a way that acknowledges the comorbidities that people experiencing gambling harm may face.

One of these NCGM submitters provided references within their submission to the Needs Assessment and the Royal Australian & New Zealand College of Psychiatrists September 2017 position statement on problem gambling noted that approximately 90% of people diagnosed with harmful gambling have at least one other mental health diagnosis.

One service provider recommended that levy rates should be increased to match the rates that businesses in Aotearoa New Zealand pay in taxes (for instance, casinos are taxed at a rate of 20 percent on net gaming revenue; lotteries are taxed at 20 percent on gross sales). This submission raised that an equitable funding model would ensure adequate funding is available for essential services and would contribute to addressing disparities.

Some submissions considered the mix of services and supports imbalanced

One service provider considered that the proposed funding levels and mix of services do not provide coverage by priority populations and geographical area. It suggested that investment and additional funding should be allocated to areas that are assessed to have high need. From a service provider perspective, it also recommended that the allocation for wage and cost-of-living uplifts for primary prevention services be reviewed to be more realistic. Another service provider raised a need for more kaupapa Māori support, as well as more services dedicated to the needs of rangatahi and people living in rural areas.

Allocate additional funding to adequately assess and evaluate service coverage across all gambling harm service providers and address potential face-to-face service gaps in for example, Palmerston North, Invercargill, Tauranga and Whakatane.

One researcher and one service provider called for additional, and more sustainable, funding to be allocated to conference support, specifically for the biennial international gambling conference and the associated international think tank. A key research submitter, considered that the funding is insufficient in terms of recognising and covering the costs associated with the conference and the think tank, including the lived experience and other scholarships (which cover registration, travel, and accommodation costs), and the significant staff time spent organising and hosting these two events. One service provider echoed these concerns, and expressed that they would not be able to support future events without adequate funding, given the burden placed on organisations involved, and called for the allocation for conference support to be increased to \$250,000.

One service provider urged the Ministry to review the service plan “to ensure culturally and linguistically appropriate services are adequately resource”, particularly for priority populations. One gambling industry submission also noted that services should be supported in a more equitable way, with specific backing for services dedicated to Māori and Pacific communities in areas such as South Auckland.

One local government submission sought clarity around how budget and client numbers will be allocated across the country, and how this is calculated based on data and assessment of needs, given the current suite of services is proposed to continue.

Comments from hui participants

- As with discussion at the strategic level, hui participants noted the importance of **alignment at the operational level between the provision of related services**. They noted that these other services are likely to include mental health, welfare, and AOD services. Some participants discussed continuity of care across service provision. While continuity of *practitioner* was not expected, participants suggested structuring funding in a way that allows for crossover between service provision (allowing continuity of care) is important to enhance the experiences of service users.
- **Strengthening the peer support workforce** was noted in most hui as a core component of the delivery of gambling harm services. Participants noted that adequate workforce development (as noted in the Needs Assessment, strategic plan, and service plan) is key to recruiting and retaining workforce with the best skills and experience. Lived experience and service provider participants highlighted the value of peer support workers specifically.

4.3 New services and investments

Of the submissions that provided feedback on question six, 24 agreed with the new services and investments and 12 did not agree. Of the 24 that agreed, 11 provided qualified support and included constructive feedback.

4.3.1 There was widespread support in principle for self-exclusion functions

NB: There was general support for self-exclusion systems, but there was some conflation of the proposal to develop an online gambling self-exclusion system, and increased funding for MVE within Hauora Māori services. We have provided references to numbers of submissions for both systems where possible, though the conflation of these two services makes quantitative analysis of this content challenging.

Thirteen submissions explicitly supported the development of an online gambling exclusion system.

Allocate additional funding to evaluate the MVE Coordination programme and identify and remove barriers to implementing MVEs.

Submissions emphasised the need to create a system for gambling self exclusion that linked with the CONCERN database and built on the work already completed for MVE.

Several submissions noted that the cost for establishing an online-self-exclusion system is significant, and considered that further exploration might be required before committing the proposed budget to this project. Thirteen submissions suggested that the CONCERN database be used for an online gambling exclusion system:

There should, however, be one centralised database (the existing CONCERN database) for all excluded persons. There is no need to incur the cost of setting up a second database and second administration system. There are cost benefits in having one system and health benefits if persons who are excluded from online gambling are able to easily exclude themselves from land-based gambling and vice-versa.

There is merit in players who have excluded themselves from physical venues also having the ability to exclude themselves from online gambling sites via one single process. There is merit in persons who have excluded themselves from online gambling sites also being prevented from accessing similar products at local venues. Having a single exclusion process makes the exclusion more effective, and avoids the situation of the harmful gambling continuing on a different platform.

The submissions quoted above have utilised the NCGM form submission in whole or in part.

Six gambling industry submitters (utilising the NCGM form submission in whole or in part) considered that the Ministry may have misunderstood the role of the CONCERN database and FRT:

The CONCERN database is simply a database. To expand the use of facial recognition, funding support is required for the software licensing fees that are incurred in having the technology at each venue. This funding support should be provided immediately.

A service provider highlighted the importance of making any online self-exclusion systems user-friendly for priority populations, including providing multilingual options for priority population groups such as Asian, Māori, and Pacific users.

Eight submissions, seven of which were NCGM submitters (using the NCGM form submission in whole or in part) and one of which was an other gambling industry submitter, did not support the proposed funding boost to MVE coordination capacity within Hauora Māori services. These submissions considered that any funding increases for MVE should instead be allocated towards technology developments for MVE, such as improving the automation of the system.

One researcher who agreed in principle with the proposed new services and investments suggested that the self-exclusion priority in the draft service plan could go further:

upgrading the current multi-venue self-exclusion system to allow people to exclude themselves from physical (land-based) and online gambling environments in a single process, as occurs with the Spelpaus system in Sweden.

Furthermore, this submitter recommended that all new services and programmes should be subject to transparent evaluation that is available in the public domain.

Comments from hui participants

- Some participants raised questions about **MVE and FRT programmes**. They were critical of MVE as a process and stated that the reliance on venue staff to engage gamblers experiencing gambling harm was inconsistently adhered to. However, a few participants queried why FRT was not used more frequently to assist MVE. One participant suggested that the gambling levy should fund FRT and training in gambling venues.

4.3.2 There was cross-sector support for a NZQA harm-reduction qualification

Thirteen submissions across the gambling sector provided support for the funding and development of NZQA education and training content. This support was often qualified with recommendations to refine the proposal.

The most substantial recommendation, made by nine submissions using the NCGM form in whole or in part, was to fund or build on the work done by Hospitality New Zealand to develop a harm minimisation leadership course.

Four submissions provided detailed feedback regarding the NZQA qualification development.

One service provider supported the proposal to develop an NZQA qualification and noted that consultation with service providers would be important in the development of this qualification. This submission also noted that harm minimisation papers should be part of the compulsory curriculum for accepted addiction qualifications.

One gambling industry submission “*wholeheartedly supports an educational approach but suggests that a level 7 qualification is the wrong starting point*” and preferred an entry level course. This submission went on to endorse the qualification developed by Hospitality New Zealand.

One health organisation submission noted that an NZQA qualification (amongst other workforce development recommendations) should be developed at NZQA level four as well as at level seven. It stated that:

This will support the mental health and addiction workforce, particularly those with lived experience and support workers, who form the largest workforce in mental health and addiction sector. Equally important is the focus on training and retaining a robust public health workforce.

One submission highlighted the need to embed cultural competencies specific to priority populations into any new qualifications to ensure the workforce can deliver more effective, culturally aligned services.

Submissions provided support to expand the peer support workforce

Seven submissions (five service providers, two health organisations) provided support to expand the peer workforce. These submissions highlighted the importance of supporting peer support workers to enter the sector, particularly those who can connect with priority populations such as Asian, Māori, and Pacific service users.

Directly fund service providers for workforce development. Provide adequate funding for public health workforce development, wage uplifts and cost-of-living pressures. Adequately resource service providers to host both clinical and peer support interns. Allocate adequate funding to ensure the sustainable delivery of the International Gambling Conference.

No submissions expressly opposed expanding the peer support workforce.

4.3.3 Clinical internships were seen as a positive initiative

Five submissions provided express support for clinical internships. One of these submissions referred to ‘scholarships’, which we have interpreted and categorised as commentary on clinical internships.

Two submissions noted that while they support the internship initiative, they had reservations about the feasibility of this given the time-intensive nature of providing a quality internship programme. One of these submitters considered:

we must acknowledge that this process is resource-intensive for our clinicians. While highly valuable, providing guidance and supervision to students demands significant time and effort. Clinicians are responsible for inducting students, conducting peer reviews, offering coaching, and often seeking client permissions—all of which can divert attention from their primary responsibilities. While we welcome this initiative, it is essential to implement it in a way that adds real value to the workforce without overburdening clinicians.

Clinical service promotion is needed to better promote the importance of gambling harm

Three submissions provided feedback regarding the clinical service promotion.

One service provider provided substantial commentary and feedback. They suggested that the Ministry establish and fund a national steering group to guide the ongoing development and implementation of a national service promotion action plan that is aligned with an overarching national health promotion strategy. This service provider suggested that the steering group should comprise representatives from Hauora Māori, Pacific, Asian and general population gambling harm providers, alongside Lived Experience, and the steering group should include a review of the Gambling Helpline in a national health promotion action plan. This submission also suggested increasing the funding allocated to service promotion to between \$2.18 M and \$3.74 M, and developing mechanisms for linking local service promotion to national initiatives and leveraging investment across the sector.

One service provider supported further investment in clinical service promotion, noting that some primary healthcare clinicians lack sufficient knowledge about the public health approach to gambling harm and the neurological changes associated with prolonged gambling exposure. They also noted that:

there are considerable gaps in understanding referral pathways for patients impacted by gambling harm. Current clinical systems often do not effectively

integrate with gambling harm minimisation services, which limits access to the support that patients need.

This service provider acknowledged the strains the Ministry and HNZ are under and emphasised the need to work collaboratively with service providers and other sector partners to ensure the most efficient and effective provision of harm minimisation services.

One submission did not state support or opposition to the current proposal, but did consider that detailed plans for public awareness campaigns, including educational programs in schools, workplaces, and communities, were missing from the service promotion proposal.

4.4 Research and evaluation

Submissions were split on support for research and evaluation priorities set out in the draft service plan, with 18 submissions supporting the proposed priorities, and 16 submissions providing critical feedback.

4.4.1 Submissions valued accurate and high-quality data, research, and evaluation

Independent and quality data, research, and evaluation is critical to understanding gambling harm

Of the submissions that expressed support for the research and evaluation priorities, one individual noted the importance of this activity in understanding the size and nature of gambling harm to support recovery.

One health submission advocated for increased analysis of gambling trends, particularly in relation to rangatahi, online gambling, and the gaming/gambling convergence. Similarly, one service provider proposed identifying the impact of current gaps in service user data and developing an interim solution to address this. Another service provider called for the development of a modern client data management system that accounts for cultural differences such as the gradual information disclosure process that is common among Asian clients. This service provider suggested this could be done by taking an adaptable and culturally sensitive approach to data collection.

Six gambling industry submissions emphasised the importance of the evaluation being “conducted by a trusted, reputable and independent organisation”. One of these submitters also requested that when undertaking the evaluation, meaningful input be obtained from the industry, including venue personnel who work at the coalface. The review and rethink need to be a collaborative process.

One researcher highlighted the importance of robust and informed research practices. They considered having a detailed knowledge of the sector and a detailed knowledge of the context of the research landscape is imperative for relevant research, especially in regard to insightful data interpretation and subsequent recommendations.

A clear case to demonstrate the point is the Needs Assessment for the proposed Strategy. As mentioned in Point 1, limiting the academic literature search to only four academic journals has severely limited the research accessed and,

subsequently, compromised the conclusions drawn on which the proposed Strategy is based. By not accessing journals such as BMC Public Health and Health Promotion International (and many others), research on gambling environments (including the effects of gambling advertising and marketing) have been missed and this is evident in the proposed research priorities that completely omit these potential areas of research.

This researcher notes that the gambling research workforce in Aotearoa New Zealand has dwindled, reducing capability and capacity for high-quality informed research in the gambling space.

Another gambling industry submission agreed with proposals to develop more robust, timely, and transparent data and research, particularly to support decision-making. This submission considered there should be more research undertaken on the online, unregulated gambling market, given the gap in data.

Gambling industry submissions agreed with research and evaluation priorities in principle

Seven gambling industry submissions were supportive of the evaluation work, on the condition that this is undertaken by an independent, reputable organisation with sector feedback also included. Another gambling industry submission recommended that more detailed Aotearoa New Zealand-specific research should be completed in the most harmful area of gambling, specifically NCGM gambling. Similarly, another gambling industry submission supported for research relating to the Aotearoa New Zealand context, specifically with an understanding of the operator responsibility policies and procedures that exist. Another gambling industry submission suggested funding regular continuation of the new gambling prevalence survey, that is set to replace data collection following the cessation of the HLS, under the levy.

Submitters noted concern for the decrease in budget and recommended investing in collaborative, long-term research capacity

Two service providers agreed with the priorities but were concerned about the proposed decrease in research budget, as this would limit the breadth and scope of information available to inform policy, operational decisions, and evaluation of the draft Strategy. One of these service providers suggested that a major strategic review should be required, drawing on research that gathers prevalence data about gambling through a longitudinal study. Two service providers advised that investing in sustained research capacity is essential, rather than relying on one-off studies, including investment in longer-term, collaborative research programmes and dedicated research positions within service providers for staff with the required cultural competence and institutional knowledge.

One researcher noted that the proposed research budget (which is 15% less than the current strategy) will not allow for any large scale or new longitudinal projects to be conducted, to provide the Aotearoa New Zealand specific evidence base on which to inform new initiatives and on which to base community level and national level decisions.

One health submission recommended that the Ministry commission research into the impact of gambling harm on disabled people, in an approach that is led and informed by disabled people and people with experience of gambling harm.

Comments from hui participants

- A few participants noted that **high quality, consistent data collection** was important to monitor and evaluate progress in the gambling harm space. These participants considered that more specificity was required in the research and evaluation section of the service plan. It was unclear if these participants had engaged with Appendix 5 of the consultation document which provides more detail on the research and evaluation plan.

4.4.2 Some submissions called for more culturally appropriate and methodologically robust evaluation and research

One service provider recommended the Government should ensure research procurement values longer-term programmes of collaborative research, develop research capability within gambling harm providers, and recompenses service providers for the support they provide to research projects.

One individual expressed concern that there is insufficient funding to prioritise evaluation and research including collecting data and evidence on priority populations, such as Pacific communities. One service provider suggested more Pacific-focused and -led research and evaluation – including design, analysis, and dissemination by Pacific researchers – in addition to allocating funding for service providers who participate in research activity. Another service provider requested greater transparency around the procurement of gambling research and raised the need for “*a diverse range of Māori specific research that is underpinned by kaupapa Māori research methodology and methods*”.

One individual called for the voice of people with lived experience and family members to be heard. One gambling industry submission recommended establishing feedback mechanisms from service users, communities, and stakeholders to ensure that the draft Strategy can be continuously refined based on real-world experiences and emerging needs. One service provider urged the Ministry to establish a panel including diverse expertise and community perspectives to assess the effectiveness of the draft Strategy. This submission also suggested that the Ministry commission a study to determine the cost-benefit analysis of gambling harm in Aotearoa New Zealand, including a clear baseline to measure the impact of gambling harm over time and clearly defining the costs of gambling harm to inform levies.

One gambling industry submission urged the Ministry to engage in “*international collaboration to learn from other countries’ experiences, adopting global best practices, and participating in international research*”. Another gambling industry submission recommended that the Ministry clearly state the terms of reference for research, with a focus on providing up-to-date prevalence data and ensuring service providers and venues have the tools and technology to collect data to fill in research gaps, before increasing funding.

One researcher emphasised enabling “*topical, timely and innovative*” research to be funded, given that research priorities are ever-changing with the rapid evolution of gambling activities and technologies. This submitter reiterated the importance of forward-thinking and proactive research to provide the evidence base required to inform meaningful policy change, and made the following related suggestions:

- a more even distribution of research funding across the three years of the draft Strategy
- the addition of academic scholarships for master's, doctoral, and post-doctoral level researchers to the funding priorities, as a cost-effective way to grow the workforce
- the addition of research funds being made available in each of the three years, including researcher-initiated projects
- the funding and development of effective knowledge translation plans for each research project, to maximise reach and effect of dissemination of research
- the addition of an independent, academic evaluation of the draft Strategy, including evaluating whether new and current programmes are making a difference.

One individual advocated for a greater focus on online gambling in research priorities.

5 Proposed levy and weighting options

This section outlines submissions' comments on the levy and levy weightings. This includes:

- the levy and whether it provides a reasonable way to reflect relative harm
- player expenditure forecasts for each gambling sector
- preferred weightings for expenditure and presentations
- the estimated draft levy rates for each sector.

Four questions were asked about the levy, two of which included 'Yes/No' responses. **Table 6** Forty-one submissions responded to at least some of the questions about the draft service plan (21 gambling industry submissions, 10 individuals, nine service providers, one researcher).

Figure 3: Number of submissions, by sector, who commented on the proposed levy formula and levy rates

Key themes on the proposed levy formula and levy rates were:

- Most submissions did not agree that the player expenditure forecasts are realistic.
- There was a variation of preferences for levy weightings.
- Submissions were concerned that online gambling operators do not paying a fair share of the levy.
- Gambling industry submissions called for training and technology programmes to be funded from the levy.

Other topics raised were the (lack of) levy paid by offshore online gambling providers and queries around scope to increase the levy to create more resources for service providers.

5.1 Player expenditure forecasts

5.1.1 Most submissions did not agree that the player expenditure forecasts are realistic

Of the 16 submissions that answered question eight, 10 did not agree that the player expenditure forecasts were realistic. These were largely individuals, but also included three gambling industry submitters and one service provider.

Three submissions (two individuals and one gambling industry) cited the exclusion of online gambling operators as the rationale for why the expenditure forecasts were unrealistic.

Two submissions (one individual and one gambling industry) did not agree that the player expenditure forecasts were realistic as they were concerned the data on which the forecasts were built on was out of date or incomplete.

One gambling industry submission considered that the proposed forecasts for the casino sector seem to be unrealistic growth increases:

Due to cost of living, interest rates, the new gambling opportunities and the emerging gambling online choices available to customer, a modest growth of 2-3% for the land-based casino sector, would be more realistic.

Moreover, one service provider suggested that all gambling operators should also pay higher business tax rates, increasing revenue from gambling operators:

I propose that these rates should increase to match the taxation levels that regular businesses pay ie 28%. This adjustment would ensure a fair contribution from the gambling sector to community funding.

This submission highlighted that the draft Strategy indicates that the levy is lower for the highest-earning sectors which may undermine the potential for increased community funding. Revising this approach and implementing higher levies on the most profitable sectors has the potential to create a more realistic expenditure forecast that better reflects the actual financial landscape of the gambling industry while also benefiting the wider community.

Of the six submissions that agreed that the player expenditure forecasts for each sector were appropriate, none offered further explanatory comments.

Comments from hui participants

- A few participants **queried whether, despite the intention of the full cost-recovery model, the levy funds were sufficient to provide funding for the growing needs of gambling harm service users.** Some service providers highlighted the often interlinked and complex requirements that service users can present with, some of which cannot be disentangled from gambling harm. They queried where the responsibility and thus funding should lie regarding intersectional and interlinked harm.

5.2 Levy weightings

5.2.1 There was a variation of preferences for levy weightings

Thirty-three submissions provided feedback on levy weightings. Of the options provided in the consultation document, support was varied, with 30/70 being the most popular, followed by 5/95. Twelve gambling industry submission (using the NCGM form submission in whole or in part) also presented an argument for a 50/50 alternative weighting option.

Table 7: Level of support for each weighting preference, by number of submissions

5/95	10/90	20/80	30/70	50/50	No preference
4	2	2	5	12	8

- 5/95: One gambling industry submission, two service providers, one individual.
- 10/90: Two gambling industry submissions.
- 20/80: One service provider, one individual.
- 30/70: One gambling industry submission, three service providers one researcher.
- 50/50: 12 gambling industry submissions.
 - **NB:** This was not presented in the draft Strategy but was suggested by 12 submissions which are all reproductions or iterations of the NCGM form submission.
- No preference: One gambling industry submission and seven individuals.
- **NB:** Two gambling industry submissions also responded, preferring a weighting of *either* 5/95 or 10/90.

Regarding the 50/50 weighting, the author of the NCGM form submission considered that placing a high weighting on help-seeking is not appropriate, as help-seeking from one form of gambling does not necessarily mean that more people in general are suffering harm from that type of gambling. Furthermore this submitter said that help-seeking is not a good indication of the degree of gambling harm, which was supported by statements by the Gambling Commission:

An increase in presentations from one sector can be the result of an intense social media campaign encouraging gamblers in that sector to seek help. Further, an increase in presentations can be a direct result of new training for venue staff and a more proactive approach being taken to referring people to the treatment providers.

Additionally, this gambling industry submitter considered that a 50/50 weighting acknowledges and accounts for the fact that not all the levy fund is used directly on treatment provider costs. The levy funds a public health approach and covers the cost of general research on and evaluation of gambling.

Of the four submissions that preferred a 5/95 weighting, three cited the greater degree of harm caused by NCGMs as being the primary reason. A gambling industry levy payer considered that:

the costs of presentations and wider costs to prevent and reduce problem gambling harm be apportioned to the products causing the most harm, and that citation data gives an accurate view of this on a proportionate basis, even if it does not do so on a total volume basis.

Additionally, a Māori service provider offered support for the 5/95 option as it:

reflects where most of the harm comes from, especially for whānau Māori, being class 4 gaming machines.

These submissions supported a levy weighting of 5/95 to ensure that most of the funding collected by the levy is directed towards addressing the harm cause by NCGMs, particularly for priority populations groups who are disproportionately impacted by this form of gambling harm.

The two submissions that preferred a 10/90 weighting were both casinos. Both submissions noted that presentations are the best available longitudinal quantitative proxy for harm, attributing a 90 percent weighting to presentations is the only plausible way of ensuring a balanced and appropriate apportioning of the costs.

Of the two submissions that preferred a 20/80 weighting, one (service provider) commented that this option provides a more balanced approach to setting levy rates across sectors, ensuring a fairer distribution of financial burdens based on contributions and operational realities:

Fairer levy systems can enhance compliance and reduce market distortion, helping sectors facing heavier burdens. Given the gambling industry's rapid evolution, the flexible 20/80 structure is crucial for adapting to changes. Additionally, involving stakeholders in decision-making...can foster acceptance and cooperation in implementing levy structures.

Five submissions preferred a 30/70 weighting, the same weighting that is currently in use. These submissions cited the following reasons for this preference:

- As presentation is a (potentially inaccurate) proxy figure for harm, a greater weighting on expenditure is preferred.
- A 30/70 weighting placed a higher burden on NCGMs which some submission considered the most harmful type of gambling.

Comments from hui participants

- An industry participant queried whether the levy options being consulted on should take the (current) **30/70 weighting as the midpoint option**, rather than the lowest end option.

Twelve submissions cited the 50/50 preference outlined in the NCGM form submission:

The new levy should be set using a 50/50 weighting (50% expenditure, 50% presentations). This weighting is appropriate given the wide definition of harm in the Gambling Act 2003, the fact that presentations are not a sound proxy for harm, the fact that the presentation data can be subjective, the wide public health approach, and the fact that online gambling services are being funded by the levy, but online gambling providers are currently not levy payers.

These submissions, made only by members of the gambling industry, wanted to see a more even distribution of the levy amongst the four types of gambling operators.

5.3 Other levy comments

5.3.1 Submissions were concerned that online casinos do not pay a fair share of the levy

Seven submissions (one researcher, one service provider, five gambling industry) noted concern about online casinos not paying a fair share of the levy. While submissions often acknowledged work was ongoing to regulate online casinos, submissions urged the Ministry to ensure that levy calculations were included in the 2026 regulation of online casinos.

A researcher suggested that:

some contingencies should be made to include levy contributions from the online casino sector, once regulation of that sector comes into force. Proxy estimates should be made for expenditure and treatment presentations given that no data will be available until a year after operations. Nonetheless, this does not mean that the online casino industry should be exempt from paying the levy before hard data are obtained.

Seven gambling industry submissions highlighted that the 2026 regulations will take effect mid-levy period. They considered if it would be sensible for the Ministry to instigate an early review of the levy given the significance of the online casinos entering the Aotearoa New Zealand market, once the 2026 regulations are in place. These submitters were supportive of the move to regulate online casinos, but did not support the ‘imbalance’ in levy payments (real or perceived) that this would create for levy payers from 2026 to the next levy review period. shows the tally of responses by question.

Responses were received from four of the seven classification groups, as detailed in

Figure 3 below.

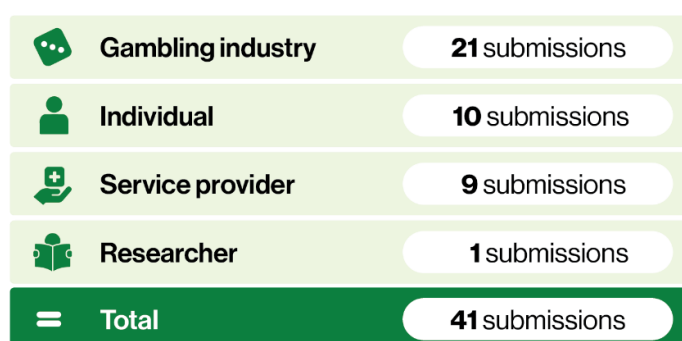
Table 6: Responses to questions about the proposed levy formula and levy rates

Question	Yes	No	Other comments	Total
8. Are the player expenditure forecasts for each gambling sector (D) realistic?	6	10	1	17
9. Are there realistic pairs of expenditure/presentation weightings (W1 and W2) other than those discussed in this consultation document?	4	10	0	14

Question	Yes	No	Other comments	Total
10. Which pair of weighting options for W1 and W2 do you prefer, if any, and why? Please explain. Please keep in mind that the levy weighting options only affect the proportion of the levy to be paid by each gambling sector and do not affect the total amount of the levy.		N/A		26
11. Do you have any comment on the estimated levy rates for each sector, keeping in mind that the levy formula itself is set in legislation and is not under consideration in this consultation? Please add any comments.		N/A		24

Forty-one submissions responded to at least some of the questions about the draft service plan (21 gambling industry submissions, 10 individuals, nine service providers, one researcher).

Figure 3: Number of submissions, by sector, who commented on the proposed levy formula and levy rates



Key themes on the proposed levy formula and levy rates were:

- Most submissions did not agree that the player expenditure forecasts are realistic.
- There was a variation of preferences for levy weightings.
- Submissions were concerned that online gambling operators do

not paying a fair share of the levy.

- Gambling industry submissions called for training and technology programmes to be funded from the levy.

Other topics raised were the (lack of) levy paid by offshore online gambling providers and queries around scope to increase the levy to create more resources for service providers.

5.4 Player expenditure forecasts

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Moreover, one service provider suggested that all gambling operators should also pay higher business tax rates, increasing revenue from gambling operators:

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5.5 Levy weightings

5.5.1 There was a variation of preferences for levy weightings

Thirty-three submissions provided feedback on levy weightings. Of the options provided in the consultation document, support was varied, with 30/70 being the most popular, followed by 5/95. Twelve gambling industry submission (using the NCGM form submission in whole or in part) also presented an argument for a 50/50 alternative weighting option.

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Of the four submissions that preferred a 5/95 weighting, three cited the greater degree of harm caused by NCGMs as being the primary reason. A gambling industry levy payer considered that:

the costs of presentations and wider costs to prevent and reduce problem gambling harm be apportioned to the products causing the most harm, and that citation data gives an accurate view of this on a proportionate basis, even if it does not do so on a total volume basis.

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Comments from hui participants

- An industry participant queried whether the levy options being consulted on should take the (current) **30/70 weighting as the midpoint option**, rather than the lowest end option.

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These submissions, made only by members of the gambling industry, wanted to see a more even distribution of the levy amongst the four types of gambling operators.

5.6 Other levy comments

5.6.1 Submissions were concerned that online casinos do not pay a fair share of the levy

Seven submissions (one researcher, one service provider, five gambling industry) noted concern about online casinos not paying a fair share of the levy. While submissions often acknowledged work was ongoing to regulate online casinos, submissions urged the Ministry to ensure that levy calculations were included in the 2026 regulation of online casinos.

A researcher suggested that:

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Comments from hui participants

- Some participants raised concerns that **online gambling sites, particularly those based overseas, were not paying a fair share of the levy**. They sought clarity on how these sites would be taxed and how they would be assessed regarding the levy weighting ahead of the proposed 2026 regime being established.

6 Strategy process

This section outlines comments on the strategic direction of the Strategy consultation and development process. This includes responses to questions 13 and 14, as well as general comments made about the strategy development and consultation process.

Key themes on the future Strategy development process were that:

- most submissions did not want the strategy development process to extend to five years
- a few submissions agreed that a five-yearly review cycle is preferable
- submissions were divided on support for simplifying consultation requirements from two phases to one
- some submissions called for a review of the overall Strategy process.

6.1 Future strategic development proposals

Two questions were asked about the future Strategy development process, both of which included 'Yes/No' responses. **Table 8** shows the wording of those questions and the number of submitters who responded and their response. shows response by group.

Table 8: Responses to questions about the future Strategy development process

Question	Yes	No	Total
13. Do you agree that the strategy should be developed every five years instead of three?	5	18	23
14. Do you agree that the legislation should not require separate strategy proposals and further consultation by the Gambling Commission, but it should allow for the Gambling Commission to give its on view on the proposed funding and problem gambling levy as part of the general consultation phase?	10	9	19

Twenty-four submissions responded to at least some of the questions about the draft service plan (16 gambling industry submissions, six individuals, one service provider, one researcher).

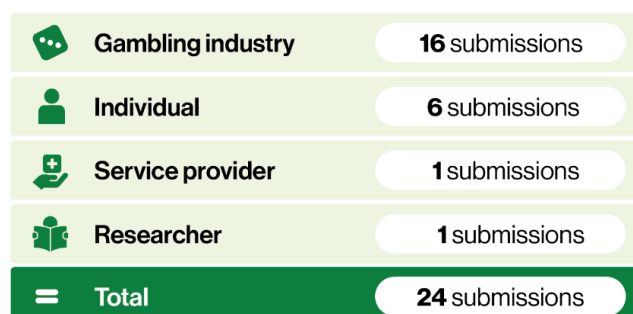


Figure 4: Number of submissions, by classification, that provided feedback on the future Strategy development process

6.1.1 Most submissions did not want the strategy development process to extend to five years

Fifteen submissions (of the 18 that opposed a change) stated that they would prefer for the existing three-year cycle to continue as is. Submissions cited reasons such as enabling the Strategy to keep up with technology changes and maintaining accountability for spending.

Eight submissions (mostly gambling industry) were particularly concerned with the accountability implications of moving from a three to five-year cycle. These participants wanted the Ministry and other government agencies to be regularly held accountable for how the gambling levy was spent.

Changing the review cycle from three years to five is not supported. It is clear that the Ministry needs to be held accountable for the spend. Three-yearly reviews, including a formal Needs Assessment, help to achieve accountability and efficacy.

Two submissions were concerned that rapid changes in technology is an important reason to maintain a shorter cycle, allowing all stakeholders involved in gambling harm reduction to take stock of advances in technology and respond appropriately.

Three years is adequate. MOH officials should be efficient in reviewing policies and procedures. Technology changes are rapid and hence MOH needs to keep up.

Additionally, five submissions (four gambling industry, one service provider) preferred a three-year review, as a longer cycle would likely be less responsive to shifts in the gambling eco-system that an effective strategy would need to address, including health implications and statutory changes.

One gambling industry submitter suggested that while the Strategy should remain on a three-yearly cycle for the time being, they would support a move to a five-yearly cycle “as *the landscape for gambling in New Zealand settles*”. This submitter highlighted that a longer review cycle would allow for strategic priorities to be delivered, embedded, and evaluated for effectiveness, which could inform subsequent strategies.

A few submissions agreed that a five-yearly review cycle is sensible

Five submissions (one gambling industry, three individuals, one researcher) agreed that the strategy should be developed every five years instead of every three years.

One of the gambling industry submissions noted that long-term sustainability and adaptability was missing from the current draft Strategy:

Developing a framework for long-term sustainability, including plans for adapting to future changes in the gambling landscape, economic conditions, and emerging technologies, ensures that the strategy remains relevant and effective beyond the initial period.

6.1.2 Submissions were divided on support for simplifying consultation requirements from two phases to one

The 10 submissions that supported the proposed change provided no further comment beyond general support. Of these 10, six were individuals, two were gambling industry submissions, one was from a service provider, and one was from a researcher.

Eight submissions did not support a change to a single-phase consultation, all of which were gambling industry submissions.

The current two-stage process enables feedback to be provided at an operational level to the Ministry and more high-level strategic feedback provided to the Gambling Commission. Given the very large amounts of money involved, and the importance of getting gambling treatment harm right, the current two-stage process is justified.

Seven of the nine submissions that opposed this proposal utilised content (in whole or in part) from the NCGM form submission.

6.1.3 Some submissions called for a review of the overall the strategy development process

Twelve submissions (11 gambling industry, one individual) expressed concern that the Ministry had not undertaken a strategic review of the strategy development process as recommended by the Gambling Commission. Some of these submitters called for a fresh approach to the design of the Prevention and Minimisation of Gambling Harm Strategy. Nine submissions further noted that they were concerned that the Ministry was not taking the advice of the Gambling Commission regarding more collaborative engagement with the gambling industry.

A few submissions gave general feedback that the draft Strategy is ‘more of the same’ and that it is unlikely to inspire the transformative change that some suggested was needed.

Change is needed. We cannot keep doing the same thing and expecting a different outcome.

Submissions that commented on the lack of strategic review considered this a priority in the context of the increased cost of the gambling levy proposed in the 2026-28 cycle.

7 Thematic analysis by sector

This section describes the way different sectors addressed the common themes throughout the submissions.

7.1 Online gambling was a concern for most groups

7.1.1 Online gambling requires greater visibility in the Strategy

NCGM submitters

Fourteen NCGM submitters discussed online gambling. Many of these submitters called for upcoming online gambling regulations to focus on harm minimisation and align with land-based gambling measures such as mechanisms for self-exclusion. Some of these submitters highlighted that, as levy players, they concerned that online gambling operators were not contributing to the levy and Strategy budget.

Other gambling industry submitters

Nine non-NCGM gambling industry submitters advocated for greater visibility and accountability of online gambling, including offshore gambling. Two non-NCGM gambling industry submitters called for upcoming online gambling regulations to focus on harm minimisation and align with land-based gambling measures such as mechanisms for self-exclusion. One of these submitters advised that harm minimisation standards established by the regulator for online casino licenses should be flexible to evolve with technology, research, and emerging best practice.

Service provider

Six service providers advocated for greater visibility and accountability of online gambling including offshore gambling.

Health organisations

Six health organisations raised concerns with online gambling, particularly as it related to gaming and advertising at public health level.

Researcher

One researcher advocated for greater visibility and accountability of online gambling including offshore gambling.

7.1.2 Submitters had differing views on the proposed levy and expenditure, with concern that online casinos do not contribute

NCGM submitters

Sixteen NCGM submitters commented on the gambling levy.

Twelve NCGM submitters presented an argument for a 50/50 alternative weighting option, for a more even distribution of the levy amongst the four types of gambling operators.

Four NCGM submitters noted concern about online casinos not paying a fair share of the levy, and urged the Ministry to ensure that levy calculations were included in the 2026 regulation of online casinos.

Other (non-NCGM) gambling industry submitters

Six other (non-NCGM) gambling industry submitters commented on the proposed gambling levy.

One gambling industry submitter did not agree that the player expenditure forecasts were realistic. It considered that the proposed forecasts for the casino sector seem to be unrealistic growth increases.

One gambling industry submitter preferred a 5/95 weighting. Two gambling industry submitters preferred a 10/90 weighting, and two further gambling industry submitters preferred a weighting of *either* 5/95 or 10/90.

One gambling industry submitter noted concern about online casinos not paying a fair share of the levy, and urged the Ministry to ensure that levy calculations were included in the 2026 regulation of online casinos.

Service providers

Six service providers commented on the proposed gambling levy.

One service provider did not agree that the player expenditure forecasts were realistic, and suggested that all gambling operators should also pay higher business tax rates, increasing revenue from gambling operators.

Two service providers preferred a 5/95 weighting. One service provider preferred a 20/80 weighting. Three service providers preferred a 30/70 weighting.

One service provider noted concern about online casinos not paying a fair share of the levy, and urged the Ministry to ensure that levy calculations were included in the 2026 regulation of online casinos.

Researcher

One researcher preferred a 30/70 weighting. This submitter also noted concern about online casinos not paying a fair share of the levy, and urged the Ministry to ensure that levy calculations were included in the 2026 regulation of online casinos.

7.2 The strategic focus of the draft Strategy could address gambling harm more directly

7.2.1 Submitters from different sectors expressed a desire for greater strategic focus, workforce

capacity, and cultural competency to meet the needs of priority populations

Service providers

Ten service providers commented on the strategic focus, workforce capacity, and cultural competency and suggested these areas could be strengthened to provide greater support for priority populations.

Three service providers expressed support for a focus on priority groups who experience disproportionate gambling harm, including specific attention to Māori, Pacific people, Asian people, and young people. One service provider advocated for enhanced regulatory measures, greater cultural sensitivity, and more effective support systems for Asian communities in particular.

Four service providers discussed the inequities faced by Māori and called for greater funding for kaupapa Māori services and stronger workforce cultural competency. Two of these service providers advised that supporting priority populations requires a deep understanding of the unique needs and aspirations of iwi, hapū, marae, community, and whānau. Another service provider advocated for a te ao Māori approach.

Two service providers highlighted the growing gambling harm experienced by rangatahi, particularly given the convergence of online gaming and gambling. One of these submitters recommended allocating funding to develop clinical support services tailored to meet the needs of young people, including both online and face-to-face support and self-help resources.

One service provider called for older people to be included as a priority group in the draft Strategy, given the risk and impacts they face. This service provider and one health submitter considered that rainbow and disabled people should be recognised as priority groups.

Health organisations

Four health organisations commented on the strategic focus, workforce capacity, and cultural competency and suggested these areas could be strengthened to provide greater support for priority populations.

One health organisation expressed support for a focus on priority groups who experience disproportionate gambling harm, including specific attention to Māori, Pacific people, Asian people, and young people. Another health submitter discussed the inequities faced by Māori and called for greater funding for kaupapa Māori services and stronger workforce cultural competency.

Two health organisations highlighted the growing gambling harm experienced by rangatahi, particularly given the convergence of online gaming and gambling. One of these submitters encouraged greater resource to research and develop youth-centric service provision given the increased exposure to gambling products, advertising, and gamblification among youth.

One health organisation raised that disability is intersectional including tāngata whaikaha disabled Māori, disabled Pacific people, disabled Asian people and disabled younger people who are at even higher risk of gambling harm.

7.2.2 Some submitters considered that the Needs Assessment showed no reduction in gambling harm

NCGM submitters

Six NCGM submitters considered that the findings of the Gambling Harm Needs Assessment 2024 demonstrated that the current Strategy has been unsuccessful: it has not reduced the prevalence of problem gambling in spite of increased funding for the period. Two of these submitters noted that the shift towards online gambling is disrupting the gambling levy setting arrangements.

Service providers

One service provider considered that the findings of the Gambling Harm Needs Assessment 2024 demonstrated that the current Strategy has not been successful in reducing gambling harm.

7.2.3 A clearer, stronger public health approach to recognise the complexities of gambling harm is needed

Service providers

Two service providers expressed a desire for greater clarity of the public health approach that underpins the draft Strategy and suggested outlining measures to address the range of factors contributing to gambling harm. These submitters called for cross-sector collaboration between central government agencies involved in gambling harm prevention and minimisation to strengthen efforts.

Health organisations

Two health submitters proposed:

- reviewing and tightening gambling-related policy and regulations
- combining upstream and downstream approaches to protect population health with established methods and advocacy
- awareness-raising and educational activities that focus on social determinants of harmful gambling behaviour among priority populations.

Researcher

One researcher considered that the draft Strategy does not embody a true public health approach given that the gambling environment is omitted from the draft Strategy and the focus is on treatment. It recommended understanding and responding to gambling provision and industry behaviours.

7.2.4 Service providers were concerned with the absence of te Tiriti o Waitangi

Service providers

Five service providers expressed concern at the absence of te Tiriti o Waitangi in the draft Strategy. They were concerned about the implications of this absence such as inadequate reflection of critical insights from Māori communities and practitioners in health service design and delivery. One service provider urged the Ministry to include a clear statement on the role of te Tiriti o Waitangi in the draft Strategy and provide context for the strategic framework in guiding the health and disability sector.

7.2.5 Greater alignment with other mental health priorities and frameworks is needed

Service providers

Two service providers recommended stronger integration with other relevant mental health and population-based health strategies, such as the Pae Ora Strategies, for improved collaboration and collective accountability in the system.

Health organisation

One health submitter recommended stronger integration with other relevant mental health and population-based health strategies, such as *Kia Manawanui Aotearoa: the long-term pathway and Oranga Hinengaro System and Service Framework*, for improved collaboration and collective accountability in the system.

7.2.6 The inequitable distribution of NCGMs was still considered problematic by some submitters

Service providers

Two service providers considered that the availability and concentration of NCGMs should be restricted, particularly in areas of higher deprivation. NCGMs were seen to perpetuate disproportionate harms among priority population groups such as Māori and Pacific peoples. One of these submitters recommended that the problem definition should clearly stipulate the historical context of colonisation, the targeting of Māori by the gambling industry, and the oppressive systems that have shaped the currently gambling landscape in Aotearoa New Zealand.

Health organisations

Two health organisations considered that the availability and concentration of NCGMs should be restricted, particularly in areas of higher deprivation. This was also because NCGMs were seen to perpetuate disproportionate harms among priority population groups, such as Māori and Pacific peoples.

7.3 Service delivery could be improved

7.3.1 There was cross-sector support for self-exclusion functions and workforce development proposals

NCGM submitters

Eleven NCGM submitters commented on self-exclusion and the workforce development proposals in the service plan.

Nine NCGM submitters supported the development of an online gambling exclusion system, emphasising a need for this to be linked with the CONCERN database and build on work already completed for MVE.

Nine NCGM submitters provided support for the funding and development of NZQA education and training content in principle – with the caveat that their preference if the Hospitality New Zealand qualification.

Two NCGM submitters expressed their support for clinical internships.

Other gambling industry submitters

Two other gambling industry submitters supported the development of an online gambling exclusion system, emphasising a need for this to be linked with the CONCERN database and build on work already completed for MVE.

Service providers

Seven service providers commented on self-exclusion and workforce development proposals in the service plan.

Two service providers supported the development of an online gambling exclusion system, emphasising a need for this to be linked with the CONCERN database and build on work already completed for MVE.

Two service providers provided support for the funding and development of NZQA education and training content.

Five service providers provided support to expand the peer workforce.

Two service providers expressed their support for clinical internships.

Health organisations

Two health organisations provided support for the funding and development of NZQA education and training content.

Two health organisations provided support to expand the peer workforce.

One health organisations expressed their support for clinical internships.

7.3.2 Submitters were divided on support for the proposed research and evaluation priorities

NCGM submitters

Nine NCGM submitters commented on research and evaluation priorities.

Seven NCGM submitters supported the evaluation work on the condition that this is undertaken by an independent, reputable organisation with sector feedback also included.

Two NCGM submitters recommended more context-specific and detailed research should be undertaken in Aotearoa New Zealand.

Service providers

Six service providers commented on research and evaluation.

Two service providers agreed with the priorities but were concerned about the proposed decrease in budget as this would limit the breadth and scope of information available to inform policy, operational decisions, and evaluation of the new Strategy.

Two service providers advised that investing in sustained research capacity is essential, rather than relying on one-off studies. They recommended investment in longer-term, collaborative research programmes and dedicated research positions within service providers for staff with the required cultural competence and institutional knowledge.

One service provider suggested more Pacific-focused and led research and evaluation including design, analysis, and dissemination by Pacific researchers.

One service provider requested greater transparency around the procurement of gambling research and raised the need for “*a diverse range of Māori specific research that is underpinned by kaupapa Māori research methodology and methods*”.

Health organisation

One health organisation recommended that the Ministry commission research into the impact of gambling harm on disabled people. They recommended this research be led and informed by disabled people and people with experience of gambling harm.

Researcher

One researcher made research and evaluation suggestions, including more evenly distributing research funding across the three years of the new Strategy and adding an independent, academic evaluation of the new Strategy to assess the impact of programmes.

7.3.3 Submitters were concerned with the absence of a budget for technology

NCGM submitters

Twelve NCGM submitters expressed concern that the technology budget had been removed from the draft Strategy, noting that the sector has invested significantly in harm minimisation technology, such as FRT, which is proving useful for managing excluded persons and meeting the requirements of relevant regulations.

Other gambling industry submitter

One other gambling industry submitter called for funding to be allocated for the development and testing of additional technology-based tools, such as a system that integrates player monitoring across all NCGM venues.

Service providers

One service provider expressed concern at the lack of targeted investment for technology and infrastructure development and support for gambling harm providers to better position themselves to be sustainable and adapt to a changing gambling environment. Another service provider agreed with the strategic intent to invest in digital tools but considered that this investment needs to be targeted to filling gaps in existing services, and that responsibility for developing tools should lie with those with current and relevant expertise.

7.3.4 NCGM submitters suggested greater visibility of face-to-face support, after-hours care, and prevention and early intervention

NCGM submitters

Seven NCGM submitters shared similar views about the need to ensure counselling services are available in every region, are flexible, and are responsive to client needs. Four NCGM submitters recommended that counselling services be available 24/7 to ensure they are client-centric, flexible, and responsive. Two NCGM submitters expressed support for gambling-related education and health promotion, specifically Tūturu, the ‘Nan’s Song’ initiative, the ‘Let’s Kōrero’ series, national destigmatisation campaigns, and both Safer Gambling Aotearoa and Gambling Host resources.

7.3.5 NCGM submitters recommended alternative approaches to service delivery and evaluation

NCGM submitters

Seven NCGM submitters considered that the current Strategy (2022/23 – 2024/25) lacks accountability and recommended setting specific, quantitative targets for treatment services.

These submitters offered suggestions on alternative approaches to service delivery, including a commitment to comprehensive and long-term engagement, specifically extending treatment beyond the immediate or initial intervention to ongoing monitoring and support, and a focus on preventing relapse.

7.3.6 Submitters expressed a range of views on the proposed increase in budget for services, and the proposed mix of services and supports

NCGM submitters

Nine NCGM submitters opposed the increase in budget and considered that this was neither needed nor warranted. Three of these NCGM submitters expressed concern that the “existing model of funding large non-profit non-government organisations to undertake clinical treatment has not worked” and proposed that the procurement of clinical services should be simplified to become attractive for small private providers.

Service providers

One service provider considered that the proposed funding levels and mix of services do not provide coverage by priority populations and by geographical area. It suggested that investment and additional funding should be allocated to areas that are assessed to have high need. Another service provider suggested improving cultural and linguistic appropriateness of services and support targeted to these populations.

7.3.7 A few service providers considered that more culturally appropriate services are required

Service providers

Three service providers advocated for more culturally appropriate services, with suggestions of “*marae-based tautoko*” in which marae are central hubs for additional high-intensity support to enhance service provision and deliver support by Māori for Māori communities in familiar, trusted environments. These submitters also suggested using more mobile health units to increase engagement and accessibility.

7.4 Keep the status quo of consultation process

7.4.1 Many submitters did not want the strategy development process to be extended and submitters were divided on support for simplifying consultation requirements

NCGM submitters

Fourteen NCGM submitters commented on the strategy development process.

Ten NCGM submitters did not support a move to a five-year levy/strategy period. They prefer the existing three-year cycle to continue as it is because they considered that this contributes to accountability and efficiency of spend and activities undertaken by the Ministry.

Eight NCGM submitters did not support a change to a single-phase consultation because they considered that the current two-phase process is justified in enabling operational-level feedback to be provided to the Ministry and high-level feedback to be provided to the Gambling Commission.

Eleven NCGM submitters expressed concern that the Ministry had not undertaken a strategic review of the strategy development process as recommended by the Gambling Commission. These submitters considered that this should be a priority in the context of the increased cost of the gambling levy proposed in the 2026-28 cycle.

Other (non-NCGM) gambling industry submitters

Three gambling industry submitters stated that they would prefer for the existing three-year cycle to continue as is. One of these submitters suggested that, while the Strategy should remain on a three-yearly cycle for the time being, they would support a move to a five-yearly cycle “*as the landscape for gambling in New Zealand settles*”.

Service providers

One service provider stated that it would prefer for the existing three-year cycle to continue as is and supported the proposed change to a single-phase consultation.

One service provider expressed concern that the Ministry had not undertaken a strategic review of the strategy development process.

Researcher

One researcher agreed that the Strategy should be developed every five years instead of every three years and supported the proposed change to a single-phase consultation.

8 Out of scope

This section outlines feedback from submissions that did not directly relate to the draft strategic plan, the draft service plan or the proposed levy. These topics are relevant to the policy or legislative settings for preventing and minimising gambling harm and have been included here for completeness.

8.1 Gaming

Gaming is not currently within the scope of the Act and therefore not included in the draft Strategy. Some stakeholders across both consultation hui and submissions raised concerns **with the ‘gateway’ effect of gaming**, particularly for rangatahi and how gaming additions can develop into gambling harm. These participants noted the increasing crossover between gaming and gambling apps and online games, with the increased use of loot boxes in games and the gamification of traditional online gambling services. Specific references were made to the new TAB app, which appears to use a social media model as a marketing technique. Stakeholders were highly concerned that there was not enough being done by the Government to mitigate the threats of online gaming/gambling connections, and that this was not addressed at all in the draft Strategy.

Among the written submissions, one researcher urged the Ministry to consider providing support for people who are predominantly gamers but experience gambling harm through gaming, as they are a (priority) population predominantly comprising young people. Similarly, one service provider suggested recognising gaming as a “*gateway mode to harmful gambling*” and including measures to prevent young gamers from experiencing gambling harm by allocating funding to develop and pilot targeted prevention and early intervention initiatives. Another service provider called for the consideration of gateway gambling in youth, and wondered if gamblification of gaming should be regulated and included in the levy. This submission supported the approach recently taken by the United Kingdom to implement regulations that ban loot boxes for those aged under 18 years old without parental consent. One gambling industry submission proposed “*reviewing and potentially updating the legal and policy framework to address modern gambling modalities, such as cryptocurrencies and eSports betting*” to ensure comprehensive coverage of all gambling activity.

One health submitter described how young people are increasingly exposed to games and gambling-like tools and tactics which are designed to influence decision-making. This submission noted that gamblification, such as loot boxes, is present in many online environments where children and young people are present. Many young people do not understand the risks or may lack the critical thinking skills required to engage safely with gambling-like tactics within games. This submission also noted that an app, recently launched a well-established Aotearoa New Zealand gambling organisation, targets a younger audience and mirrors social media platforms. It uses influencers to glamorise gambling and encourage gambling as a social tool. The recommendations provided by this submission included:

- prioritising research, prevention, and treatment efforts for rangatahi, with a focus on support for harm from the gambling and gaming convergence and education about the harms from advertising
- the Ministry working closely with the DIA to address concerns from services and encourage the development of strong regulations for online gambling and advertising of gambling products, to reduce exposure for young people.

8.2 Advertising

Advertising regulation or enforcement is not within the scope of the draft Strategy and is managed by the DIA. Many stakeholders across both submissions and consultation hui raised this as a concern. They considered it counterproductive for some gambling operators to be able to legally advertise while significant money is spent to mitigate and prevent gambling harm. Some stakeholders queried the legality of online gambling advertisements from gambling operators based outside Aotearoa New Zealand.

One health submission expressed disappointment that the draft Strategy does not address the importance of restricting gambling advertising and marketing as a key measure to reduce harm. This submission called for stronger restrictions on gambling advertising and sponsorship, noting that there is currently minimal regulation of this activity. Similarly, one service provider advocated for funding allocations to advance “*public policy initiatives which restrict access, availability and advertising of gambling products*” as part of a strategic focus on population-health measures. Another service provider noted that the use of advertising and online promotion is known to increase risk of harm. One other submission urged prohibition of advertising by gambling operators including online gambling sites. One service provider shared similar views, citing particular concern for Pacific youth:

To enhance the safeguarding of our vulnerable communities, it is imperative to emphasise the need for the government to prioritise the prohibition of all gambling advertisements. Frequent exposure to such advertisements has the potential to normalise gambling behaviour...

One gambling industry submission proposed that implementing stricter regulations on gambling marketing and advertising can play a critical role in harm prevention especially in relation to promotional activity that targets vulnerable populations such as youth. Another gambling industry submission considered that responsible advertising is required to ensure customers can distinguish between licensed and unlicensed operators. One individual suggested a ban on marketing of gambling services and a reduction of gambling outlets.

One local government submission expressed its concern with advertising standards, noting the promotion of TAB at all major sporting events and online gambling platforms increasing marketing activity nationally. Another local government submission expressed its concern with the way that some forms of gambling are visible in television advertising. It called for these forms of gambling to be recognised as potentially harmful.

8.3 Compliance and enforcement

Compliance and enforcement are not within the scope of the draft Strategy and is managed by the DIA; however, some stakeholders across both submissions and consultation hui raised this as a relevant topic of interest. Participants at a general hui queried how health protection officers could connect into local compliance processes.

Among the written submissions, two gambling industry submissions called for better enforcement against unregulated offshore operators, given they contribute to a high degree of problem gambling but are not required to contribute to the levy. Another gambling industry submission considered the draft Strategy was missing “*detailed plans for monitoring compliance, enforcing regulations, and imposing penalties for non-compliance*” to ensure gambling operators adhere to harm minimisation standards. One other gambling industry submission suggested empowering the regulator to take the following enforcement action:

- Operators without a licence should face appropriate penalties if they target New Zealand citizens with marketing and promotions.
- The regulator should work with international regulators and law enforcement agencies to ensure New Zealand laws are recognised and adhered to.

One individual requested greater funding for enforcement of services and activities within the service plan, in addition to having a strong regulator. Another individual advised that it may require a significant, one-off investment to “*enforce more strict host responsibility rules, overhaul the gambling industry as a whole and make efficient and effective assistant and support infrastructure for those suffering gambling harm*”.

One service provider recommended that the government consider implementing greater fines for violations that pose significant risks to vulnerable populations and for staff negligence in monitoring problem gambling behaviours, as the current fines do not adequately reflect the harm caused by venues failing to fulfil operator responsibilities. Another service provider encouraged evaluation of the effectiveness of clinical services, gambling operator responsibility programs, and the DIA given its lead role in compliance of gambling regulations.

Every aspect of the gambling system is accountable for preventing and minimising gambling harm.

8.4 Data

Some stakeholders across both consultation hui and submissions raised data in two contexts. Firstly, **whether the right data is being captured to inform monitoring and evaluation on gambling harm**. Stakeholders queried whether accurate data on gambling harm was being captured and made available to the Ministry, HNZ, and other key decision-makers. Discussions on this topic acknowledged the difficulty of maintaining accurate and up to date data but suggested more could be done at both a national and regional level.

Secondly, a few submitters highlighted concerns with **data sovereignty**. There is a requirement for the Ministry and the Government more broadly to respect the principles of



data sovereignty for all New Zealanders. This was of particular concern for Māori participants who have had negative experiences with the use of their data by the Government in the past.

Among the written submissions, one gambling industry submission considered that the draft Strategy lacks detail on data privacy. It suggested that clearer guidelines and safeguards for protecting individuals' personal and gambling-related data are essential to maintaining trust and complying with privacy laws.

Appendix A: Consultation questions

#	Question	Answer options
Strategic plan		
1	Do you agree with the proposed strategic goal, outcomes, actions and system priorities?	Yes
		No. If no, please explain why.
2	Does the draft strategic plan adequately reflect changes in the gambling environment?	Yes
		No. If no, what else should be included and why? Please explain.
3	Do you have any comments to make on the work to support priority populations?	Yes. Please add any comments.
		No
Service plan		
4	Does the draft service plan adequately cover what it needs to cover, for example, does it include the right types of services and activities?	Yes
		No. If no, what is not adequately covered and why? Please explain.
5	Do you consider the proposed funding levels, mix of services and service supports appropriate?	Yes
		No. If no, what changes should be made and why? Please explain.
6	Do you agree with the proposed new services and investments?	Yes
		No. If no, what changes should be made and why? Please explain.
7	Do you agree with the priorities for research and evaluation that have been outlined in the draft service plan?	Yes
		No. If no, what changes should be made and why? Please explain.
Levy formula and levy rates		
8	Are the player expenditure forecasts for each gambling sector (D) realistic?	Yes
		No. If no, please explain why not.

#	Question	Answer options
9	Are there realistic pairs of expenditure/presentation weightings (W1 and W2) other than those discussed in this consultation document?	Yes. If yes, please explain what and why.
		No
10	Which pair of weighting options for W1 and W2 do you prefer, if any, and why? Please explain. Please keep in mind that the levy weighting options only affect the proportion of the levy to be paid by each gambling sector and do not affect the total amount of the levy.	[free text]
11	Do you have any comment on the estimated levy rates for each sector, keeping in mind that the levy formula itself is set in legislation and is not under consideration in this consultation? Please add any comments.	[free text]
Anything else?		
12	Is there anything else you would like to tell us about the draft strategy or preventing and minimising gambling harm more generally? Please add any comments.	[free text]
Future Strategy development process under the Gambling Act 2003		
13	Do you agree that the strategy should be developed every five years instead of three?	Yes
		No. If no, do you have another time period you would recommend? If so, please explain what and why.
14	Do you agree that the legislation should not require separate strategy proposals and further consultation by the Gambling Commission, but it should allow for the Gambling Commission to give its view on the proposed funding and problem gambling levy as part of the general consultation phase?	Yes
		No. If no, do you have any comments on simplifying the existing consultation requirements? Please explain.

Appendix B: Recommendations made by submitters and hui participants

Submitters and hui participants made recommendations to the Ministry, HNZ, and DIA. Here we have detailed the relevant, specific, in-scope recommendations. Other general suggestions have not been included in this list for succinctness and readability.

Suggestions made by a leading national service provider

This service provider provided several specific recommendations, we have listed these here and throughout the report. Recommendations from other submitters follows below.

Strategic plan

1. Te Tiriti o Waitangi
 - a. Include a clear statement regarding the role of Te Tiriti of Waitangi in the Strategy and provide context regarding the strategic framework guiding the health and disability sector.
 - b. Clearly reflect the Articles of Te Tiriti o Waitangi in strategic goals, outcomes, actions, system priorities and the Service Plan.
1. Review of Strategy
 - a. Undertake a comprehensive review of the Strategy, as recommended by the Gambling Commission, with a view to aligning future funding, implementing an outcomes framework to drive investment and strengthening engagement, collaboration and cooperation across the wider gambling harm sector.
2. Ministry Funding Requirements
 - a. Increase the overall budget for the Strategy from \$87.72m to \$93.32M (3.38% of total annual expenditure on gambling activities) to address service gaps as outlined in our response to the Service Plan.
 - b. This increase is relative to the increase in total annual expenditure on gambling activities. Utilise this additional funding to address the Service Plan gaps identified below.
3. Regulatory framework
 - a. Include clear strategic outcomes regarding a strengthened regulatory framework to drive gambling harm prevention and minimisation.
 - b. Set out actions that promote evidence-based regulatory measures.
 - c. Enhance collaboration between Central Government agencies involved in gambling harm prevention and minimisation to ensure the objectives of the Strategy are met.
4. Infrastructure
 - a. Invest in systems and capability to ensure the sustainability of gambling harm providers.
 - b. Include a strategic priority to build a sustainable network of service providers who are responsive to the ever-changing context of gambling harm.

- c. Allocate funding to support infrastructure development within service providers.
5. Community level investment:
 - a. Prioritise investment to ensure decision making and actions are as close to communities and priority populations as possible.
 - b. Review the Service Plan to ensure resourcing at a community and service provider level reflects the strategic intention to support decision making at a community level.
6. Adequately resource services for priority populations
 - a. Review the Service Plan to ensure culturally and linguistically appropriate services are adequately resourced.
 - b. Review the Service Plan to ensure adequate resourcing of culturally and linguistically appropriate services.
7. Online gambling
 - a. Include online gambling in the Strategy with a clear strategic approach to address the likely increase in harm including prevention initiatives and intervention services that are appropriate for meeting the needs of Tāngata Whaiora in the online environment.

Service Plan

8. Population health measures: Allocate funding to advance evidence based public policy initiatives designed to:
 - a. Restrict advertising and promotion of gambling products.
 - b. Restrict the availability of electronic gambling machines (pokies).
 - c. Enhance harm minimisation regulations particularly in the online environment.
9. Service coverage and access
 - a. Address face-to-face service gaps and after-hours access along with solutions for support services that recognise the unique needs of youth, rainbow people, people with disabilities and older people.
 - b. Allocate additional funding to adequately assess and evaluate service coverage across all gambling harm service providers and address potential face-to-face service gaps in for example, Palmerston North, Invercargill, Tauranga and Whakatane.
 - c. Allocate funding to extend service providers' hours of face-to-face operations to better align with the preferences and needs of Tāngata Whaiora who report challenges attending services during business hours.
 - d. Allocate funding to service providers to staff their phones at peak after hours times when data shows Tāngata Whaiora are in crisis and attempt to contact the service.

- e. Allocate funding to develop clinical support services tailored to meet the needs of young people, disabled people, and the rainbow community. This needs to include online and in person services and self-help resources.
 - f. Review MOH's dataset to include gender identity and sexual orientation.
 - g. Allocate funding to undertake research on the gambling harms individuals and communities with disabilities are experiencing and co-design services to ensure best practice is established for marketing, outreach, and service delivery when older people present for health services, in particular mental health concerns.
 - h. Allocate funding to develop and pilot programmes to raise awareness of gambling harm among older people and enhance screening for gambling harm
10. Gambling gaming convergence
- a. Recognise gaming as a gateway mode to harmful gambling and allocate funding to develop and pilot prevention and early intervention initiatives to prevent youth gamers from experiencing gambling harm.
11. Online gambling service delivery
- a. Address changes in the regulatory environment for online gambling by allocating funding for tailored online gambling harm prevention initiatives.
 - b. Address the need for tailored interventions and preventative measures to address growing online gambling harms.
 - c. Allocate funding for the development and piloting of targeted interventions for those experiencing gambling harm in the online environment. This includes the development of digital self-help tools.
 - d. Allocate funding for a comprehensive "always on" online advertising campaign promoting digital self-help tools, and counselling support services.
 - e. Further discussion needs to take place to address where the funding for an online gambling exclusion system will be sourced.

Health promotion

12. Develop a 10-year health promotion strategy including a review of the role of Health New Zealand's health promotion team and align the Service Plan accordingly. Enhance the resourcing of community and priority population initiatives.
- a. Resource the development of an overarching 10-year health promotion strategy that guides investment in both national and local initiatives.
 - a. Develop a steering group to guide the development and implementation of a national strategy and action plans. The steering group should comprise representatives from the Hauora Māori, Pacific, Asian and General population service providers alongside gambling harm lived experience experts.
 - b. Provide a clear definition of the role of the central health promotion service to emphasise the central provision of strategic oversight, programme evaluation and the development of a strong evidence base.

- c. Provide a breakdown of cost allocations against Priority Three of the Service Plan which currently includes an aggregated allocation of \$7.56m.
- d. Revisit the investment and transparency of funding to ensure community actions are appropriately funded.
- e. Allocate a transparent budget for community actions.
- f. Resource the development of guidelines for allocating funding to community actions, including funding objectives, selection criteria, funding cycle etc.
- g. Resource the development of an evaluation framework for measuring the impact of community actions.
- h. Remove funding and resourcing within the Service Plan for development of Gamble Host materials.
- i. Remove provision in the Service Plan for the ongoing development of the Safer Gambling Test. Replace with provision for the central health promotion service to promote access to the revised Gambling Harm Test when it is available.
- j. Remove provision in the Service Plan for the development of digital tools for financial literacy. Reinvest funding allocated in development of financial capability expertise within service provider's clinical workforce.
- k. Include additional information regarding the rationale and plans for developing digital tools to promote harm minimisation messages, help-seeking and site-blocking.
- l. Remove the provision for Health New Zealand's health promotion service to support TLA policy reviews.
- m. Reallocate funding to gambling harm public health providers who support public health service teams, TLAs and community groups to participate in policy reviews.

Service promotion

13. Resource the establishment of a Steering Group to guide the ongoing development and implementation of a national service promotion action plan that is aligned with an overarching national health promotion strategy.
 - a. Increase the funding allocated to providers for service promotion.
 - b. Resource the establishment of a steering group to guide the ongoing development and implementation of a national service promotion action plan that is aligned with an overarching national health promotion strategy.
- b. This steering group should comprise representatives from Hauora Māori, Pacific, Asian and General Population Gambling Harm Providers, alongside the Gambling Harm Lived Experience Advisory Group.
 - c. Undertake a review of the role of the Gambling Helpline in a national health promotion action plan.

- d. Increase the funding allocated to service promotion to between \$2.18 and \$3.74 million.
- e. Develop mechanisms for linking local service promotion to national initiatives and leveraging investment across the sector.

Gambling Helpline

14. Evaluate the efficacy and outcomes of the Gambling Helpline and investigate alternative models at initial point of contact.
 - a. Allocate funding to evaluate the efficacy and outcomes of the National Gambling Helpline.
 - b. Allocate funding to investigate alternative models at initial point of care that effectively:
 - i. Alleviate help seekers' immediate concerns
 - ii. Provide specialist gambling harm support at first contact
 - iii. Build trust and engagement with service providers and actively support help seekers to access ongoing support and self-help resources.

Workforce development

15. Directly fund service providers for workforce development.
16. Provide adequate funding for public health workforce development, wage uplifts and cost-of-living pressures.
17. Adequately resource service providers to host both clinical and peer support interns. Allocate adequate funding to ensure the sustainable delivery of the International Gambling Conference.
 - a. Allocate workforce development funding for clinical and public health directly to gambling harm service providers.
 - b. Provide sustainable funding to service providers across the life of the Strategy.
 - c. Allocate funding to regularly bring the sector together to share knowledge, undertake collaborations and build strong networks. Responsibility for convening these platforms should lie with an organising committee comprising representatives from across gambling harm providers.
 - d. Increase the allocation for public health workforce development from \$424,000 (1.4% of budget) to \$644,000 (2.1% of budget).
 - e. Clarify the allocation for wage uplifts and cost-of-living pressures for primary prevention services.
 - f. Clarify any other initiatives that are planned with the \$1.764 uplift for primary prevention services.
 - g. Adequately and equitably fund wage and cost-of-living uplifts for primary prevention services.
 - h. Allocate funding to service providers to incentivise and enable them to host interns effectively.

- i. Allocate additional peer support FTE to priority population providers – Asian, Pacific and Hauora Māori providers.
- j. Allocate additional peer support FTE to this providers services to meet the needs of young service users.
- k. Allocate funding for peer support internships with appropriate funding for service providers to incentivise and enable them to host interns effectively.
- l. Adequately and equitably fund wage and cost-of-living uplifts for peer support services.
- m. Increase the allocation for conference support from \$180,000 to \$250,000 including provision for funding of organising providers.

Multi-venue Exclusions (MVE)

18. Allocate additional funding to evaluate the MVE Coordination programme and identify and remove barriers to implementing MVEs.
 - a. Allocate funding to undertake evaluation of current MVE Co-ordination function.
 - b. Allocate funding to investigate barriers to accessing and effectively implementing MVEs.
 - c. Allocate funding to effectively promote MVEs as a self-help tool.

Gambling harm intervention services data set

19. Identify the impact of current gaps in service user data and develop an interim solution.
20. Highlight the immediate risk of gaps in the national data set and identify the implication of these gaps.
21. Allocate funding and resources to implement an immediate solution to collect data from those organisations who cannot upload data to CLIC.

Research

22. Ensure research procurement values longer-term programmes of collaborative research, develops research capability within gambling harm providers and recompenses service providers for the support they provide to research projects.
23. Maintain the current investment in research to address research gaps identified above.
24. Add additional bullet points to the list of criteria for research proposals that value:
 - a. The development of research capability within gambling harm service providers.
 - b. Longer-term, collaborative research programmes.
 - c. Allocate funding to ensure service provider participation in research is recompensed.

Levy

25. Adopt the 30/70 weighting for the levy.

26. Describe approach to addressing an online casino gambling levy.
27. Account for a likely increase in expenditure forecasts for TAB NZ.
28. Note the exclusion of online casino gambling in levy calculations.
29. Describe the plans or process for addressing an online casino gambling levy.
30. Review the projected player expenditure forecasts for TAB NZ, considering the impact of increased marketing and the launch of new online products.

Other submitter suggestions

Strategic plan

31. Ground the draft Strategy and the service plan in te Tiriti o Waitangi.
32. Direct resources to target gambling support services to communities with a high Māori population.
33. Introduce cashless gambling machines
 - a. Data shows that electronic gambling machines (NCGMs) are commonly used among gamblers with problem gambling behaviour. A solution proposed in Australia was to introduce a cashless system, so that people must buy credits to use in machines. This has the advantage of being able to enforce daily, monthly or yearly spending limits to reduce financial loss.
34. Include public health, health promotion, general addictions-focused, and gambling-specific journals in Needs Assessment search methodology.
35. Develop a workforce breakdown including workforce development underspend and clinical service provider engagement.
36. Recognise gambling disorder as a mental illness and broaden treatment options.
37. Include older people in priority populations.
38. Include disabled people in priority populations.
39. Establish specific, measurable targets and key performance indicators for each priority area.
40. Include work to develop population-level measures alongside obtaining prevalence data about gambling.
41. Reinstate investment in technology research and development.
42. Lower the age restrictions for whānau seeking harm reduction services (currently children aged 14 years and under cannot access services)
43. Add “accessible” to strategic outcome one to describe the services and supports.
44. Integrate the draft Strategy with other key policies including:
 - Kia Manawanui Aotearoa: the long-term pathway
 - Oranga Hinengaro System and Service Framework
 - Pae Ora Strategies.

45. Fund and develop effective knowledge translation plans for each research project, to maximise reach and effect of dissemination of research.
46. Emphasise growing social media aspects of gambling including considering it as a fifth sector.
47. Provide online safety guidance and regulations for caregivers and family and whānau, involve communities and schools in promotion and prevention, and regulate online channels.
48. Focus on harm prevention and minimisation in line with the findings of the 'Online Gambling Position Paper'.
49. Translations to be co-designed with individuals who have lived experience of gambling harm to ensure that language, tone, and terminology align with everyday speech that will resonate with the target audience.
50. Include gender identity and sexual orientation in data reporting.
51. Offer technology such as facial recognition technology to more venues and roll this out across the sector.
52. Allocate funding to develop and test additional technology-based tools.
53. Tax gambling business more than 20 percent on revenue.
54. Establish and fund a national steering group to work alongside the Gambling Harm Lived Experience Advisory Group.

Service plan

55. Player cards limiting the amount of time spent gambling be introduced as part of the self-exclusion system.
56. Chairs and other seating should be removed from NCGM venues to make the spaces less conducive to long periods of gambling.
57. Introduce gambling harm reduction programmes in prisons.
58. ATM withdrawal limits should be enforced more routinely.
59. Gambling venues should not be able to capitalise on cultural traditions and holidays.
60. Investment is required to better understand and address the needs of those gambling due to social isolation.
61. Guidelines for healthcare practitioners could be updated to enable better understanding of the connection between mental distress from gambling harm to other health conditions.
62. More robust training is required for gambling venue staff to better equip them to identify harmful gambling, interact with continuous gamblers, and support those experiencing mental distress to connect with gambling harm support.
63. More needs to be done to support the children of harmful gamblers.
64. Gambling addiction, or gambling disorder, should be officially recognised as a mental health condition.

65. Include functionality in the CLIC database that allows for key performance metrics such as wait time, client appraisal of the service received, and client outcome, to be recorded and published in an anonymised format.
66. Expand the CONCERN database to include online gambling and offer options for exclusion that are in plain language and easy to comprehend.
67. Enable an online multilingual MVE application process for land-based gambling and combine this with exclusion from online gambling.
68. Implement automated time limits on NCGMs (for example, a 20-minute pause in play every three hours).
69. Create a user account/access card to link with harm reduction initiatives (such as MVE or time restrictions).
70. Add research funds being made available in each of the three years including researcher-initiated projects.
71. Add an independent, academic evaluation of the draft Strategy including evaluating whether new and current programmes are making a difference.
72. Fund 24/7 crisis line that is staffed adequately at all times.
73. Establish outreach programmes as part of existing service provision into rural and remote communities.
74. Include minimum response times in contracts for provision of treatment.
75. Provide funding for sub-specialty training in addiction psychiatry to ensure service demand is met in context of ongoing psychiatry workforce shortages.
76. Fund marae-based tautoko – central hubs for additional high-intensity support.
77. Increase funding for workforce members with Pacific language capability.
78. Utilise the CONCERN database for the impending online self-exclusion register and do not build a new database.
79. Make CONCERN (or any other self-exclusion database) multi-lingual.
80. Develop a level four qualification and, or instead of, a level seven qualification.
81. Commission more detailed Aotearoa New Zealand-specific research in the most harmful area of gambling (that is, NCGM gambling).
82. Commission research into the impact of gambling harm on disabled people.
83. Commission a study to determine the cost-benefit analysis of gambling harm in Aotearoa New Zealand including a clear baseline to measure the impact of harm over time and clear definition of the costs to inform levies.
84. Distribute research funding more evenly across the three years of the draft Strategy.
85. Add academic scholarships for master's, doctoral, and post-doctoral level researchers to funding priorities as a cost-effective way to grow the workforce.
86. Increased analysis of gambling trends, especially those related to rangatahi and online gambling.
87. Remove the provision in the service plan for the ongoing development of the *Safer Gambling Test* – replace this with a provision for the central health promotion service to promote access to the revised *Gambling Harm Test* when it is available

88. Remove the provision in the service plan for the development of digital tools for financial literacy – reinvest the funding allocated into the development of financial capability expertise within service providers' clinical workforce
89. Include additional information with the rationale and plans for developing digital tools to promote harm minimisation messages, help-seeking, and site-blocking.
90. Fund effective blockers to be installed on devices (e.g. *Gamban*)
91. Geo-blocking of offshore online gambling websites.
92. Undertake more research to determine the gambling harm caused to older people.
93. Increase screening for gambling harm when working with older clients in health and social services.
94. Fund and distribute the following education and training programmes:
 - a. Nan's Song initiative
 - b. Let's kōrero
 - c. Hospitality New Zealand NZQA qualification for training of gambling operator staff.
95. An objective, balanced, evidence-based toolkit for territorial authorities should be developed to assist with gambling venue policy reviews. The toolkit should, however, be developed by an independent body, not the Ministry, given that the Ministry advocates for restrictive gambling venue policy settings during the policy reviews (the Ministry is conflicted). The toolkit should include an update of the November 2013 resource produced by KPMG that included an objective risk assessment scoring system.
96. When evaluating future tenders, a weighted attribute method should be used, with consideration given to whether the treatment provider has met their targets. Tenders should not simply be awarded to the existing incumbents and be focused solely on price.
97. The targets should be three-year targets (to align with the strategy period), with an assessment made every 12 months to determine whether sufficient progress is being made to achieve the target. The Association suggests that the following targets be put in place:
 - a. A 50% reduction in the relapse rate for persons who identify non-casino gaming machines as their primary gambling mode.
 - b. All persons who seek face-to-face counselling will have their first face-to-face session in the township nearest to them within 48 hours of the request being made.
 - c. 90% of persons who seek counselling via the helpline will have their call answered within 30 seconds.
 - d. At least 75% of the persons who seek counselling via the helpline, email, chat, or text services should be referred to a face-to-face counselling service and undertake face-to-face counselling.
 - e. A 20% reduction in the prevalence of harmful gambling among adults.

Levy and funding recommendations

98. 50/50 levy weighting (gambling industry submission) this weighting is appropriate given the wide definition of harm in the Act, the fact that presentations are not a sound proxy

for harm and presentation data can be subjective, the wide public health approach, and the fact that online gambling services funded by the levy, but online gambling providers are not levy payers.

Recommendations regarding overall strategic development and legislative processes

- 99. Undertake a comprehensive reform of the Gambling Act 2003 and Strategy development process, as per the request of the Gambling Commission.
- 100. Regulate offshore gambling sites and include these sites in the levy payment formula.

Appendix C: List of submitters

Sorted numerically

ID code ²³	Submission name
CS1	Individual
CS2	Individual
CS3	Individual
CS4	Kōrari Māori Public Health Ngā Kete Matauranga Pounamu Trust
CS5	Individual
CS6	Individual
CS7	Individual
CS8	Individual
CS9	Individual
CS10	Individual
CS11	Individual
CS12	ONE Foundation Limited
CS13	Individual
CS14	Aotearoa Gaming Trust
CS15	Te Kōhao Health
E1	Otaki RSA
E2	Individual
E3	Dunedin City Council
E4	Te Rangihaeata Oranga Trust
E5	Trust Aoraki Limited

²³ Key: CS = Citizen Space submission
E = email submission

ID code ²³	Submission name
E6	Torutek Limited
E7	Auckland University of Technology Gambling and Addictions Research Centre, and Auckland University of Technology Department of Psychology and Neuroscience
E8	Individual
E9	First Light Community Foundation
E10	Pub Charity Limited
E11	New Zealand Community Trust
E12	Te Kāhui Mokoroa
E13	New Zealand Drug Foundation
E14	Disabled Persons Assembly NZ Inc.
E15	Asian PMGH Lived Experience Group
E16	Asian Family Services
E17	New Zealand College of Public Health Medicine
E18	Age Concern New Zealand
E19	Te Hiringa Mahara, the Mental Health and Wellbeing Commission
E20	Trillian Trust
E21	Problem Gambling Foundation Group
E22	Lotto New Zealand
E23	The Salvation Army Te Ope Whakaora
E24	Whanganui District Council
E25	Class4Hub
E26	SkyCity Entertainment Group Limited
E27	Hospitality New Zealand
E28	TAB New Zealand

ID code ²³	Submission name
E29	Clubs New Zealand
E30	Christchurch Casino
E31	Petone Working Men's Club
E32	Air Rescue Services Limited
E33	The Royal New Zealand College of General Practitioners (RNZCGP)
E34	Entain Australia and New Zealand
E35	Netsafe
E36	Gaming Machine Association of New Zealand
E37	Next Payments NZ Limited
E38	ILT Foundation
E39	New Zealand Coalition of Catholic Social Services
E40	Te Pou
E41	The Lion Foundation
E42	Atamira Platform Trust
E43	Drug and Alcohol Practitioners' Association Aotearoa New Zealand (DAPAANZ)
E44	National Committee for Addiction Treatment
E45	Te Rūnanga O Ngāti Whātua
E46	Youthtown Incorporated
E47	Grassroots Trust
E48	The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
E49	Mapu Maia

Sorted alphabetically

ID code ²⁴	Submission name
E18	Age Concern New Zealand
E32	Air Rescue Services Limited
CS14	Aotearoa Gaming Trust
E16	Asian Family Services
E15	Asian PMGH Lived Experience Group
E42	Atamira Platform Trust
E7	Auckland University of Technology Gambling and Addictions Research Centre, and Auckland University of Technology Department of Psychology and Neuroscience
E30	Christchurch Casino
E25	Class4Hub
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E36	Gaming Machine Association of New Zealand
E47	Grassroots Trust
E27	Hospitality New Zealand
E38	ILT Foundation
CS1	Individual

²⁴ Key: CS = Citizen Space submission
E = email submission

ID code ²⁴	Submission name
CS2	Individual
CS3	Individual
CS5	Individual
CS6	Individual
CS7	Individual
CS8	Individual
CS9	Individual
CS10	Individual
CS11	Individual
CS13	Individual
E2	Individual
E8	Individual
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E49	Mapu Maia
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E39	New Zealand Coalition of Catholic Social Services
E17	New Zealand College of Public Health Medicine
E11	New Zealand Community Trust
E13	New Zealand Drug Foundation
E37	Next Payments NZ Limited
CS12	ONE Foundation Limited
E1	Otaki RSA

ID code ²⁴	Submission name
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E40	Te Pou
E4	Te Rangihaeata Oranga Trust
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E48	The Royal Australian and New Zealand College of Psychiatrists
E23	The Salvation Army Te Ope Whakaora
E6	Torutek Limited
E20	Trillian Trust
E5	Trust Aoraki Limited
E24	Whanganui District Council
E46	Youthtown Incorporated



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