Preventing and Minimising Gambling Harm

Strategic Plan 2004–2010

Needs Assessment

Proposed Three-year Funding Plan

Proposed Problem Gambling Levy Rates

Draft document for consultation

March 2004
Foreword

In recent years gambling-related harm has emerged worldwide as a significant social and health issue. In response Parliament passed the Gambling Act in 2003. The Act has one of its purposes to: ‘prevent and minimise the harm caused by gambling including problem gambling’. The Ministry of Health has been allocated responsibility for developing and implementing an integrated problem gambling strategy, which the Act states must include:

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

From 1 July 2004 the Ministry of Health will assume responsibility, from the Problem Gambling Committee, for funding and co-ordinating problem gambling services. These services will be funded through a levy on gambling operators.

Problem gambling is a new service area to the Ministry of Health, and in order to provide a well-planned and transparent approach, we have prepared several documents for consultation. The Gambling Act 2003 makes explicit the Ministry of Health’s consultation requirements for the development of services and activities for the prevention and minimisation of gambling harm. In line with these requirements, and in order to ensure our proposed approach reflects the needs, priorities and realities of New Zealanders, the Ministry is now seeking feedback on the following draft documents:

1. Strategic Plan for Preventing and Minimising Gambling Harm: 2004–2010
2. Needs Assessment
3. Proposed Three-year Funding Plan

These four documents have been bound together for the purposes of consultation and should be read as a set. Contributions are now invited and we urge you to have your say to ensure that we have a comprehensive approach to prevent and minimise gambling harm now and in the future.

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Deputy Director-General
Public Health

Janice Wilson
Deputy Director-General
Mental Health
How to Have Your Say

Your feedback is important, as it will help shape the final documents, so please take the time to make a submission. While the Ministry welcomes all feedback on the four parts of the document, the following broad questions may assist to focus submissions.

1. Do you agree with the Ministry of Health’s proposed strategic approach to preventing and minimising gambling harm?
2. Are there things that you particularly endorse about the approach?
3. Do you suggest any changes to the Ministry’s proposed approach?
4. Does the proposed funding plan target areas of service development that will make a significant contribution to the prevention and minimisation of gambling harm?

There are four different ways you can make a submission:

1. Write down your comments and post them to:
   Preventing and Minimising Gambling Harm Submissions
   Ministry of Health
   PO Box 5013
   Wellington.

2. Email your submission to:
   problemgambling@moh.govt.nz

3. Attend a consultation meeting where your comments will be recorded manually. The dates, times and locations of these are included with the covering letter to this draft document.

4. Write down your comments in the on-line submission form at:
   www.moh.govt.nz/problemgambling

The document is also available for downloading on the Ministry’s website at www.moh.govt.nz/problemgambling.

All submissions are due by Friday 30 April 2004.
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1. Introduction

This Draft Strategic Plan for Preventing and Minimising Gambling Harm: 2004–2010 provides a high-level framework to guide the development and implementation of an integrated approach to prevent and minimise gambling-related harm. The six-year strategy will help to identify funding priorities that cover the transition from the Problem Gambling Committee (PGC) to the Ministry of Health and initial responsibilities. Research and evaluation, contract monitoring and ongoing dialogue with the sector and wider community will provide a comprehensive information base from which to develop a longer-term strategy to prevent and minimise the harm caused by gambling.

The Gambling Act 2003 acknowledges that a whole-of-government approach is required to prevent and minimise gambling harm. The wide effects of gambling harm require several agencies to work collaboratively to contribute to a comprehensive approach, involving primary, secondary and tertiary prevention activities. Over time, and as knowledge of gambling-related issues in New Zealand increases, each agency will have its own discrete responsibilities as part of a whole-of-government approach. This Draft Strategic Plan for Preventing and Minimising Gambling Harm: 2004–2010 defines the Ministry of Health’s responsibilities and directions within such an approach.

Background

The gambling environment

The gambling environment has been evolving rapidly worldwide. In particular, there has been a significant growth in electronically delivered forms of gambling, such as Internet gambling and video gaming machines. New Zealand has not been immune to these global developments, and the last decade has been characterised by a growth in gambling opportunities and player expenditure. Expenditure on non-casino gaming machines rose from an estimated $597 million in the 2000/01 fiscal year to an estimated $941 million in 2002/03 (Department of Internal Affairs 2003).

Geographic mapping and analysis of the availability of gambling opportunities and problem gambling services show distinct patterns, particularly of where non-casino gaming machines are located (Wheeler 2003). In particular, it highlights their accessibility to populations in the most socioeconomically deprived areas (that is, areas of 8–10 in the 2001 New Zealand Deprivation Index (NZDep 2001). The maps paint a picture of availability of, and accessibility to gambling opportunities for at-risk populations. Such populations have been identified in the literature on addictive behaviours as potentially at higher risk of experiencing the effects of a range of social and health problems, including gambling-related harm. The 1999 National Prevalence Study
found that while household expenditure on gambling increases with household income, low-income groups spend proportionately more of their household income on gambling (Abbott and Volberg 2000).

Another significant issue in New Zealand is the community purposes funding derived from the profits of gambling. The non-casino gaming machine sector in particular provides a substantial amount of funding to community groups through community purposes funding, and many organisations rely on this funding source for their sustainability. This contribution to New Zealand communities is acknowledged by the Ministry of Health.

**Prevalence**

Data from the 1999 National Prevalence Survey suggest that at the time of the survey 0.8 percent of the adult population were problem gamblers and an additional 0.5 percent were pathological gamblers (Abbott and Volberg 2000). For various methodological reasons the survey’s authors consider these estimates ‘conservative’ or possibly ‘highly conservative’.

Some population groups have higher problem gambling prevalence rates than others. The 1999 survey reported high rates of problem gambling for Māori and Pacific respondents. This finding is reflected in practice, with Māori and Pacific peoples being over-represented in access-to-treatment data. The 1999 survey did not find high rates of problem gambling in the Asian population. Anecdotally, it is reported that there is an increasing problem among some sectors of the Asian population. This has not been supported by survey data to date. However, service access data from the 2002 Problem Gambling Committee (PGC) indicate there is an increase in the number of Asian clients accessing problem gambling intervention services.

**Demand**

Each year the total pool of people who access problem gambling services has continued to increase. The number of new clients seeking help from PGC-funded services in 2002 increased by 21 percent from the previous year. A total of 27,323 people in the New Zealand population have now been ‘counselling’ for a gambling problem over the past six years.

Approximately 75 percent of those who first received personal counselling help in 2002 sought help as a consequence of their gambling on gaming machines in pubs and clubs. This has been an increasing trend over the past six years and corresponds with a steady increase of non-casino gaming machines in New Zealand. While there are many variables that may influence this trend, overseas studies have also identified a potential correlation between the number of non-casino gaming machines and the rate of presentation at problem gambling services.

The group of Māori seeking help for problem gambling over the five years 1997–2002 has shown the largest increase. The PGC 2002 data show Māori making up over 25 percent of PGC new problem-gambling service clients (Paton-Simpson et al 2003).

The number of female gamblers accessing problem-gambling services has more than quadrupled since 1997 (an increase of 309.7 percent). It should also be noted however that this percentage was off a low base, and that by 2002 females made up a little less than half of new clients.
It is clear, however, that these statistics probably underestimate the problem. An increasing number of people are being identified with gambling problems, but are not presenting at specialist problem gambling treatment services. There are anecdotal reports that suggest that the number of people with a gambling problem and a co-existing substance misuse problem or a mental health disorder is increasing. There are also significant numbers of people in criminal justice settings being identified as having a gambling problem, but who are unlikely to access dedicated problem gambling services.

Population trends

Today Māori are significant participants in gambling activities, and are involved in the gaming industry as players, operators and recipients of the proceeds of gambling as well as consumers and providers of problem gambling services. Increasingly more Māori are experiencing a range of gambling-related harms.

The plan suggests mechanisms for Māori participation in gambling service development and delivery. While the overall goals to minimise gambling harm are as relevant to Māori as non-Māori, the specific strategies to realise these goals may be different. Gambling opportunity and community capacity will be different in each area.

New Zealand’s ethnic demography has changed significantly over the past decade. In particular, the Asian population in New Zealand increased dramatically over the 1990s, and is now slightly larger than the Pacific ethnic group. According to the 2001 Census, Pacific peoples in New Zealand numbered almost 231,801, making up 6.5 percent of the total population. Both Asian and Pacific peoples are affected by gambling harm, and service planning and provision need to change continually to reflect these changing demographics.

Gambling Act 2003

Following the 2001 Gaming Review, which was administered by the Department of Internal Affairs, the Responsible Gambling Bill was introduced to Parliament. The Gambling Act 2003 repeals the Gaming and Lotteries Act 1977 and Casino Control Act 1990 and amends the Racing Act 2003. The key purposes of the Gambling Act 2003 are to:

- control the growth of gambling
- prevent and minimise the harm caused by gambling including problem gambling
- authorise some gambling and prohibit the rest
- facilitate responsible gambling
- ensure the integrity and fairness of games
- limit opportunities for crime or dishonesty associated with gambling
- ensure that money from gambling benefits the community
- facilitate community involvement in decisions about the provision of problem gambling.
Under the Gambling Act 2003, the Department of Internal Affairs continues its roles as the primary regulator of the gambling sector and the key policy advice provider to Government on gambling regulatory issues. The Act set out a new role for the Ministry of Health in policy, programme development, and funding of services to prevent and minimise gambling harm, including advising Government on associated issues.

**Problem Gambling Committee (PGC)**

The PGC is a private charitable trust that was originally established (under a different name) in 1996. It subsequently applied for, and obtained, Government recognition. It is made up of equal numbers of industry and service provider representatives. The PGC has been responsible for funding and co-ordinating services for problem gamblers and their families over the past seven years.

To date, the PGC has focused on funding interventions to meet the needs of individuals and their families, such as counselling and helpline services. It has also funded some research and recently it has funded a small number of public health programmes. Several Māori-led services have been established around the country, as well as Asian services in Auckland and Christchurch, and Pacific services in Auckland and Hamilton.

The transfer of responsibility for problem gambling services from the PGC to the Ministry of Health will take place on 1 July 2004. Over the transition period the Ministry will continue to work closely with the PGC to ensure a smooth transition of services and initiatives.

**Prevention and harm minimisation**

The term ‘prevention’ is used in this document to encompass measures that protect the healthy development of community members, prevent or delay the onset of gambling harm, and minimise the harm associated with problem gambling.

Primary prevention (public health) activities aim to reduce the risks of and minimise gambling harm by enhancing community and individual capacity, thereby helping to prevent problems from developing. Secondary prevention activities limit harm in the early stages of problem development, while tertiary prevention activities treat the long-term effects of problem gambling. The overall objective of these activities is harm *minimisation*.

Harm minimisation encompasses:

- supply reduction strategies to limit the availability of gambling
- demand reduction strategies to limit the development of gambling harm
- problem limitation strategies to minimise gambling-related harm for individuals.

When gambling harm disproportionately affects certain populations, appropriate activities will be tailored within these domains to address the relevant risk or protective factors. The Draft Strategic Plan promotes approaches that can be utilised at different levels of the prevention continuum in a variety of settings and for a range of populations.
Supply reduction strategies

With the Ministry of Health, the Department of Internal Affairs has a key role in addressing problem gambling. It administers the Gambling Act, one key objective of which is to control the 2003 growth of gambling. It is also responsible for licensing and compliance, and it takes a lead role in developing harm minimisation regulations.

Although the Ministry of Health does not have direct responsibility for regulations and enforcement issues, its public health activities interweave with supply-side interventions through advocacy, increasing community awareness of risk and mobilising communities to have an informed voice that is heard through their territorial local authorities.

Demand reduction strategies

The Ministry of Health’s responsibilities will include a range of demand reduction strategies. Public health approaches will aim to reduce the demand for gambling in communities by raising public awareness about the risks of gambling and providing information for communities to make more informed choices about gambling. Community readiness, community development and community action approaches are critical components in reducing the demand for gambling opportunities. They contribute to strengthening a community’s capacity to care for itself and its members’ ability to make healthier choices about their lifestyles.

Problem limitation strategies

Problem limitation strategies span the continuum of prevention, from universal or population approaches to individual approaches for those personally affected by gambling harm. A range of services for problem gamblers and their families exist and will be developed further. These services include psychosocial interventions for problem gamblers and their families, a telephone helpline, and early and brief interventions in primary health care settings.

Strategic framework for the health and disability sector

The New Zealand Health Strategy and the New Zealand Disability Strategy together set the overarching guide for planning, developing and funding health and disability services in New Zealand.

Several more detailed strategies for services, health issues and population groups exist or are being developed, including the Primary Health Care Strategy, He Korowai Oranga (the Māori Health Strategy) and the Pacific Health and Disability Action Plan. These strategies provide detailed guidance for the health and disability sector, particularly DHBs (which are directly responsible for the health and participation of their local communities), about how to achieve the goals of the health and disability strategies.

Figure 1 shows the framework for the implementation of the Government’s health and disability goals.
2. The proposed approach

This Draft Strategic Plan outlines the way in which the Ministry of Health plans to address the continuum of gambling harm. It includes primary prevention and population approaches, through to more selected intervention services for individuals and their families and significant others. The strategy acknowledges that research is a critical component of any strategic approach, because it provides an evidence base from which to inform workforce and provider development, as well as policy, programme and service development at national and regional levels.

The plan provides a high level framework for preventing gambling harm. A needs assessment has been undertaken to inform a proposed funding plan that translates this high-level document into actions at local, regional and national levels. In this section the principles on which the Draft Strategic Plan is based are presented and discussed.

Goal

The goal of the Draft Strategic Plan is to assist Government, communities and families/whānau to work together to prevent the harm caused by problem gambling and to reduce gambling related inequalities.

Principles

Ten principles underpin the draft strategic plan.

1. Whole-of-government approach

Problem gambling is complex; its prevention and minimisation requires a multi-faceted approach. No single discipline, organisation or individual is solely responsible for preventing problem gambling. A range of people, communities and organisations should be actively encouraged to participate in problem gambling prevention initiatives and be empowered to act as part of a community-wide prevention network.
A whole-of-government approach requires several agencies to work collaboratively to achieve a comprehensive approach that addresses primary, secondary and tertiary prevention across multiple domains. Mobilising different levels of government to create a co-ordinated and comprehensive prevention strategy requires significant organisational and administrative effort. The widespread social, cultural and economic effects of gambling will see several agencies and sectors becoming more involved.

2. **Cultural relevance**

The design and delivery of prevention programmes must be able to meet the needs of people from diverse cultural backgrounds.

3. **Reducing health inequalities**

Reducing inequalities in health is a key objective of the New Zealand Health Strategy. Health inequalities are associated with socioeconomic disadvantage, so the Draft Strategic Plan will have a particular focus on gambling harm that affects those who are socioeconomically disadvantaged. Significant health inequalities exist among different groups in New Zealand, which can be seen in the distribution of the problem-gambling burden, where particular population groups are experiencing higher rates of harm than others in the population. Initiatives to prevent and minimise gambling harm will work to reduce these inequalities.

4. **Continuum of harm and intervention**

The Ministry plans to fund problem gambling services that cover the continuum of harm across the population. Figure 2 illustrates the possible spectrum of responses to gambling-related harm: the more severe the effects or harm, the more intensive the intervention needed. The availability of a range of intervention approaches that are appropriate at different points along this continuum is critical.

**Figure 2:** Gambling harm continuum of need and intervention
The area within the triangle represents the general population. The area at the apex represents that section of the population experiencing substantial gambling harm. It is important to note that movement along this continuum is not just one way and that at various points people exit and no longer require assistance from problem gambling intervention services.

5. Long-term approach

Initiatives to prevent and minimise problem gambling harm will require both long-term investment and long-term evaluation before any clear trends in harm reduction can be determined. They will also require a systematic and co-ordinated approach to ensure an effective and efficient use of resources.

6. Population health approach

The New Zealand Health Strategy set the platform for Government’s actions on health. It signalled a shift towards a population health framework that better recognises that populations are not homogeneous in their health status. A population health framework is a way of examining the differences in health status among and within populations. It is a useful framework for strengthening intersectoral arrangements and examining trends. In a New Zealand context this is particularly important in terms of meeting the health needs of at-risk groups.

7. Primary prevention: public health approach

A public health approach seeks to reduce risks and prevent gambling problems arising. Primary prevention interventions and programmes can contribute to strengthening a community’s capacity and readiness to advocate for healthy social, physical, spiritual and cultural environments. Activities include:
- promoting healthy public policy
- increasing community awareness and action
- strengthening strategic alliances, skills and knowledge
- monitoring and surveillance

The Draft Strategic Plan will promote a comprehensive public health approach that integrates a mix of interventions and services delivered at national, regional and local levels. These activities will involve collaboration between communities, gambling operators, territorial authorities and other agencies.

8. Secondary and tertiary prevention: intervention services

Problem gambling will not be managed with a single approach, but with a variety of different interventions and approaches directed at different populations. The aim of intervention services is to support those affected by a range of gambling problems to identify and manage those problems, thus limiting gambling-related harm to themselves and others.
The interventions for problem gambling are similar to those used with other addictive behaviours and include:

1. assessment, screening and early intervention approaches in primary health care settings
2. short-course interventions for people with mild to moderate problems
3. therapeutic interventions for people with moderate to severe problems.

The PGC purchases a range of intervention services for individuals and others affected by gambling, including a national telephone helpline and a network of counselling services. The Ministry of Health proposes to extend the availability and range of intervention approaches to address accessibility issues, as well as continuing and developing the current data collection systems.

9. Evidence-based approach

The Ministry of Health will build on existing research to guide problem gambling service and policy development. Although there is much to be learnt from overseas research on interventions in addictive behaviours and other health issues, there is a paucity of current research relating to the prevalence of gambling harm specifically and the effectiveness of interventions with New Zealand populations.

Given the effect of gambling on at risk communities, research will be a priority. Ongoing service monitoring and programme evaluation will form critical aspects of an evidence base.

10. Workforce development

As the public health approach develops further, there will need to be workforce initiatives to ensure providers have the capacity and capability to work with people and communities to minimise gambling harm.

The transition from the PGC to the Ministry of Health will require some realignment of current services to the new service specifications and an examination of new opportunities, such as those provided by Primary Health Organisations (PHOs) and the wider mental health sector. The Ministry is committed to supporting the transition by promoting workforce initiatives to support and develop services. This includes maximising opportunities for treatment service providers and existing public health providers to develop new skills and new environments.

3. Objectives and priorities for action

The objectives of the Draft Strategic Plan are to:

1. promote healthy public policies in relation to gambling harm
2. encourage supportive environments to minimise gambling harm
3. enhance the capacity of communities to define and address gambling harm
4. maintain and develop accessible, responsive and effective interventions
5. assist the development of people’s life skills and resilience in relation to preventing or minimising gambling harm
6. enhance workforce capacity
7. develop a programme of research and evaluation.

**Objective 1: Promote healthy public policies in relation to gambling harm**

A public health model seeks to influence the direction of policy at many levels eg; territorial authorities, community agencies, the workplace and gambling providers. The public health model will promote the adoption of policies and initiatives to minimise gambling harm across a range of sectors.

The Department of Internal Affairs is responsible for regulating and monitoring gambling activity. The Ministry of Health will work with the Department of Internal Affairs to investigate the potential for regulatory measures for a range of supply-, demand- and harm-reduction initiatives.

**Priorities for action**
1. Work with current stakeholders to develop public policy frameworks to address gambling-related harm.
2. Provide advice on gambling policies in related areas such as social services, justice, education, economic development and consumer protection.
3. Investigate and develop policy links with related health areas such as alcohol and other drugs, reducing inequalities and promoting mental health.
4. Develop and maintain mechanisms for involvement of at risk groups in developing, implementing and monitoring gambling-related policy and activities.

**Objective 2: Encourage supportive environments to minimise gambling harm**

Gambling opportunities are widespread, readily accessible and increasingly visible in public places and places frequented by families. Gambling via the Internet and over the telephone has brought new opportunities for gambling into the home and work environments. Ideally, such environments should support individuals to make healthy choices with their time, money and relationships. However, rapid changes have seen an increase in gambling opportunities outstrip individuals’ and communities’ abilities to prepare for such changes in familiar environments.

**Priorities for action**
1. Promote environments and gambling settings that minimise gambling harm or the risk of gambling harm.
2. Support gambling providers to encourage the public to adopt responsible gambling practices.
Promote and advise on programmes in gambling venues that assist gambling providers to be responsible hosts (ie, host responsibility programmes).

Promote protective factors and resiliency.

Support the development of programmes to raise awareness of gambling issues in at-risk communities.

**Objective 3: Enhance the capacity of communities to define and address gambling harm**

Community health promotion programmes are crucial to a well-informed public and to developing community capacity to take action on gambling harm. As an emerging health and social issue, communities are at different stages of readiness to address gambling harm. Some communities have begun developing frameworks for local action on gambling issues and developing processes for more comprehensive community input into decision-making at a local level. Other communities, where gambling has become normalised, are at different stages of awareness and readiness for change.

Community readiness, development and action will be important aspects of minimising harm in these communities. A four-step approach to developing community health promotion programmes is to:

1. assess community readiness for addressing gambling issues
2. increase the level of community awareness around gambling harm
3. increase the level of community development and/or community capacity to take action on gambling harm
4. increase the level of community action.

**Priorities for action**

- Develop and implement community readiness frameworks.
- Develop and implement community-based health promotion programmes.
- Develop a set of community indicators that assess, monitor and evaluate the impact of new gambling opportunities.
- Strengthen networks among agencies whose functions have links with minimising gambling harm.
- Work with whānau, hapū and other Māori communities to facilitate and manage the development and implementation of community-based problem gambling prevention programmes.
- Work with Pacific and Asian communities to develop community-based gambling health promotion programmes.
Objective 4: Maintain and develop accessible, responsive and effective interventions

For the problem gambler and their family/whānau, a range of intervention services is needed to minimise the harm. The interventions for problem gambling are similar to those used with other addictive behaviours, including assessment, screening and early intervention approaches in primary health care settings; short-course interventions for people with mild to moderate problems; and therapeutic interventions for people with moderate to severe problems.

Dedicated Māori problem gambling intervention services provide a range of accessible and effective options that reflect the needs of whānau, hapū and other Māori communities.

Dedicated Pacific and Asian services recognise that culture can be a vehicle for seeking and maintaining wellness. These services offer a holistically oriented framework for understanding people in their particular ethnic, social, cultural, spiritual, physical and economic contexts.

Priorities for action

1. Undertake a national assessment of intervention service needs, including mapping populations and programmes to establish gaps in coverage.
2. Contract for a range of primary, secondary and tertiary intervention services.
3. Develop culturally responsive problem gambling intervention services for Māori, Pacific and Asian peoples.

Objective 5: Assist the development of people’s life skills and resilience in relation to preventing or minimising gambling harm

This objective seeks to modify some of the risk factors that may predispose a person to experiencing gambling harm. The actions seek to enable people to gain the knowledge and skills to meet life’s challenges. Relevant life skills specific to gambling generally include: skills to deal with leisure time, budgeting, decision-making, financial pressure and relationship difficulties. Some of these factors are of particular importance for recent migrants.

Specific to gambling, a person’s sense of personal control is helped through their knowing how the game works and the odds of winning and losing, keeping track of time and losses in play, setting gambling limits and knowing how to limit credit card use.

Developments in health practice have highlighted the importance of cultural identity as an essential component of health care. A key aspect of this is building and maintaining cultural resilience in communities. The prioritised actions below are specific to gambling.

Priorities for action

1. Identify areas and populations in need to target with appropriate awareness-raising interventions or skill development, ie, young people.
2. Develop and implement life skills programmes, which include using leisure time; dealing with relationship or employment problems; coping with financial gains or losses; budgeting; and using credit.
Develop and implement programmes that provide information on the odds of winning and losing, gambling behaviour and how to respond to risky gambling situations, and the health and social risks associated with gambling.

Provide opportunities and resources for at-risk communities to develop and implement culturally relevant campaigns that provide information on the health and social risks associated with gambling.

Support the development of activities in communities that build cultural resilience by strengthening identity.

Objective 6: Enhance workforce capacity

Workforce development will be key to reorienting health, social and related services to assist them to address gambling harm. Collaboration among non-government organisations and health and social services already providing problem gambling services will also be integral.

This is a new area of activity for the public health workforce, so it will require training in gambling-specific issues. There may also be some reorientation required in areas where public health approaches have been integrated into intervention services. Community readiness assessment training will be an important aspect of this.

There is the opportunity in primary health care to provide an integrated package of service provision and to intervene at an earlier stage in the harm continuum, with screening and assessment for people with gambling problems and advice about healthier lifestyles. There is also an opportunity to weave gambling screening and brief assessment throughout these services. This will require workforce development in primary health care settings in screening and brief and early intervention.

Priorities for action

Promote opportunities to strengthen the skills in and knowledge of a range of health and social services to prevent and minimise gambling harm.

Reorient existing problem gambling and public health services to meet new service specifications.

Work with primary health care and other community service providers to include screening, brief assessment, and brief and early intervention as part of general health screening.

Work with Māori service providers to establish the most effective ways to introduce gambling harm-minimisation strategies throughout their services.

Identify and develop Pacific and Asian provider and workforce capacity to address gambling harm.

Objective 7: Develop a programme of research and evaluation

There is limited current data available about the causes and prevalence of gambling-related harm. There is also little evidence about the outcomes and efficacy of interventions. There is an urgent need to build a stronger evidence base on which to plan approaches to prevent gambling-related harm.
A research and evaluation agenda will be developed to support ongoing service and policy provision. This will include a range of research, evaluation and monitoring projects, including data collection and analysis (eg, using client-service data); longitudinal information-gathering systems; programme evaluations; social, economic and cultural impact studies of gambling growth and developments in gambling products; population surveys; population needs assessments; analyses of service utilisation; and the problem gambling geography project. The development of research methodology, evaluation techniques and performance indicators for service providers will form an important aspect of this plan.

Designing research in conjunction with population groups experiencing significant harm from gambling will be explicit in the research agenda. Research and evaluation are necessary when considering health outcomes, and there is a need for rigorous research on all aspects of gambling-related harm and behaviour in high-risk groups in order to advance gains and reduce gambling harm.

**Priorities for action**

- Carry out population surveys on gambling prevalence, participation, attitudes and behaviours.
- Evaluate the effectiveness of current programmes and interventions to prevent and minimise gambling harm.
- Maintain and enhance monitoring and surveillance systems, information systems and databases.
- Develop Māori, Pacific and Asian peoples’ capacity for greater involvement in research and evaluation.
### Glossary of key terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tr>
<td>Integrated approach to problem gambling</td>
<td>This integrated approach encompasses those public health measures designed to prevent gambling harm, alongside intervention services designed to minimise the harm experienced by people with gambling problems.</td>
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<tr>
<td>(Gambling) harm</td>
<td>The Gambling Act 2003 defines harm as ‘harm or distress of any kind arising from, or exacerbated by, a person’s gambling; and includes personal, social, or economic harm suffered by the person; or the person’s spouse/partner, family/whānau, or wider community; or in the workplace; or by society at large’.</td>
</tr>
<tr>
<td>Harm-minimisation approach</td>
<td>An approach that works to reduce the adverse health, social and economic consequences of gambling for the community and the individual. Education, awareness raising and intervention services play key roles in a harm-minimisation approach.</td>
</tr>
<tr>
<td>Problem gambling</td>
<td>Patterns of gambling behaviour that compromise, disrupt or damage health, personal, family or vocational pursuits.</td>
</tr>
<tr>
<td>Population health approach</td>
<td>An approach that focuses on the population as a whole, but also maintains a focus on smaller groups within the population, particularly higher-risk groups. Such an approach allows the problem to be tackled at national and subnational levels.</td>
</tr>
<tr>
<td>Primary prevention</td>
<td>Activities that prevent problems happening by enhancing community and individual capacity.</td>
</tr>
<tr>
<td>Secondary prevention</td>
<td>Activities that limit harm in the early stages of problem development.</td>
</tr>
<tr>
<td>Tertiary prevention</td>
<td>Activities that treat the long-term effects of gambling harm.</td>
</tr>
</tbody>
</table>

### References


Part 2: Problem Gambling Needs Assessment: Towards the Ministry of Health’s Funding Plan for Preventing and Minimising Problem Gambling Harm

1. Introduction

This needs assessment brings together a range of different information in order to paint a picture of problem gambling need, in terms of population needs and service coverage gaps.

The prevalence and incidence data combined with demand for treatment data highlight several population groups that experience harm from problem gambling disproportionately. Māori are significant in this respect, across several geographic areas and in the three highest areas of deprivation (areas 8–10 in NZDep 2001). Pacific peoples also experience harm disproportionately. There is growing concern about the impact of gambling in the Asian community. The needs assessment also highlights the prevalence of problem gambling harm within the prison population. Areas of high deprivation where gambling opportunities are disproportionately placed will require particular attention.

Current service coverage has gone some way towards meeting need, but the trends of increased demand for services and increased availability of gambling opportunities will require growth in secondary prevention approaches through a range of intervention services, and public health action to raise the awareness of the general population to the potential of gambling harm. Activities will need to be targeted to those populations and geographic areas identified as experiencing significantly more harm than the general population.

Details of the proposed problem gambling prevention activities to be funded by the Ministry of Health are in the proposed three-year funding plan in part three of this document. The proposed funding distribution has been directly informed by this needs assessment.

Background

The Gambling Act 2003 requires the Ministry of Health to undertake a comprehensive needs assessment of problem gambling to inform the development of a proposed three-year funding plan for problem gambling services and activities. This Problem Gambling Needs Assessment should be read in conjunction with the Draft Strategic Plan for Preventing and Minimising Gambling Harm: 2004–2010 which outlines strategic directions and priorities for action over the next three years.
The needs assessment outlines the state of problem gambling in New Zealand by bringing together a range of different information, including:

- a review of prevalence, incidence and demand
- a review of current services and programmes
- identification of at-risk populations

The needs assessment gathers information across the continuum of harm, from primary through to secondary and tertiary prevention. In doing so it highlights the gaps between service provision, the goal and directions outlined in the strategic plan, and the needs of the population. The needs assessment has informed the development of part three of this document, Health Services to Prevent and Minimise Gambling Harm: Proposed Three-Year Funding Plan, 2004/05–2006/07, for both public health programmes and intervention (treatment) services. It aims to inform funding decisions in order to produce an equitable distribution of health services, health gain, and better outcomes for the population.

**Limitations**

Due to time constraints, this needs assessment has relied on available data and literature. However, there is limited data on the cost-effectiveness of problem gambling services in both the intervention and public health areas. When possible, this assessment has utilised available cost-effectiveness studies in the fields of addictive behaviours and similar public health programmes to provide a range of options for comprehensive prevention approaches.

**Problem gambling harm and the prevention continuum**

The term ‘problem gambling’ covers degrees of involvement or harm. It allows for the level of harm for any individual, community or population to be both individually and socially referenced. Problem gamblers have been recognised as having many characteristics and behaviours in common with other addictive behaviours (particularly substance misuse), and in its most severe forms problem gambling is acknowledged as a psychiatric disorder (American Psychiatric Association 1994).

In the international literature problem gamblers (including pathological gamblers) have been found to have a heightened risk of experiencing relationship difficulties including separation and divorce, a range of physical and psychological problems, job loss, bankruptcy and bad debts, and even imprisonment (Gerstein et al 1999). These problems have also been reported in the New Zealand literature and from anecdotal evidence provided by people working with problem gamblers.

Along with the harm to the individual gambler, problem gambling has resulted in economic and social costs to families and communities. The Australian Productivity Commission has estimated that on average each serious problem gambler will adversely affect the lives of seven other people through, for example, family break-ups, workplace problems or contact with the criminal justice system.
Defining the concept of prevention is important as it signals the philosophy and range of activities to be adopted by the Ministry of Health and the wider health and social service sector. Prevention is broadly understood to encompass measures that protect the healthy development of community members, delay the onset of gambling harm, and minimise problem gambling-related harm through a range of interventions.

2. Determinants of problem gambling

Blaszczynski and Nower (2002) have proposed an integrated framework for understanding problem gambling, which includes environmental, social and personal factors that may influence the incidence of problem gambling. This framework attempts to make sense of the factors that contribute to the predisposition to and precipitation and maintenance of problem gambling. It also describes the risk factors that lead to the behaviours.

The framework is useful for broadly categorising and considering factors relating to the incidence of problem gambling. Social factors include socioeconomic status (eg, as defined by NZDep 2001), cultural factors, education, social modelling and the influence of peers. Environmental factors include the availability and accessibility of gambling activities and the promotion of gambling (social marketing). Personal factors include personality traits, motivations and neurotransmitter systems. In this section the social and environmental factors are focused on, in line with the emphasis of the strategic plan.

Social factors

Gender

The 1999 National Prevalence Survey (Abbott and Volberg 2000) showed that both men and women are affected by gambling harm. Significantly, however, the number of female gamblers receiving assistance from problem gambling treatment services quadrupled between 1997 and 2002 (Paton-Simpson et al 2003).

Socioeconomic status

Literature from Australia suggests that employment status, educational level and income level affect the risk of problem gambling (Breen et al 2002). Abbott and Volberg (2000) found that low-income groups spend proportionally more of their household incomes on gambling and that gambling harm disproportionately affects low-income New Zealanders, with Māori and Pacific peoples over-represented in this group.
Ethnicity

Throughout the world, indigenous populations have been reported as having higher prevalence rates of problem gambling than non-indigenous populations (Abbott and Volberg 2000; Productivity Commission 1999; Wardman et al 2001). In New Zealand, Māori, Pacific and Asian peoples are at greater risk of problem gambling than other groups. In the 1999 National Prevalence Survey (Abbott and Volberg 2000) it was estimated that 31 percent of current probable pathological and problem gamblers were Māori and 14 percent Pacific peoples. The proportions of Māori and Pacific peoples in the general population at the time of the survey were 12 percent and 4 percent respectively.

The findings from the national survey are consistent with the presentation data from problem gambling services, where there is also high utilisation by Māori and Pacific peoples (Paton-Simpson et al 2003). Increasing numbers of Asian people are accessing problem gambling services.

Environmental factors

Environmental risk factors for problem gambling include the availability and accessibility of gambling opportunity, socioeconomic deprivation and the marketing of gambling. Integrating the geography of risk factors helps to identify regions and communities that may be affected disproportionately by problem gambling.

The data and analysis of the availability of gambling opportunities and problem gambling services are drawn from *Problem Gambling Geography of New Zealand* (Wheeler 2003). The data sets include ethnicity (specifically Māori and Pacific peoples), general deprivation (NZDep 2001), gambling opportunity (non-casino gaming machine locations and numbers), and use of problem gambling services. However, there are no data sets available about the marketing of gambling opportunities.

Availability of gambling opportunities

The opportunity to gamble is an important risk factor for problem gambling. Both the participation in gambling and the likelihood of problem gambling increase significantly when gambling opportunities increase (Dickson et al 2002; Korn and Shaffer 1999; Lester 1994; Volberg 1994).

Many forms of gambling exist in New Zealand, including track betting, casinos, Lotto and non-casino gaming machines (NCGMs). There are six casinos in New Zealand (in Auckland, Hamilton, Christchurch, Dunedin and Queenstown). There is also increasing availability of Internet gambling and interactive betting. Significantly, the type of gambling appears to be an important risk factor for the development of problem gambling (Breen and Zimmerman 2002). Those gambling forms that allow for continuous play and short time spans between staking and outcome (eg, NCGMs and ‘scratchies’) are particularly likely to lead to excess. The majority of people presenting for assistance or treatment for problem gambling in New Zealand have problems with NCGMs (Paton-Simpson et al 2003).
Non-casino gaming machines

Problem gambling is particularly associated with continuous types of gambling, where winnings can be quickly reinvested (Abbott and Volberg 2000). NCGMs (‘pokies’) are a significant form of continuous gambling. They were the problem source for 74.8 percent of all new personal counselling clients who accessed problem gambling services in 2002. Therefore, it is worth taking a detailed look at the number of and increase in NCGMs in relation to other social and environmental factors.

In 2003 there were 22,417 licensed NCGMs in use in New Zealand, an increase of around 11 percent from the previous year. Figure 3 shows the general increase in gaming machines since 1994.

Figure 3: Gaming machine numbers, three-monthly intervals, June 1994–June 2003

Since the enactment of the Gambling Act 2003 the Department of Internal Affairs reports a reduction in NCGMs over the past six months.

NCGMs and deprivation

One of the key risk factors for problem gambling is socioeconomic deprivation, as measured by the deprivation index NZDep 2001 (Wheeler 2003). In New Zealand, NCGMs are not distributed evenly around the country; they are more likely to be found in more deprived areas. Figure 4 presents the number of NCGMs by deprivation decile. Around 53 percent of all NCGMs are in census area units (CAUs) in deciles 8, 9 and 10, the most deprived 30 percent of CAUs in New Zealand.
Deprivation is highly correlated with ethnicity, with Māori and Pacific peoples tending to be concentrated in the more deprived areas. About 56 percent of Māori and 72 percent of Pacific peoples live in the most deprived 30 percent of CAUs (deciles 8, 9 and 10). This high correlation is reflected in problem gambling helpline phone calls, which have an over-representation of Māori and Pacific peoples (Paton-Simpson et al 2003). Table 1 presents the deprivation deciles along with the number of gaming machines and the proportions of ethnic groups.

### Table 1: Non-casino gaming machines and population/ethnicity by NZDep 2001 decile

<table>
<thead>
<tr>
<th>NZDep 2001 decile</th>
<th>Non-casino gaming machines</th>
<th>Population/ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NCGM sites (%)</td>
<td>Total NCGMs (%)</td>
</tr>
<tr>
<td>(Least deprived)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>81 (3.8)</td>
<td>707 (3.2)</td>
</tr>
<tr>
<td>2</td>
<td>96 (4.5)</td>
<td>766 (3.4)</td>
</tr>
<tr>
<td>3</td>
<td>134 (6.3)</td>
<td>1213 (5.4)</td>
</tr>
<tr>
<td>4</td>
<td>146 (6.9)</td>
<td>1284 (5.7)</td>
</tr>
<tr>
<td>5</td>
<td>201 (9.5)</td>
<td>2036 (9.1)</td>
</tr>
<tr>
<td>6</td>
<td>245 (11.6)</td>
<td>2333 (10.4)</td>
</tr>
<tr>
<td>7</td>
<td>220 (10.4)</td>
<td>2224 (9.9)</td>
</tr>
<tr>
<td>8</td>
<td>317 (14.9)</td>
<td>3525 (15.7)</td>
</tr>
<tr>
<td>9</td>
<td>454 (21.4)</td>
<td>5479 (24.4)</td>
</tr>
<tr>
<td>(Most deprived)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>226 (10.7)</td>
<td>2848 (12.7)</td>
</tr>
</tbody>
</table>

Source: Data in the table is summarised from census area unit data.
Figure 5 presents the number of NCGMs per 10,000 population for DHBs. The number of NCGMs per person is relatively similar across DHBs, with most reporting an increase in the machine density in the 2002/03 fiscal year. However, there are significantly higher machine densities in the West Coast and Lakes DHBs, and large increases in machine density in the Lakes and Northland DHBs for the 2002/03 fiscal year.

There are 85 problem gambling services and 110 alcohol and other drug (AOD) treatment service sites in New Zealand. In areas of no or intermittent problem gambling counselling services, AOD addiction services have been used to fill service gaps. Table 2 presents the number of gaming machines, problem gambling service providers and AOD treatment service sites by DHB.
Table 2: Non-casino gaming machines and service providers by District Health Board

<table>
<thead>
<tr>
<th>DHB</th>
<th>Total population 2001</th>
<th>NCGM sites 2003</th>
<th>NCGMs 2003</th>
<th>AOD sites*</th>
<th>PGS sites**</th>
<th>NCGMs 2002</th>
<th>% change in machine numbers 2002 to 2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northland</td>
<td>140,121</td>
<td>92</td>
<td>939</td>
<td>7</td>
<td>7</td>
<td>776</td>
<td>+21.0</td>
</tr>
<tr>
<td>Waitemata</td>
<td>429,975</td>
<td>131</td>
<td>1,585</td>
<td>3</td>
<td>6</td>
<td>1,436</td>
<td>+10.4</td>
</tr>
<tr>
<td>Auckland</td>
<td>367,767</td>
<td>174</td>
<td>2,070</td>
<td>8</td>
<td>5</td>
<td>1,859</td>
<td>+11.4</td>
</tr>
<tr>
<td>Counties Manukau</td>
<td>375,561</td>
<td>126</td>
<td>1,682</td>
<td>4</td>
<td>11</td>
<td>1,551</td>
<td>+8.4</td>
</tr>
<tr>
<td>Waikato</td>
<td>317,763</td>
<td>190</td>
<td>2,068</td>
<td>10</td>
<td>10</td>
<td>1,871</td>
<td>+10.5</td>
</tr>
<tr>
<td>Lakes</td>
<td>95,997</td>
<td>64</td>
<td>800</td>
<td>2</td>
<td>2</td>
<td>611</td>
<td>+30.9</td>
</tr>
<tr>
<td>Bay of Plenty</td>
<td>178,179</td>
<td>103</td>
<td>1,218</td>
<td>6</td>
<td>1</td>
<td>1,037</td>
<td>+17.5</td>
</tr>
<tr>
<td>Tairawhiti</td>
<td>43,968</td>
<td>22</td>
<td>252</td>
<td>2</td>
<td>4</td>
<td>241</td>
<td>+4.6</td>
</tr>
<tr>
<td>Taranaki</td>
<td>103,041</td>
<td>82</td>
<td>740</td>
<td>8</td>
<td>4</td>
<td>640</td>
<td>+15.6</td>
</tr>
<tr>
<td>Hawke’s Bay</td>
<td>143,544</td>
<td>91</td>
<td>1,039</td>
<td>2</td>
<td>4</td>
<td>933</td>
<td>+11.4</td>
</tr>
<tr>
<td>Whanganui</td>
<td>63,594</td>
<td>49</td>
<td>486</td>
<td>1</td>
<td>1</td>
<td>425</td>
<td>+14.4</td>
</tr>
<tr>
<td>MidCentral</td>
<td>154,986</td>
<td>99</td>
<td>993</td>
<td>4</td>
<td>3</td>
<td>904</td>
<td>+9.8</td>
</tr>
<tr>
<td>Hutt</td>
<td>131,841</td>
<td>63</td>
<td>830</td>
<td>4</td>
<td>3</td>
<td>714</td>
<td>+16.2</td>
</tr>
<tr>
<td>Capital and Coast</td>
<td>245,937</td>
<td>119</td>
<td>1,430</td>
<td>9</td>
<td>5</td>
<td>1,443</td>
<td>-0.9</td>
</tr>
<tr>
<td>Wairarapa</td>
<td>38,211</td>
<td>26</td>
<td>221</td>
<td>1</td>
<td>0</td>
<td>224</td>
<td>-1.3</td>
</tr>
<tr>
<td>Nelson-Marlborough</td>
<td>122,487</td>
<td>76</td>
<td>733</td>
<td>6</td>
<td>2</td>
<td>703</td>
<td>+4.3</td>
</tr>
<tr>
<td>West Coast</td>
<td>30,297</td>
<td>54</td>
<td>402</td>
<td>3</td>
<td>3</td>
<td>375</td>
<td>+7.2</td>
</tr>
<tr>
<td>Canterbury</td>
<td>427,107</td>
<td>262</td>
<td>2,761</td>
<td>16</td>
<td>4</td>
<td>2,507</td>
<td>+10.1</td>
</tr>
<tr>
<td>South Canterbury</td>
<td>52,782</td>
<td>45</td>
<td>402</td>
<td>3</td>
<td>3</td>
<td>375</td>
<td>+7.2</td>
</tr>
<tr>
<td>Otago</td>
<td>170,739</td>
<td>145</td>
<td>1,170</td>
<td>6</td>
<td>3</td>
<td>955</td>
<td>+22.5</td>
</tr>
<tr>
<td>Southland</td>
<td>103,365</td>
<td>91</td>
<td>675</td>
<td>4</td>
<td>4</td>
<td>630</td>
<td>+7.1</td>
</tr>
<tr>
<td>Total New Zealand</td>
<td>3,737,262</td>
<td>2,121</td>
<td>22,417</td>
<td>110</td>
<td>85</td>
<td>20,138</td>
<td>+11.3</td>
</tr>
</tbody>
</table>

* Alcohol and other drug treatment service sites.
** Problem gambling service sites.

Of particular note is the Wairarapa DHB, which has no problem gambling counselling services. Other DHBs have limited problem gambling services relative to their population, the number of NCGMs available and their geographical size. It is important to note that DHBs often cover large geographical areas, so these summaries often hide problem areas within DHBs.

**NCGMs by urban/rural centre**

Urban/rural centres are the main focus for defining possible gaps in service provision. There are 271 such areas, ranging from small rural towns to large urban zones, and from populations of around 200 (Ohura, Ruapehu District) to around 360,000 (Central Auckland). It is likely that new services would be located in these identified population centres rather than in isolated rural areas.

To prioritise the areas that could be most in need of problem gambling public health programmes and/or intervention services, the following criteria were used:
- high level of deprivation
- easy access to NCGMs
- no contracted problem gambling service within boundary.
Of the 271 urban/rural centre areas, 216 have no problem gambling service access point within the boundary as defined by Statistics New Zealand. Of these 216 areas, 161 have at least one NCGM and 69 contain at least one deprived CAU (in decile 8, 9 or 10). The top 20 of these 69 areas are listed in Table 3 in order of descending total population living in deprived CAUs.

Table 3: Urban/rural centres with no problem gambling intervention service access point and at least one non-casino gaming machine

<table>
<thead>
<tr>
<th>Urban/rural centre</th>
<th>Pop. 2001</th>
<th>Pop. in deprived CAUs</th>
<th>NCGM sites</th>
<th>NCGMs</th>
<th>NCGMs per 10,000 pop.</th>
<th>AOD sites</th>
<th>% Māori</th>
<th>% Pacific</th>
<th>% Asian</th>
<th>% NCGMs in deprived CAUs*</th>
<th>% pop. in deprived CAUs*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whakatane</td>
<td>17,778</td>
<td>10,467</td>
<td>11</td>
<td>135</td>
<td>75.9</td>
<td>1</td>
<td>32.1</td>
<td>1.0</td>
<td>1.4</td>
<td>88.1</td>
<td>58.9</td>
</tr>
<tr>
<td>Waiheke Island</td>
<td>7,137</td>
<td>7,137</td>
<td>5</td>
<td>41</td>
<td>57.4</td>
<td>1</td>
<td>11.1</td>
<td>2.2</td>
<td>1.7</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Kawerau</td>
<td>6,975</td>
<td>6,975</td>
<td>5</td>
<td>73</td>
<td>104.7</td>
<td>0</td>
<td>56.1</td>
<td>1.8</td>
<td>0.9</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Te Puke community</td>
<td>6,774</td>
<td>6,774</td>
<td>7</td>
<td>87</td>
<td>128.4</td>
<td>1</td>
<td>23.2</td>
<td>1.9</td>
<td>3.1</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Feilding</td>
<td>13,638</td>
<td>6,432</td>
<td>8</td>
<td>91</td>
<td>66.7</td>
<td>0</td>
<td>14.9</td>
<td>1.0</td>
<td>1.2</td>
<td>0.0</td>
<td>47.2</td>
</tr>
<tr>
<td>Taumarunui</td>
<td>5,136</td>
<td>5,136</td>
<td>5</td>
<td>61</td>
<td>118.8</td>
<td>1</td>
<td>44.5</td>
<td>0.9</td>
<td>1.8</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Te Awamutu zone</td>
<td>13,446</td>
<td>5,127</td>
<td>9</td>
<td>129</td>
<td>95.9</td>
<td>0</td>
<td>21.2</td>
<td>0.7</td>
<td>1.2</td>
<td>44.2</td>
<td>38.1</td>
</tr>
<tr>
<td>Marton</td>
<td>4,749</td>
<td>4,749</td>
<td>6</td>
<td>47</td>
<td>99.0</td>
<td>0</td>
<td>23.3</td>
<td>1.0</td>
<td>0.8</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Foxton community</td>
<td>4,620</td>
<td>4,620</td>
<td>5</td>
<td>46</td>
<td>99.6</td>
<td>0</td>
<td>24.2</td>
<td>1.0</td>
<td>1.1</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Waihi</td>
<td>4,524</td>
<td>4,524</td>
<td>6</td>
<td>83</td>
<td>183.5</td>
<td>0</td>
<td>17.6</td>
<td>1.3</td>
<td>1.9</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Masterton</td>
<td>19,500</td>
<td>4,443</td>
<td>9</td>
<td>132</td>
<td>67.7</td>
<td>1</td>
<td>17.3</td>
<td>2.1</td>
<td>1.4</td>
<td>93.2</td>
<td>22.8</td>
</tr>
<tr>
<td>Te Kuiti</td>
<td>4,377</td>
<td>4,377</td>
<td>5</td>
<td>67</td>
<td>153.1</td>
<td>1</td>
<td>44.8</td>
<td>1.2</td>
<td>1.5</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Opotiki</td>
<td>3,999</td>
<td>3,999</td>
<td>6</td>
<td>49</td>
<td>122.5</td>
<td>1</td>
<td>58.7</td>
<td>1.5</td>
<td>0.9</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Whangamata</td>
<td>3,861</td>
<td>3,861</td>
<td>7</td>
<td>80</td>
<td>207.2</td>
<td>0</td>
<td>13.7</td>
<td>0.7</td>
<td>0.8</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Turangi</td>
<td>3,441</td>
<td>3,441</td>
<td>3</td>
<td>47</td>
<td>136.6</td>
<td>0</td>
<td>57.5</td>
<td>1.1</td>
<td>1.2</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Dannevirke</td>
<td>5,349</td>
<td>3,159</td>
<td>8</td>
<td>75</td>
<td>140.2</td>
<td>2</td>
<td>23.8</td>
<td>1.1</td>
<td>1.4</td>
<td>76.0</td>
<td>59.1</td>
</tr>
<tr>
<td>Katikati community</td>
<td>4,916</td>
<td>2,915</td>
<td>3</td>
<td>39</td>
<td>133.7</td>
<td>0</td>
<td>12.4</td>
<td>2.1</td>
<td>3.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Waimate</td>
<td>2,757</td>
<td>2,757</td>
<td>6</td>
<td>30</td>
<td>108.8</td>
<td>1</td>
<td>4.7</td>
<td>0.3</td>
<td>0.5</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Raglan</td>
<td>2,667</td>
<td>2,667</td>
<td>2</td>
<td>36</td>
<td>135.0</td>
<td>0</td>
<td>28.8</td>
<td>1.1</td>
<td>0.7</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Otorohanga</td>
<td>2,628</td>
<td>2,628</td>
<td>4</td>
<td>43</td>
<td>163.6</td>
<td>0</td>
<td>36.2</td>
<td>0.9</td>
<td>1.7</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* The top 20 in terms of total population living in deprived CAUs are listed. Note that CAUs in NZDep 2001 deciles 8, 9 or 10 are counted as deprived.

Key geographical areas of note include Whakatane, Masterton, Kawerau and Feilding, which have high access to non-casino gaming machines, significant proportions of their populations in deprived CAUs, and no problem gambling service problem gambling services. However, these figures need to be viewed in context; for example, the proximity of Whakatane and Kawerau might suggest a single service could serve this general area.

This selection and ranking process is based on subjective criteria and may result in locations being excluded that should be of interest or concern. For more detail at the geographical level of territorial local authorities and urban/rural centres, see Appendix A in Wheeler (2003).
3. Gambling prevalence and incidence

Information in this section is from the 1999 New Zealand Gaming Survey (NZGS) (Abbott and Volberg 2000; Abbott et al 2000; Abbott and McKenna 2000; Abbott 2001), unless otherwise specified.

Many New Zealanders have participated in gambling in one form or another. According to the 1999 NZGS, 94 percent of people aged 18 years and over had participated in one type of gaming activity in their lifetime. This represents the lifetime gambling participation rate. Slightly less (86 percent) had participated in one or more activities in the previous six months before the survey, which represents the current gambling participation rate. Two-fifths (41 percent) reported gambling once a week or more. Table 4 shows gambling rates by sex, age and ethnic group. Non-gamblers, as reported in Table 4, are defined as those who have never gambled or who have gambled but not in the six months before the survey.

People aged 65 years or older were the most likely age group not to have gambled at all or in the six months before the survey (20 percent). Asian and Pacific peoples were the most likely ethnic groups not to have gambled at all or in the last six months before the survey (34 percent and 20 percent respectively). However, the Pacific rate should be treated with caution due to high sampling errors.

People who gamble once a week or more can be classified into two groups: regular non-continuous gamblers and regular continuous gamblers. Regular non-continuous gamblers participate once a week, or more, only in activities like Lotto, where winnings cannot be reinvested immediately following a win. Regular continuous gamblers participate once a week or more in activities that allow winnings to be reinvested shortly after a win, such as gaming machines and horse or dog races. This distinction is important, as participation in continuous activities is more strongly associated with problem gambling.

Table 4: Gambling status by sex, age and ethnicity

<table>
<thead>
<tr>
<th>Selected characteristics</th>
<th>% non-gamblers</th>
<th>% past six months gamblers</th>
<th>% regular non-continuous gamblers</th>
<th>% regular continuous gamblers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>13.1</td>
<td>43.7</td>
<td>31.0</td>
<td>12.1</td>
</tr>
<tr>
<td>Female</td>
<td>14.4</td>
<td>47.1</td>
<td>29.6</td>
<td>9.0</td>
</tr>
<tr>
<td>Age group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24</td>
<td>13.2</td>
<td>61.2</td>
<td>13.9</td>
<td>11.7</td>
</tr>
<tr>
<td>25-34</td>
<td>11.5</td>
<td>50.3</td>
<td>28.2</td>
<td>10.1</td>
</tr>
<tr>
<td>35-44</td>
<td>12.1</td>
<td>48.0</td>
<td>30.8</td>
<td>9.1</td>
</tr>
<tr>
<td>45-54</td>
<td>13.1</td>
<td>36.7</td>
<td>39.0</td>
<td>11.3</td>
</tr>
<tr>
<td>55-64</td>
<td>14.5</td>
<td>36.2</td>
<td>36.3</td>
<td>13.0</td>
</tr>
<tr>
<td>65 plus</td>
<td>19.8</td>
<td>38.6</td>
<td>32.3</td>
<td>9.3</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>European</td>
<td>13.0</td>
<td>46.1</td>
<td>30.2</td>
<td>10.7</td>
</tr>
<tr>
<td>New Zealand Māori</td>
<td>9.6*</td>
<td>42.8</td>
<td>35.2</td>
<td>12.4</td>
</tr>
<tr>
<td>Pacific peoples</td>
<td>19.5*</td>
<td>44.8</td>
<td>26.5*</td>
<td>9.2</td>
</tr>
</tbody>
</table>
Males, people aged 45-54 and Māori had relatively high representation among regular non-continuous gamblers. There was similar representation among regular continuous gamblers, except that 55-64-year-old people were the most likely age group to be regular continuous gamblers.

**Problem gambling**

The 1999 NZGS has also been used to estimate the prevalence of problem gamblers and a subset of these - probable pathological gamblers. Both problem and probable pathological gamblers in the 1999 NZGS were identified by using a gambling screen that was revised from the South Oaks Gambling Screen (SOGS-R). The SOGS-R can identify both lifetime and current problem and probable pathological gamblers. Lifetime gamblers are people who identified having ever experienced the symptoms of problem gaming, while current gamblers are people who identified having experienced the symptoms in the six months before the survey.

According to the 1999 NZGS and based on the SOGS-R, 1.9 percent of New Zealanders aged 18 years and over were lifetime problem gamblers. An additional 1.0 percent were lifetime probable pathological gamblers. In terms of current problem gamblers (a subset of lifetime problem gamblers), it was estimated that 0.8 percent of New Zealand adults were current problem gamblers in 1999. An additional 0.5 percent were current probable pathological gamblers (see Table 5). Note that these estimates are probably conservative.

<table>
<thead>
<tr>
<th>Type of gambler</th>
<th>1999 %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime gamblers</strong></td>
<td></td>
</tr>
<tr>
<td>Lifetime problem gamblers</td>
<td>1.9</td>
</tr>
<tr>
<td>Lifetime probable pathological gamblers</td>
<td>1.0</td>
</tr>
<tr>
<td>Total</td>
<td>2.9</td>
</tr>
<tr>
<td><strong>Current gamblers</strong></td>
<td></td>
</tr>
<tr>
<td>Current problem gamblers</td>
<td>0.8</td>
</tr>
<tr>
<td>Current probable pathological gamblers</td>
<td>0.5</td>
</tr>
<tr>
<td>Total</td>
<td>1.3</td>
</tr>
</tbody>
</table>

**Gambling and problem gambling among recent male and female prison inmates**

At its most severe, gambling harm can encompass imprisonment, so it is worth looking at the rates of gambling among prison inmates as part of the assessment. As part of the NZGS a survey was conducted in four New Zealand male prisons and three New Zealand female prisons to establish gambling participation and problem gambling among new prisoners. Similar to adult males in the general population, 96 percent of the male inmates reported having gambled at least
once in their lifetime and 84 percent said they had gambled at least once in the six months before imprisonment. Of greater concern was that two-thirds of male inmates said they participated in gambling activities at least once a week before imprisonment (Table 6). In comparison, all female inmates reported having gambled at least once in their lifetime, and 97 percent said they had gambled at least once in the six months before imprisonment. Nearly three-quarters said they participated in gambling activities at least once a week before imprisonment. These rates were very high relative to the adult female general population.

Table 6: Gambling frequency of recent male and female prison inmates

<table>
<thead>
<tr>
<th>Gambling frequency</th>
<th>% male prison inmates</th>
<th>% female prison inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gambled at least once in lifetime</td>
<td>96</td>
<td>100</td>
</tr>
<tr>
<td>Gambled at least once in six months before prison</td>
<td>84</td>
<td>97</td>
</tr>
<tr>
<td>Gambled at least once a week before prison</td>
<td>66</td>
<td>73</td>
</tr>
</tbody>
</table>

More than half the male problem gamblers in prison and three-quarters of the female problem gamblers were Māori. However, Māori were no more likely than non-Māori to be problem gamblers, for both males and females.

Male inmates had much higher participation rates in NCGMs and horse or dog races (two forms of continuous gambling related to problem gambling) than adult males of the general population. Female inmates also had higher participation rates in continuous forms of gambling than the general female population.

Male and female respondents from the prison survey were also tested for levels of problem gambling using the SOGS-R screen. More than one-fifth (21 percent) of male inmates and 31 percent of female inmates were classified as lifetime probable pathological gamblers, and a further 10 percent of males and 12 percent of females were classified as lifetime problem gamblers (Table 7). Furthermore, 16 percent of males and 22 percent of females were considered current probable pathological gamblers. A further 7 percent of males and 12 percent of females were classified as current problem gamblers. These levels were considerably higher than for adult males and females in the general population.

Table 7: Percentage of recent male and female prison inmates classified with gambling problems

<table>
<thead>
<tr>
<th>Type of gambler</th>
<th>% male prison inmates</th>
<th>% female prison inmates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime gamblers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime problem gamblers</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Lifetime probable pathological gamblers</td>
<td>21</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>31</td>
<td>43</td>
</tr>
<tr>
<td>Current gamblers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current problem gamblers</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>Current probable pathological gamblers</td>
<td>16</td>
<td>22</td>
</tr>
</tbody>
</table>
Gambling expenditure

In the 1999 NZGS people who said they had gambled in the six months before the survey were also asked about how much they spent on gambling activities in a typical month. On average, people spent $41 per month on gambling activities compared with $37 in 1991. In 2003, gamblers lost more than $1.8 billion on gambling activity.

Males spent more than females ($53 compared with $30 per month). People aged 45-54 were the age group with the highest gambling expenditure at $58 per month, while people aged 18-24 ($30) and people aged 65 years and over ($31) had the lowest expenditure. Employed people had higher expenditure levels than people not in the labour force ($46 compared with $30).

Data from the survey of male prison inmates shows their average monthly gambling expenditure before imprisonment ($305) was considerably higher than that of adult males in the general population ($53). Looking at expenditure by gambling type, male prison inmates spent an average $100 per month on NCGMs, $41 on casino gaming machines and $37 on horse or dog races. Female prison inmates also spent considerably more per month on gambling activities ($190) compared with adult females of the general population ($30).

Nearly three-quarters (73 percent) of New Zealand adults had participated in Lotto in the six months before the survey. As a result, Lotto took the largest share of the total reported gambling expenditure in 1999 (36 percent). Although considerably fewer people participated in horse or dog race betting (18 percent) and NCGMs (14 percent), these two activities took the second and third largest share of the total reported gambling expenditure in 1999 (18 percent and 7 percent respectively). This is interesting considering that both these gaming activities are activities that regular continuous gamblers participate in, and previous research has shown they are more strongly associated with the development of problem gambling than non-continuous activities.

Although high proportions of the population had participated in other lotteries (or raffles) or Instant Kiwi ‘scratchies’ (48 percent and 36 percent respectively), relatively smaller proportions of total expenditure was spent on these two activities (7 percent and 6 percent respectively).

2003 New Zealand Health Survey

Information from the 2003 New Zealand Health Survey (NZHS) provides a slightly different view of gambling prevalence and expenditure. Provisional results from the NZHS show that 70 percent of males and 68 percent of females aged 15 years and over had participated in one of the gambling activities listed in the questionnaire in the 12 months before the survey. These activities differed slightly from those in previous surveys. Respondents were also asked if there were any weeks where they spent more than $30 on those activities. The provisional results show that males were more likely than females to say they had spent more than $30 during any week over the last year (13 percent compared with 6 percent). Looking at only those males who had spent more than $30 during any week during the year before the survey, two-fifths (42 percent) did so at least five weeks of the year. This compares to one-third of females (34 percent). Overall this means that approximately 1.5 percent of males and 0.7 percent of females had spent more than $30 a week for at least 5 weeks during the year before the survey.
These respondents were also asked a series of questions relating to the effect gambling had on them. Table 8 summarises the results.

Table 8: Percentage of gamblers who had various effects from gambling by sex (respondents to NZHS 2002/03 survey who had spent at least $30 a week during at least five weeks of the year before the survey.

<table>
<thead>
<tr>
<th>Effect from gambling</th>
<th>Males % yes</th>
<th>Females % yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the last 12 months, have you ever felt worried or depressed after playing any of those games?</td>
<td>29</td>
<td>43</td>
</tr>
<tr>
<td>In the last 12 months, has anyone been worried or concerned enough to ask you about your gambling?</td>
<td>17</td>
<td>26</td>
</tr>
<tr>
<td>In the last 12 months, have you ever gone into debt or borrowed money or had your credit card owing from money spent on gambling?</td>
<td>7</td>
<td>19</td>
</tr>
<tr>
<td>Do you feel that you have ever had a problem with gambling?</td>
<td>27</td>
<td>33</td>
</tr>
<tr>
<td>And in the last 12 months?</td>
<td>17</td>
<td>27</td>
</tr>
<tr>
<td>In the last 12 months, have you said you were winning from gambling when in fact you lost?</td>
<td>10</td>
<td>17</td>
</tr>
<tr>
<td>In the last 12 months, have you felt you would like to stop gambling but didn’t think that you could?</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>In the last 12 months, have you felt guilty or bad for doing wrong because of your gambling?</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>In the last 12 months, have you felt at any time the need to bet more and more money?</td>
<td>20</td>
<td>36</td>
</tr>
<tr>
<td>In the last 12 months, have you had to lie to people important to you about how much you gambled?</td>
<td>13</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 8 shows that feeling worried or depressed after gambling was the most common negative effect from gambling for both males and females. In addition, over a quarter of males and a third of females said they felt that they had a gambling problem.

Demand for services

The growing number of NCGMs in New Zealand has been mirrored by increasing numbers of new clients receiving counselling for problem gambling, either through telephone helplines or personal counselling (see Figure 6). The Problem Gambling Committee (PGC) National Statistics 2002 showed that NCGMs were the problem source for around 80 percent of helpline callers and 75 percent of personal counselling clients in 2002, while track betting problems accounted for 6.7 percent of clients (Paton-Simpson et al 2003). Furthermore, the amount lost on NCGMs increased from an estimated $360 million in the 1998/99 fiscal year to an estimated $941 million in the 2002/03 fiscal year (Department of Internal Affairs 2003).
In 2002 gaming machines (casino and non-casino) were the primary problem for 95 percent of female problem gambling clients and 79 percent of male clients. The number of female gamblers accessing problem gambling services has more than quadrupled since 1997, with females making up 45 percent of new clients in the 2002/03 fiscal year. Almost half the clients were aged under 35, with people aged under 18 accessing gambling services increasingly.

Māori and Pacific peoples are more likely to report gaming machines as their primary mode of problem gambling. Māori have shown the largest increase in the groups accessing services over the past five years, making up more than 25 percent of clients in 2002. Pacific peoples made up about 6.7 percent of service users, although the rate is nearly three times higher in some areas. Asian peoples made up 6.5 percent of telephone helpline callers in 2002 and tended to nominate casino tables as their main mode of problem gambling, although the numbers are small in comparison with other groups.

A growing number of people with gambling-related problems have a coexisting substance misuse problem or mental health disorder. For example, 9.4 percent of callers to the gambling helpline in 2002 had thought about, planned or attempted suicide in the previous 12 months. There are also significant numbers of people in the criminal justice settings with an identified gambling problem, but they are unlikely to access dedicated problem gambling services.
**Geographic spread of clients**

The national statistics for 2002 indicate that over a third of new clients to PGC face-to-face intervention services were in the Auckland area. This probably reflects the larger population in the area, the greater opportunities for gambling and the availability of intervention services. The presentation rate for face-to-face services was about 15.1 per 10,000 population for the major urban areas compared with 6.9 in other areas. The helpline had a presentation rate of 38.5 per 10,000 in urban areas and 27.1 in other areas, confirming that location has less of an impact on accessibility to telephone helplines than to personal counselling services.

Figures 7 and 8 show the number of helpline callers and personal counselling clients presenting to PGC services in 2002 by territorial local authority. These maps show that people from throughout New Zealand are accessing the telephone helpline. However, access to face-to-face problem gambling services is generally limited to the regions that provide these services.
**Figure 7:** Number of client presentations to telephone helpline by territorial local authority, 2002

Figure 8: Number of client presentations to personal counselling services by territorial local authority, 2002

4. Primary prevention and intervention services to meet the needs of the population

The following section looks at the range of current primary prevention and intervention services in relation to the areas highlighted in the prevalence and incidence data. This highlights gaps in current service coverage, both geographically and in terms of programmes targeting specific populations. Priority areas are highlighted. Details of the specific programmes and activities that will be funded by the Ministry of Health are included in the proposed three-year funding plan.

New Zealand has an existing range of problem gambling services, which have been funded predominantly by the PGC. While most of these services are intervention services for problem gamblers and their families, the PGC more recently has funded a range of primary prevention programmes and activities.

The aim of having services across the prevention continuum is to prevent people developing gambling problems as well as assisting people with problems to recover and remain well. To achieve this reorientation will require building sector infrastructure, research and evaluation, and sector workforce development. The Ministry of Health will also need to acknowledge and draw on expertise existing in the sector.

Primary prevention services

Primary prevention activities aim to prevent gambling problems arising and to protect populations from gambling-related harm by enhancing community and individual capacity. To achieve this, additional public health services and activities will need to be purchased to enhance community resiliency and address environmental and social risk factors.

Primary prevention activity funded by the PGC to a large extent has been around an ‘integrated model’, which has incorporated health promotion activity into intervention services. Table 9 lists the primary prevention activities and service types currently funded by the PGC, including service coverage areas.
Table 9: Primary prevention activities funded by the Problem Gambling Committee

<table>
<thead>
<tr>
<th>Area</th>
<th>Description of activity</th>
</tr>
</thead>
</table>
| Health promotion            | ¶ Delivering health promotion services through the integrated model  
¶ Promoting supportive environments and public policy  
¶ Delivering education and raising awareness about gambling issues to kaumātua  
¶ Delivering health promotion and education services for Asian peoples  
¶ Raising community awareness around gambling issues  
¶ Promoting kaupapa Māori health |
| Local government interface  | ¶ Developing a resource for territorial local authorities including developing, producing and distributing information packs and training to support the information packs  
¶ Working with territorial local authorities to address gambling harm |
| National co-ordination      | ¶ Developing a clearing house for resource development and distribution  
¶ Developing a gambling and public health work plan |
| Community action and development | ¶ Delivering community action projects including a Pacific component  
¶ Delivering Māori community action projects  
¶ Developing a Pacific coalition to strengthen and co-ordinate education and information to Pacific communities  
¶ Assessing community readiness and providing information and education |
| Research and evaluation     | ¶ Evaluating the community action projects |
| Industry liaison            | ¶ Working with gambling operators to create supportive environments and healthy gambling  
¶ Providing healthy gambling training to gambling venue staff, including developing resources and training packages for gambling venue operators and staff |
| Youth                       | ¶ Developing and trialling an education/youth resource for use in secondary schools, which supports and links to the Health and Physical Education in New Zealand Curriculum |
| Resources                   | ¶ Investment in awareness raising has mainly been small and localised, with resources focusing on problems and intervention services rather than public education; funding of broad-based or highly visible community education has not occurred |

**Indicators of change**

It is important that the effect of public health programmes and activities and, in particular, marketing campaigns is evaluated. A key focus will be to develop measures to assess changes in community awareness of the harm related to gambling, as well as assessing behavioural change attributable to specific strategies. This will require a baseline survey to be undertaken before any marketing or media campaign activity begins, and then monitoring and evaluating levels of awareness throughout the programme. Ideally, the social indicators identified will be applicable to a range of other public health activities.
**Problem gambling awareness training and exclusion**

Under the Gambling Act 2003 there are expectations on class 4 venue managers and casino operators to develop policies for identifying potential problem gamblers and to inform and advise them about problem gambling. Both the Gambling Act and the Racing Act 2003 provide for people to be excluded from gambling venues and for problem gambling awareness training for staff. Problem gambling awareness training for staff in casinos and the hospitality trade is required in several Australian states, but in New Zealand it has only been done on a voluntary basis, focusing mainly on casino staff.

There are difficulties identifying problem gamblers at a gambling venue, so generally staff wait for problem gamblers to identify themselves (e.g., by asking for information or to be excluded) before offering advice. Any awareness training for staff will need to cover both gambling and interpersonal communication.

**Primary prevention service gaps**

A significant proportion of the current funding for primary prevention goes towards health promotion activities within intervention services – the ‘integrated model’. Service coverage has been predominantly in the upper North Island. Two community action projects were piloted in Auckland and Hamilton and evaluation of these projects has been completed recently.

There are several Māori problem gambling primary prevention services around the country. For the most part these are fledgling services driven by the needs identified in particular communities. A national Pacific project that focuses on primary prevention activity currently exists in Auckland, and has recently been funded to expand into other parts of the country. Asian primary prevention activities exist in Auckland with some services in Christchurch. There is an identified need for additional services for these groups.

The Māori population is spread around sizeable pockets throughout the country, with a greater concentration in urban areas. The Pacific and Asian populations are more focused in the North Island and urban areas. About 53 percent of all NCGMs are in CAUs in deciles 8, 9 and 10, the most deprived 30 percent of CAUs. This is also where many Māori and Pacific peoples live. The geographic areas warranting particular attention include Northland, south and west Auckland, south Waikato, Bay of Plenty, Hawke’s Bay, Wairarapa, Wellington and Southland.

Problem gambling primary prevention activity is funded well below the level of other similar public health programmes. An average comprehensive public health programme costs approximately $8 million to $9 million per annum.
**Intervention services**

For gamblers whose personal, family, cultural or vocational pursuits are compromised, disrupted or damaged as a result of their gambling, a range of interventions services is needed. What is becoming clear in the literature related to problem gambling and other addictive behaviours is that there is no single ‘best’ model of intervention. A variety of programmes using several modalities has been shown to be effective. In treatment, one size does not fit all and the effectiveness of any intervention is likely to be culturally and temporally specific. Literature in the addictions field supports the benefits of cultural competence and safety when working with special populations.

**Client progress**

The current measurement of client progress used by PGC-funded services looks at the difference between the first and last client assessments, and then the difference during a follow-up period. Data are retained where at least 150 days have passed between the client’s first and last assessments. National statistics indicate that the mean gap between the first and last assessment in any episode of intervention was 395 days.

Analysis of the problem gambling outcome and progress measures indicated that:

- most clients benefited from formalised intervention with a reduction in their problem gambling-related harm
- as with the treatment of other addictive disorders, clients who completed treatment had better outcomes than clients who did not
- clients who completed treatment generally lost less money and felt an improved sense of control over their gambling than clients who did not
- about 18 percent of clients saw their gambling problems worsen during treatment, including an increase in monetary losses and feelings of less control.

**Māori, Pacific and Asian peoples’ treatment outcomes**

Māori treatment outcome evaluation suffers from a paucity of literature, in terms of frameworks for evaluation and data in the addictions sector. Information is available on the preferences of Māori clients in AOD treatment, and on potentially important constructs in treatment that may improve relevance and thus retention (Huriwai et al 1998, 2000). Data has also been published in relation to the perceived specific needs of Māori undertaking AOD treatments (Robertson et al 2001). There has been no specific research on treatment outcomes related to problem gambling for Māori. Generally there has been little research systematically identifying the characteristics, needs and aspirations of Māori who seek assistance with any addictive behaviours.

The development of general treatment outcome frameworks such as Hua Oranga (Kingi and Durie 2000) and a Māori-focused measure of wellbeing, Homai te Waiora ki Ahau (Palmer 2002) are an important start to address the gaps in this area. Further work is needed, however, in terms of issues specifically related to the problematic use of alcohol and other drugs and problem gambling. The lack of such basic information has precluded identifying and analysing salient issues and more systematic responses to addiction-related problems in Māori communities.
There is also a lack of outcome data for Pacific and Asian problem gamblers, although the literature in the addictions field supports the benefits of cultural competence and safety when working with special populations.

Primary health care settings for secondary intervention

Secondary prevention is an important overlap between population-level primary prevention and what traditionally has been seen as treatment or tertiary prevention. Expanding early identification and brief intervention programmes to target social and health services, workplaces and other community-based settings has enormous potential. To integrate early and brief interventions into a range of social and health services will require developing the workforce in primary health care settings, support from the dedicated problem gambling treatment sector, and intersectoral collaboration.

Screening is generally carried out to identify people who may have a gambling-related problem or who may be at risk of gambling-related harm. As part of public health promotion, opportunistic screenings can help raise awareness of gambling issues and resources. The evidence for the effectiveness of opportunistic brief interventions is much stronger than for brief interventions in specialist settings for those seeking help.

The number of people being referred to specialist services will probably increase in the short term as more people are identified by primary health care services. This, as well as any community awareness raising, could place a strain on existing intervention services – even if these contacts are assessments or only one or two sessions. Estimating how much demand could be placed on intervention services is difficult without better data about the incidence and prevalence of problem gambling and pathological gambling in the general community.

The successful implementation of a comprehensive strategy to prevent gambling harm that embeds primary health care within an overall system of care requires co-operation and co-ordination between several sectors with Ministry of Health leadership.

Tertiary prevention

Most practitioners work in an eclectic manner, using a range of cognitive/behavioural interventions, relapse prevention, motivational interviewing, desensitisation and problem-solving techniques depending on the client’s needs. These techniques are also used by other addictions workers working with problem gamblers who present at non-dedicated problem gambling services or who have co-existing AOD or mental health problems.

Note that current services are encouraged, but receive limited resourcing, to work with the families and significant others of problem gamblers – not just the person assessed as having a problem. There are no waiting lists for services and no contracted residential services.

Current intervention activities

Intervention (ie, treatment) and support services include self-help, private practice and PGC-funded services. These services offer a range of assessment and psychosocial interventions for people with more severe problems and are delivered in a variety of settings. There are dedicated Māori services around the country offering a range of services based in a particular cultural
framework. Fledgling services for Pacific and Asian peoples have also been developed. Some people with gambling problems are seen by private practitioners (some funded by community grants), but there also appears to be an increasing number of people with co-existing problems who are seen in AOD treatment services. A summary of current intervention activities is in Table 10.

Table 10: Summary of current intervention activities

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Comment</th>
</tr>
</thead>
</table>
| Telephone helpline    | Nationwide helplines, including dedicated phone lines for Māori, youth, Pacific and Asian peoples, and budgeting advice. The helpline services:  
|                       | 1 provide advice, brief interventions and referral services  
|                       | 1 have a website that gets 40 to 50 hits per day  
|                       | 1 distribute information packs to a range of different parties  
|                       | 1 co-ordinate the integrated care model, involving following up clients who have accessed PGC-funded services.                                                                                         |
| Psychosocial interventions | Nationwide there are generic access points in both islands where psychosocial interventions are delivered by problem gambling treatment providers. Some services are subcontracted (eg, to practitioners in AOD treatment services). Psychosocial interventions include:  
|                       | 1 Asian-specific services in Auckland  
|                       | 1 limited work within Corrections facilities  
|                       | 1 interventions for people resident in AOD treatment facilities in the Auckland region  
|                       | 1 dedicated Pacific intervention services  
|                       | 1 dedicated Māori intervention services.                                                                                                     |
| Early intervention    | A project involving community and social services, including training in screening and brief interventions.                                                                                             |
| Self-help             | With the support of Gamblers Anonymous.                                                                                                      |

**Integrated care model**

The integrated care model ensures that problem gamblers continue to get accessible support for as long as it takes them to resolve their problems. The model involves a helpline following up clients who have accessed intervention services for up to two years after they have accessed a service in order to check on their progress in dealing with their gambling problems and to help clients avoid relapse. This initiative has resulted in more clients returning to intervention services for additional help.

This system is an international first and the Problem Gambling Purchasing Agency (PGPA) reported that more than 1,300 clients were in the integrated care service in June 2003 (PGC statistics). Of the clients followed up after six months, 86 percent were not gambling. This initiative has been particularly successful, so the PGPA has attached contractual obligations on providers to participate in the follow up service. Therefore, when a client accesses a face-to-face intervention service they are asked whether their details may be forwarded to the helpline so follow-up can occur.
**Intervention service gaps**

Intervention service gaps

Problem Gambling Geography of New Zealand (Wheeler 2003) used data of high-level deprivation, easy access to NCGMs, and no contracted service within the boundary to create a list of areas potentially needing intervention services. This information, overlaid on a population distribution, also gives a greater indication of where problem gambling services should be placed.

Intervention service access points across the country are delivered by a range of providers at a facility or as a regular clinic. In some areas of identified risk a stronger presence than regular clinics may be required. There are areas that have no service coverage (eg, the Wairarapa). Some areas of risk do not have high demand, but this may develop as a result of marketing and increased community education. The growth of problem gambling-related harm in these areas may be held in check by effective primary and secondary prevention activities.

**Alcohol and other drug treatment centres**

An AOD service locations data set was geocoded. The data was based on the Alcohol and Drug Association of New Zealand (ADANZ) Directory of Services (2002) and included only non-residential services (although Auckland’s Odyssey House was an exception).

A specialist gambling face-to-face service list from mid-2002 included several AOD treatment services as providers. In areas of no or intermittent service, these addiction services could provide more consistent cover, although staff training in gambling-specific issues may be needed. The combination of location and dedicated problem gambling service utilisation data gives information that is useful in planning and resourcing face-to-face intervention services. Possible locations have been identified that are similar to the areas identified for public health activity.

**Alliances and coalitions**

Alliances and coalitions at community and regional levels can be particularly important for implementing a successful, integrated and co-ordinated strategy to prevent and minimise problem gambling-related harm. By emphasising integration at the community level, synergies between supply control, demand reduction and problem limitation programmes can be achieved. However, even greater co-ordination and integration can be achieved if these coalitions can be linked and co-ordinated nationally.

**Workforce development**

The problem gambling sector in New Zealand is still relatively new, and the public health workforce in problem gambling services is small and in an early stage of development. Workforce development will be a key component of building capacity within the sector to address gambling issues, as well as the reorientation of health and social services. Recruitment, retention and skill development issues need to be considered when building and maintaining capacity to prevent gambling-related harm.

From a national perspective, effective workforce development will require leadership, focus, collaboration and a strategy. A comprehensive strategy should extend beyond problem gambling...
practitioners to involve policy makers, funders, managers, researchers, educators and other frontline workers, some of whom will be generalists.

Identifying and developing provider workforce capacity to address gambling harm for Māori, Asian and Pacific communities will be an important component of ensuring cultural responsiveness.

Workforce training and education will be required to:

- support problem gambling providers to expand their knowledge and understanding of public health approaches so they can reorient their services to deliver public health services
- educate problem gambling intervention service providers about broader community-focused, public health approaches (especially in services that integrate public health and personal health interventions)
- train the wider public health workforce about issues specific to gambling
- develop knowledge and skills relating to community readiness assessments and community mobilisation
- establish effective cultural frameworks for delivering public health strategies.

Two specific areas of education and training will need to be addressed. The first will be to increase the capacity of health and social services in primary health care (eg, Iwi Social Services, primary health organisations, Budget Advice and Citizens Advice Bureau) to carry out gambling screening and, where appropriate, deliver brief and early interventions. In health services the screening may be part of a general health screen.

The second area of development will be enabling existing or new practitioners to update and upskill themselves about addiction treatments and issues, including providing practitioners from related sectors (eg, AOD, mental health and criminal justice) with opportunities to train in gambling-specific issues.

**Research**

Little problem gambling research has been undertaken in New Zealand. In the area of public health in particular there is a paucity of current research worldwide. Therefore, it is important to build up a body of research systematically by developing a comprehensive research strategy. The Ministry of Health has identified the following specific research priorities for the next three years: information gathering, socio-cultural and economic impact studies, and special population studies.

It is essential to establish an accurate information base through surveys and epidemiological and qualitative studies to provide a picture of the size and nature of the harm related to gambling. This will be achieved through the:

- New Zealand Health Survey
- Health Behaviours Survey
- Dunedin Longitudinal Study
- Geospatial Application Project.
Studies need to assess the economic, cultural and social effects of the expansion of gambling and problem gambling on national and regional economies and society’s social fabric. When possible, these studies should include cost-benefit analyses. Studies are also needed into the effect of gambling and different gambling products on high-risk populations.

**Evaluating and monitoring interventions**

To determine the value of both existing and new primary prevention and intervention services, evaluations will be conducted systematically. There will be an ongoing monitoring programme to ensure high quality services are delivered and that there is an adequate spread of and access to problem gambling services geographically and to high-need populations.

**Appendix: Methodology**

This needs assessment is underpinned by a search of literature related to addictive behaviours, problem gambling, health (including AOD), and policy and social science research undertaken to summarise the context in which problem gambling services and activities might be developed in New Zealand. Principal sources of information included the following.

**Bibliographic databases**

Bibliographic databases included:

- Medline
- Psychinfo
- the Prevention and Awareness Research E-Library.

Searches were limited to publications in English that had appeared or been cited in other documents between from 1995 to 2003.

**Websites**

Websites included:

- [www.abgaminginstitute.ualberta.ca](http://www.abgaminginstitute.ualberta.ca)
- [www.dia.govt.nz](http://www.dia.govt.nz)
- [www.gamblingresearch.org](http://www.gamblingresearch.org)
- [www.gamblingwatch.org.nz](http://www.gamblingwatch.org.nz)
- [www.naspl.org](http://www.naspl.org)
- [www.ncrg.org/research/index](http://www.ncrg.org/research/index)
Other sources

Other sources included:

- Longitudinal Evaluation of the Effectiveness of Problem Gambling Counselling Services, Community Education Strategies and Information Products
- PGPA and other key stakeholders in the addictions sector
- written and oral verbal submissions on the Ministry of Health’s 2002 National Plan
- the New Zealand Gaming Survey series published by the Department of Internal Affairs

References


Department of Internal Affairs. 2003. Total amount of money lost on NCGMs in 1998–2002 (referred to in original draft).


Introduction

This part of the document describes the Ministry of Health’s proposed plan to fund primary (public health), secondary and tertiary prevention services and activities, including research and workforce development, to minimise harm from problem gambling. The proposed funding plan aims to progress the high-level goals outlined in the Draft Strategic Plan for Preventing and Minimising Gambling Harm: 2004–2010. The Problem Gambling Needs Assessment highlighted priority areas and populations, as well as service gaps. This proposed funding plan targets funding at specific activities from 1 July 2004 and over the next three years to address those priorities and service needs.

Background

In October 2001, when the Responsible Gambling Bill was expected to progress more rapidly than it did, Cabinet agreed to funding of up to $9.8 million GST inclusive, in 2002/03, $15 million in 2003/04 and $20 million in 2004/05 (Years 1, 2 and 3). The Year 1 figure has now been eclipsed by Problem Gambling Committee spending on problem gambling services, which was $12.4 million in 2003/04.

In the Ministry’s current proposal, a significant proportion of the funding in the 2004/05 year will be towards current services and their realignment to Ministry of Health service specifications and requirements. It proposes that expansion of services, and funding of new services, will largely begin in the 2005/06 year.

Table 11: Preapproved Cabinet funding levels

<table>
<thead>
<tr>
<th>2002/03 (Year 1)</th>
<th>2003/04 (Year 2)</th>
<th>2004/05 (Year 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>$9.8 million (up to)</td>
<td>$15 million</td>
<td>$20.0 million</td>
</tr>
</tbody>
</table>
**Goals for the health services**

Implementation of the Ministry’s strategic plan for preventing and minimising gambling harm will require a comprehensive range of services and strategies to be built up over the next three years. The Ministry of Health proposes funding a variety of problem gambling services, from demand-reduction interventions to individual counselling.

The specific services and activities the Ministry proposes to fund to progress towards the goals of preventing and minimising gambling-related harm can be divided into two categories that cover the continuum of prevention activity:

- primary prevention - public health programmes and activities
- secondary and tertiary prevention – personal intervention services.

Public health approaches will aim to reduce the demand for gambling in communities by raising public awareness about the risks of gambling and by providing information to enable communities to make informed choices about gambling. Community readiness, community development and community action approaches are critical components in reducing the demand for gambling opportunities.

Intervention services will aim to reduce the effects of problem gambling by providing appropriate support and counselling interventions for the individuals and their families affected by gambling harm.

**Funding principles**

The following principles will guide funding processes for problem gambling primary prevention (public health) and secondary and tertiary intervention services:

- build on and reorient existing services
- build a comprehensive range of public health services based on the Ottawa Charter
- fund services that target priority populations
- strengthen communities
- address health inequalities
- build the knowledge base
- develop the workforce
- develop an intersectoral approach across services
- ensure links between public health and intervention services.

There are two further principles for the distribution of funding that are worth discussing more fully here:

- distribute funding equitably between providers
- ensure services are accountable.
Distribute funding equitably between providers

The distribution of funding between providers must be equitable. Mechanisms to ensure equitable funding will include:

- applying funding benchmarks appropriate to different service types as a guide to funding levels
- funding a minimum full-time equivalent capacity to ensure services are viable and minimise service fragmentation
- applying the Ministry of Health’s standard funding principles and guidelines.

Ensure services are accountable

Problem gambling service funding agreements will require appropriate management and accountability arrangements. A key accountability measure will be a detailed service description based on the Ministry of Health’s Public Health Service Handbook, Quality Requirements for Public Health Services and the Mental Health Service Framework and Service Specifications.

Funding

This section of the proposed funding plan, describes each area the Ministry proposes to fund to cover the 2004/05 to 2006/07 fiscal years to build a comprehensive range of activities and interventions for preventing and minimising gambling-related harm. Table 12 details the current PGC spend for services in the 2003/04 year across service categories and includes the proposed Ministry of Health spend from 2004/05 to 2006/07. All figures include GST.

Table 12: Problem gambling services – current and proposed spend

<table>
<thead>
<tr>
<th>Services</th>
<th>(PGC) 2003/04 ($)</th>
<th>2004/05 ($)</th>
<th>2005/06 ($)</th>
<th>2006/07 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health services</td>
<td>3,843,604</td>
<td>4,094,312</td>
<td>5,128,687</td>
<td>7,115,187</td>
</tr>
<tr>
<td>Intervention services</td>
<td>7,856,396</td>
<td>9,617,063</td>
<td>11,633,938</td>
<td>11,633,938</td>
</tr>
<tr>
<td>Research contracts</td>
<td>900,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
<td>1,000,000</td>
</tr>
<tr>
<td>Public health operating</td>
<td>–</td>
<td>401,688</td>
<td>384,813</td>
<td>384,813</td>
</tr>
<tr>
<td>Mental health operating</td>
<td>–</td>
<td>382,938</td>
<td>366,063</td>
<td>366,063</td>
</tr>
<tr>
<td>Total</td>
<td>12,600,000</td>
<td>15,496,000</td>
<td>18,513,500</td>
<td>20,500,000</td>
</tr>
<tr>
<td>Recouping</td>
<td>–</td>
<td>483,666</td>
<td>483,666</td>
<td>483,666</td>
</tr>
<tr>
<td>Total</td>
<td>12,600,000*</td>
<td>15,979,666</td>
<td>18,997,166</td>
<td>20,983,666</td>
</tr>
</tbody>
</table>

* Includes PGC’s policy development, administration and management component.

Table 13 outlines the Ministry’s proposed budget by service area for Public Health (primary prevention) services.
Table 13: Proposed public health expenditure on problem gambling by service area, 2004/05–2006/07

<table>
<thead>
<tr>
<th>Service area</th>
<th>2004/05 ($)</th>
<th>2005/06 ($)</th>
<th>2006/07 ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Generic services funding</td>
<td>1,598,000</td>
<td>1,608,000</td>
<td>1,908,000</td>
</tr>
<tr>
<td>2. Māori services funding</td>
<td>826,000</td>
<td>1,094,000</td>
<td>1,400,000</td>
</tr>
<tr>
<td>3. Pacific services funding</td>
<td>764,000</td>
<td>764,000</td>
<td>910,000</td>
</tr>
<tr>
<td>4. Asian services funding</td>
<td>546,000</td>
<td>546,000</td>
<td>600,000</td>
</tr>
<tr>
<td>5. Workforce training</td>
<td>50,000</td>
<td>100,000</td>
<td>200,000</td>
</tr>
<tr>
<td>6. Resources</td>
<td>40,000</td>
<td>150,000</td>
<td>200,000</td>
</tr>
<tr>
<td>7. Social marketing media campaign</td>
<td>40,000</td>
<td>550,000</td>
<td>1,500,000</td>
</tr>
<tr>
<td>8. Behaviour change indicators</td>
<td>30,000</td>
<td>100,000</td>
<td>200,000</td>
</tr>
<tr>
<td>9. National co-ordination services</td>
<td>200,000</td>
<td>220,000</td>
<td>200,000</td>
</tr>
<tr>
<td>Total services budget</td>
<td>4,094,000</td>
<td>5,128,000</td>
<td>7,115,000</td>
</tr>
<tr>
<td>Total operational budget</td>
<td>401,688</td>
<td>384,813</td>
<td>384,813</td>
</tr>
<tr>
<td>Total</td>
<td>4,495,688</td>
<td>5,512,813</td>
<td>7,499,813</td>
</tr>
</tbody>
</table>

Table 14 outlines the Ministry’s proposed budget by service area for Intervention (secondary and tertiary prevention) services.

Table 14: Proposed intervention services expenditure on problem gambling by service area, 2004/05–2006/07

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Helpline</td>
<td>1,400,000</td>
<td>1,400,000</td>
<td>1,400,000</td>
</tr>
<tr>
<td>Brief and early intervention</td>
<td>3,530,000</td>
<td>4,660,000</td>
<td>4,870,000</td>
</tr>
<tr>
<td>Psychosocial interventions and support</td>
<td>3,800,000</td>
<td>4,520,000</td>
<td>4,330,000</td>
</tr>
<tr>
<td>PG information system</td>
<td>220,000</td>
<td>200,000</td>
<td>200,000</td>
</tr>
<tr>
<td>Screening</td>
<td>194,000</td>
<td>223,000</td>
<td>223,000</td>
</tr>
<tr>
<td>Training/audit</td>
<td>464,000</td>
<td>620,000</td>
<td>600,000</td>
</tr>
<tr>
<td>Total services budget</td>
<td>9,608,000</td>
<td>11,623,000</td>
<td>11,623,000</td>
</tr>
<tr>
<td>Total operational budget</td>
<td>382,938</td>
<td>366,063</td>
<td>366,063</td>
</tr>
<tr>
<td>Total</td>
<td>9,990,938</td>
<td>11,989,063</td>
<td>11,989,063</td>
</tr>
</tbody>
</table>
1. Existing and proposed new services

a) Proposed public health services (primary prevention)

Reorient and expand public health (primary prevention) services

Rationale

The PGC has developed a number of public health initiatives. The services focus on the general population, Māori, Pacific peoples and Asian peoples. The 2004/05 year will be a year of consolidation focusing largely on the realignment process with only a small amount of growth. The 2005/06 and 2006/07 years will see the funding of a number of new services proposed, with further growth to existing services. An emphasis will be on the expansion of services for Māori as indicated by the needs assessment.

All existing services will need to be reoriented to align with the strategy and, more specifically, requirements of the Ministry of Health’s public health service specifications. Existing providers will be required to realign their current services to meet these specifications in accordance with a negotiated realignment pathway (provided such agreement can be reached) by 30 June 2005.

As realignment occurs, funding areas may alter. The Ministry will monitor the changing needs of the population and factor in growth in this service area as required. Table 15 shows the current PGC funding of public health services (excluding research) and the proposed Ministry levels for 2004/05–2006/07 to continue existing services and fund a range of new services.

<table>
<thead>
<tr>
<th>PGC 2003/04</th>
<th>Ministry of Health 2004/05</th>
<th>Ministry of Health 2005/06</th>
<th>Ministry of Health 2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,743,604</td>
<td>$4,094,312</td>
<td>$5,128,687</td>
<td>$7,115,187</td>
</tr>
</tbody>
</table>

Proposed service priorities

1. Generic Services Funding

Rationale

Factors that determine whether individuals experience harm from gambling can be broadly split into two main categories: environmental and personal. These risk factors include the availability and accessibility of gambling opportunities, socioeconomic deprivation and the marketing of gambling. Environmental and personal factors both need to be comprehensively addressed if a reduction in gambling harm is to be achieved.
Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,598,000</td>
<td>$1,608,000</td>
<td>$1,908,000</td>
</tr>
</tbody>
</table>

Proposed services

Services currently purchased include health promotion, community action, and raising community awareness around issues of gambling. These services would be a part of the reorientation process in years 1 and 2 with some growth in year 3 (funding permitting). This expansion would be informed by consultation with the sector, the strategic plan, the needs assessment and identified gaps in service delivery.

2. Māori services funding

Rationale

This proposed growth in Māori public health services recognises the Ministry's objective of reducing gambling related inequalities for Māori. This funding would build on the gains already made in problem gambling service provision for Māori under the ambit of the Problem Gambling Committee (PGC). Much of the work begun by the PGC is in an early stage and will require development after the Ministry of Health assumes responsibility, to work towards nationwide service coverage of problem gambling primary prevention services and activities for Māori.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$826,000</td>
<td>$1,094,000</td>
<td>$1,400,000</td>
</tr>
</tbody>
</table>

Proposed services

It is proposed that Māori primary prevention (public health) services that serve Māori communities primarily, have a Māori philosophy and a cultural component as an integral part of the programmes offered, would be funded in the following five key geographic areas:

- the Northland region
- the Tairawhiti region
- the Wanganui region
- the Wellington region
- te Tau Ihu (the north of the South Island).

This section has been informed by the needs assessment and gaps in service provision for Māori.
3. Pacific services funding

Rationale
Current services encompass Pacific-specific services, including the promotion of public health messages to raise an awareness of problem gambling issues in Pacific communities. Years 2004/05 and 2005/06 would focus on consolidation of the current services and reorientation to Ministry of Health service specifications. The funding plan proposes an expansion of these services in the 2006/07 year.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$764,000</td>
<td>$764,000</td>
<td>$910,000</td>
</tr>
</tbody>
</table>

Proposed services
The detail of service expansion has yet to be fully developed and will be informed by consultation with the sector, the needs assessment and identified gaps in current service delivery.

4. Asian services funding

Rationale
Current services encompass Asian-specific services, including community development projects to raise awareness of problem gambling issues in Asian communities. Years 2004/05 and 2005/06 would focus on consolidation of the current services and reorientation to Ministry of Health service specifications. The funding plan proposes an expansion of these services in the 2006/07 year.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$546,000</td>
<td>$546,000</td>
<td>$600,000</td>
</tr>
</tbody>
</table>

Proposed services
The detail of service expansion has yet to be fully developed and will be informed by consultation with the sector, the needs assessment and identified gaps in current service delivery.

5. Workforce development

Rationale
The public health services in the gambling sector are new and small. Recruitment, retention and skill development within the public health service workforce would need to be supported by national training in generic public health service planning and delivery skills.
Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>$50,000</td>
<td>$100,000</td>
<td>$200,000</td>
<td></td>
</tr>
</tbody>
</table>

Proposed services

In the 2004/05 and 2005/06 fiscal year three phases of training programme would be available:

1. Phase one would deliver training programmes for existing providers to support their realignment to deliver public health services. A workforce development plan would be developed before 30 June 2004, so delivery to new providers can occur early in the 2004/05 fiscal year.

2. Phase two would be timed to support new Māori services and focus on community development initiatives.

3. Phase three would focus on public health responses to problem gambling issues. The training would be for all public health service provider staff. This would enable public health staff from fledgling gambling sector providers to establish supportive networks with the wider public health workforce. The training resource will also support the wider public health workforce.

6. Resources

Rationale

In the 2004/05 year the Ministry of Health proposes to purchase resource assessment and development services through a competitive tender that would identify the most appropriate provider or providers. This would ensure public health resources are available to support the sector’s new orientation toward public health strategies.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>$40,000</td>
<td>$150,000</td>
<td>$200,000</td>
<td></td>
</tr>
</tbody>
</table>

Proposed services

The services for the 2004/05 fiscal year have three key components:

1. A stocktake of available resources and an assessment of their appropriateness for supporting public health programmes.

2. A needs analysis to assess new and existing providers’ need for public health resources. (This work would occur after current providers have completed realigning their current contracts to deliver public health services.)

3. Ongoing resource design, pre-testing, development and distribution.

The reports from components 1 and 2 would inform the design of service specifications and provider requirements for funding ongoing resource design, pre-testing, development and
distribution services. Ongoing resource reprinting and distribution would be required for the 2005/06 and 2006/07 fiscal years. In particular, designing, pre-testing and developing new resources that use consistent key messages and link with and support the social marketing campaign described below would be required.

7. Social marketing and media campaign

Rationale
A key public health approach is to promote and support public awareness and debate on issues surrounding gambling. A social marketing campaign is a service strategy to raise public awareness about gambling issues. The social marketing media campaign and the population awareness and behaviour change indicators project (see below) are also closely linked. The two projects may be purchased as an integrated project.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$40,000</td>
<td>$550,000</td>
<td>$1,500,000</td>
</tr>
</tbody>
</table>

In Year 1 a budget of $40,000 would be applied to the baseline work and research required to support a media campaign. In Year 2 the budget would increase to $550,000 and be applied to activities such as developing and testing key messages. In Year 3 a full budget of approximately $1.5 million would be required for a full range of media placements.

Proposed services
A social marketing strategy uses commercial marketing technologies to analyse, plan, implement and evaluate programmes designed to influence the voluntary behaviour of target audiences in order to improve their health. The social marketing campaign would seek to:

- encourage New Zealanders to make healthy lifestyle choices in relation to gambling
- promote discussion about the effect of gambling in the community
- reduce the uptake and incidence of gambling among target populations.

Key messages developed for the media campaign would be used and reinforced by other public health promotion activities.

8. Population awareness and behaviour change indicators

Rationale
It is important that public health programmes, in particular the social marketing campaign, are properly evaluated. While attributing any particular behavioural changes to a specific strategy may be beyond the scope of the evaluation methodology, measuring behaviour change in communities would be a key component of public health services programme planning for the future. $30,000 has been allocated in Year 1 to fund the behaviour change indicators project. Funding for later years would be based on the level of activity required.
Proposed Budget

<table>
<thead>
<tr>
<th>Year</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$30,000</td>
<td>$100,000</td>
<td>$200,000</td>
</tr>
</tbody>
</table>

Proposed services
The key focus of this work would be on measuring change in communities’ understanding of gambling as potentially negative. The service would include:

- developing population awareness and behaviour change indicators
- undertaking a baseline survey before any social marketing activity
- undertaking periodic evaluations of the behavioural change indicators throughout the social marketing media campaign
- working with (while maintaining independence from) the social marketing provider.

9. National co-ordination services

Rationale
Primary prevention (public health) services must interact effectively with personal health services. For this reason services to minimise gambling harm would benefit from an independent service providing dedicated national co-ordination and support.

Proposed Budget

<table>
<thead>
<tr>
<th>Year</th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$200,000</td>
<td>$220,000</td>
<td>$200,000</td>
</tr>
</tbody>
</table>

Proposed services
Two full-time equivalent positions would be supported.

The key objectives of the service would be to:

- improve communications, co-ordination and collaboration between agencies involved in minimising gambling-related harm
- encourage informed public debate and support for initiatives to minimise gambling harm.

A national co-ordination service provider would need to form effective working relationships with the public health resource services and the social marketing media campaign provider. The work with providers would follow and build on the first round of workforce development training.

The first year of service delivery would include undertaking needs analyses to ensure the service is provider focused and developing an appropriate website or other mechanisms to facilitate the national co-ordination services work. A conference would be co-ordinated by the provider in Year 2.
b) Proposed intervention services (secondary and tertiary prevention)

Reorient and expand intervention services (secondary and tertiary prevention)

Rationale

The focus of Problem Gambling Committee (PGC) funding has been on developing a range of personal health counselling and interventions services across the country. The services focus on the general population, Māori, Pacific peoples and Asian peoples.

All existing intervention services will need to be reoriented to align with the Strategic Plan and, more specifically, the mental health service descriptions and sector standards. Existing providers will be required to realign their current services to meet these specifications in accordance with a negotiated realignment pathway (provided such agreement can be reached) by 30 June 2005.

The 2004/05 year will be a year of consolidation focusing largely on the realignment process. In the 2005/06 and 2006/07 years, funding for a number of new services with further growth to existing services is proposed. Table 16 shows the current PGC funding of intervention services and the proposed Ministry levels for 2004/05–2006/07 to continue existing and fund a range of new services.

Table 16: Current PGC funding of intervention services and proposed Ministry levels for 2004/05–2006/07

<table>
<thead>
<tr>
<th>PGC 2003/04</th>
<th>Ministry of Health 2004/05</th>
<th>Ministry of Health 2005/06</th>
<th>Ministry of Health 2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>$7,756,396</td>
<td>$9,617,063</td>
<td>$11,633,938</td>
<td>$11,633,938</td>
</tr>
</tbody>
</table>

Proposed service priorities

1. Helpline

Rationale

The helpline services will be provided to people experiencing some form of gambling-related harm, either directly or as a result of a family/whānau member’s or significant other’s gambling.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proposed budget</td>
<td>$1,400,000</td>
<td>$1,400,000</td>
<td>$1,400,000</td>
</tr>
</tbody>
</table>
Proposed services
The service will provide direct information and access by phone (or similar telecommunication) screening, brief intervention, referral, follow-up services, and liaison and consultation services with other providers. The service will not provide face-to-face counselling or extended intervention services.

2. Brief and early intervention

Rationale
Expanding early identification and brief intervention to target social and health services, primary health care settings and other community based settings will provide an important overlap between primary prevention activities and intervention services. The early identification of an individual’s gambling problems will potentially lessen the need for more intensive services.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
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<tbody>
<tr>
<td></td>
<td>$3,530,000</td>
<td>$4,660,000</td>
<td>$4,870,000</td>
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</tbody>
</table>

Proposed services
Services will aim at the primary and secondary prevention of gambling problems and will be offered mainly in non-problem gambling intervention service settings. Components of the service may include: information, screening, brief interventions, brief assessment, referrals and liaison and consultation with other providers.

3. Psychosocial interventions and support

Rationale
This service type is where a significant proportion of current PGC funding is focused. The services are widely accessed, and referred to, around the country. The services are aimed at increasing an individual’s ability to manage their gambling problems.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
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<tbody>
<tr>
<td></td>
<td>$3,800,000</td>
<td>$4,520,000</td>
<td>$4,330,000</td>
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</table>

Proposed services
These services will include a range of psychosocial and support interventions to be delivered to individuals or groups in a variety of settings. Community follow-up services will be provided for people who require support after completing psychosocial interventions.
4. Problem gambling information system

Rationale
The PGC have developed a comprehensive data and information system that collects all PGC problem gambling service provider data. The Ministry of Health proposes that this information system continue and will negotiate to take over responsibility for this information system with the PGC.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$220,000</td>
<td>$200,000</td>
<td>$200,000</td>
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</table>

Proposed services
These services include maintaining and enhancing the unique problem gambling information system to support policy advice, service development, research and evaluation and information advice for the sector.

5. Screening

Rationale
Wider use of a validated screening tool to assess individual gambling behaviours will provide consistency and better referral to services.

Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>$194,000</td>
<td>$223,000</td>
<td>$223,000</td>
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</table>

Proposed services
A screening tool will be validated and disseminated for use throughout a number of services and settings.

6. Workforce development and training

Rationale
Training and development of the problem gambling workforce will be an important service component to support all intervention services. The sector has a small and dedicated workforce and opportunities to recruit, retain and develop the workforce will be an important priority.
Proposed budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$464,000</td>
<td>$620,000</td>
<td>$600,000</td>
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</tbody>
</table>

Proposed services

Two areas of workforce development will be addressed. The first will look at increasing the capacity of health and social services in primary health care to carry out gambling screening. The second area will be enabling existing or new practitioners to update and upskill themselves about addiction treatment and issues specific to gambling. A gap analysis of current training capability within the problem gambling workforce will be undertaken in Year 1.

7. Dedicated problem gambling services (Māori, Pacific peoples, Asian peoples)

Dedicated problem gambling intervention services will be provided for Māori, Pacific and Asian peoples that meet the needs of service users, their families, whānau and significant others, as well as those delivering the services. Intervention service gaps identified in the needs assessment will begin to be addressed over the three years of funding.

These dedicated services have been budgeted for within each of the service types.

2. Proposed research projects: joint public health and mental health

It is proposed the following projects be funded to support the service delivery infrastructure across the continuum of public and personal health services.

Research projects

Research projects would be funded to support and inform the delivery of services to minimise gambling harm. These would include:

- cost-benefit analysis
- socioeconomic impact study
- gambling harm impact study
- measuring effectiveness of intervention services including treatment options
- effectiveness of early interventions for youth, adults, Māori, Pacific and Asian peoples.

Health surveys

Survey questions focusing on gambling behaviours and prevalence will continue to be developed for inclusion in the New Zealand Health Survey. This survey programme allows for the oversampling of particular populations and geographic areas. Funding would also be allocated for the analysis of previous survey responses as part of the Dunedin Longitudinal Survey. Additional gambling-related questions would be designed for future surveys.
Evaluation

The evaluation of existing public health services is vital to add to the limited body of knowledge about effective public health interventions. Evaluation results will be incorporated into ongoing workforce development initiatives.

Problem Gambling Geography

The Ministry of Health’s *Problem Gambling Geography of New Zealand* (Wheeler 2003) is a key document informing the needs assessment work to target prevention programmes. This will require updating annually to ensure up-to-date data is used for programme planning purposes.

Proposed research budget

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$1,000,000</td>
<td>$1,000,000</td>
<td>$1,000,000</td>
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</table>

3. Recoup of Ministry of Health transitional funding

The Ministry began developing the Strategic Plan and preparing to assume responsibility for problem gambling services in 2001/02 whilst awaiting the passage of the Gambling Act. The full costs of the transition incurred during the period 2001/02–2003/04 will be recouped through the problem gambling levy and will be spread evenly over the 2004/04–2006/07 period.

Recoup of transitional funding

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$483,666</td>
<td>$483,666</td>
<td>$483,666</td>
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</table>
Part 4: Proposed Problem Gambling Levy Rates

Background

Problem gambling services co-ordinated by the Ministry of Health are funded from an appropriation. The broad purpose of the Problem Gambling Levy is to reimburse the Crown for the costs of that appropriation, and the formula for calculating the levy rates is contained in the Gambling Act 2003. Under the Gambling Act, the Ministry of Health, as the department responsible for implementing the problem gambling strategy, is required to undertake the following tasks as part of its strategy development process:

- undertake a needs assessment
- prepare a draft strategy
- develop costings for the draft strategy
- estimate the costs to the Ministry of Health, during the transition to the strategy, in the years preceding the introduction of the initial levy (2001/02–2003/04)
- take into account any under or over recovery of the levy in the previous levy period, for future levy calculations
- estimate annual funding requirements for the strategy for a three-year period
- estimate, using the formula set out in the Gambling Act, the levy rates for each sector liable to pay the levy
- consult on these matters.

The Problem Gambling Levy is set down in the Gambling Act 2003, with the purpose of the levy stated as:

to recover the cost of developing, managing, and delivering the integrated problem gambling strategy (section 319(2)).

For the initial levy period, 2004/05–2006/07, the levy is payable by the following gambling operators:

- the New Zealand Racing Board
- the Lotteries Commission
- casino operators.
- non-casino gaming machine operators.
Gambling Commission

The Gambling Commission, established in March 2004, is an independent statutory decision-making body, established under the Gambling Act 2003.

The Commission will provide advice to the Minister of Internal Affairs, act as a licensing authority in relation to casinos, and be an appeal authority against a range of decisions relating to licensing and enforcement for non-casino gambling.

Following the Ministry of Health’s general consultation on the Preventing and Minimising Gambling Harm document, the Gambling Commission will convene a meeting on the strategy and proposed levy rates, with representatives of gambling operators who will be subject to the levy, problem gambling service providers, the Ministry of Health, the Department of Internal Affairs and any other relevant parties. Within 10 working days of this meeting, the Commission must submit its recommendations to the Ministers of Health and Internal Affairs on the total amount of the proposed problem gambling levy for the 2004/05 – 2006/07 period, and the proposed problem gambling levy rates for those subject to the levy.

The levy

The levy is calculated using the formula, supplied in the Gambling Act (section 320), which provides a mechanism for allocating among gambling operators, and collecting from them, the approximate cost of an integrated problem gambling strategy.

The initial levy rates will be set for the three years 2004/05–2006/07. In the case of the initial levy, the full costs of the transition to the Ministry’s strategy, incurred in the period 2001/02–2003/04 of approximately $1.45m will be included. These transition costs will be spread and recouped evenly over the three-year period, 2004/05–2006/07.

The Ministry of Health is aware that concern has been raised over the impact of the problem gambling levy on funding for the sports and recreation, and community sectors, however, it anticipates that the proposed problem gambling levy amount is unlikely to reduce gambling industry funding for communities, from the amount provided in the 2003/04 year. This assumption is based on the forecast expenditure rates for the levy period (contained on page 64 of this document). Most clubs operating non-casino gaming machines are likely to pay less in years 2004/05 – 2006/07 under the Ministry’s proposed levy rates, than they did in the 2003/04 year. The Lotteries Commission, will be liable to pay approximately half the amount it contributed to the levy in 2003/04.

Expenditure

Player expenditure in the non-casino gaming machine, casino, New Zealand Racing Board and Lotteries Commission sectors in the last financial year have been supplied by the Inland Revenue Department (IRD). Figures on past and current levels of gambling expenditure are available on the Department of Internal Affairs website.
Presentations (People Seeking Problem Gambling Assistance)

Figures on problem gambling presentations were supplied by the Problem Gambling Purchasing Agency of the Problem Gambling Committee for the year 1 October 2002 to 30 September 2003. Presentation figures relate to all clients who presented for problem gambling counselling during that period.

Weightings

Government agreed during the Gaming Review, in determining the relative shares for each sector, that a weighting of 10 percent on expenditure and 90 percent on presentations should be used [POL Min (01) 3/10 confirmed by CAB Min (01) 39/5]. This was adopted because it reflects that the levy raised is largely to address the harm caused by gambling (harm being best measured by presentations). The Ministry of Health has therefore proposed, in consultation with the Department of Internal Affairs, to continue with a 10/90 expenditure/presentations weighting option, and has entered these weightings in the levy formula accordingly.

Forecast expenditure

The impact of the Gambling Act makes forecasting future expenditure levels extremely difficult. In projecting future growth, the following assumptions have been made:

- **Non-casino machines** – In the last year this sector grew by 19 percent. The impact of a reduction in gaming machine numbers and the stringent licensing and compliance requirements of the Act may see the rate of growth halve.

- **Casinos** – The casino sector has grown by 10 percent over the last year. A portion of past growth has been due to the introduction of new casinos and the expansion of gambling opportunities within existing casinos. The Act prohibits the licensing of new casinos and the expansion of gambling opportunities within existing premises, therefore the growth rate may reduce to 75 percent of the current rate.

- **New Zealand Racing Board** – That growth may continue at half last year’s growth rate of 4 percent.

- **Lotteries Commission** – That the decline in expenditure of 5 percent may be arrested and there will be no growth over the period of the levy.
Levy calculations*

The table below sets down the Ministry of Health’s proposed costs for delivering an integrated problem gambling strategy, including recoup of transition costs from 2001/02 to 2003/04, and allocates those costs to each gambling sector, weighted as outlined above.

\[
\text{Levy rate} = \frac{((A \times W_1) + (B \times W_2)) \times C}{D}
\]

A = is the estimated current expenditure in a sector divided by the total estimated current player expenditure in all sectors subject to the levy.

B = customer presentations to problem gambling services that can be attributed to gambling in a sector divided by total customer presentations to problem gambling services in which a sector that is subject to the levy can be identified.

C = is the funding requirement for the period for which the levy is payable.

D = forecast player expenditure in a sector for the period during which the levy is payable.

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

*Inland Revenue will provide information to the Department of Internal Affairs and Ministry of Health relating to the gaming duty paid by gaming operators. The Tax Administration Act 1994 requires both agencies to maintain the secrecy of the information received.

**Table 17: Proposed problem gambling levy**

<table>
<thead>
<tr>
<th>Problem gambling funding requirement</th>
<th>$ million</th>
</tr>
</thead>
<tbody>
<tr>
<td>2004/05</td>
<td>15.979</td>
</tr>
<tr>
<td>2005/06</td>
<td>18.997</td>
</tr>
<tr>
<td>2006/07</td>
<td>20.983</td>
</tr>
<tr>
<td>Total</td>
<td>55.989</td>
</tr>
</tbody>
</table>

**Table 18: Proposed problem gambling levy rates (33 months)**

<table>
<thead>
<tr>
<th>Collection period starts 1 October 2004</th>
<th>Non-casino gaming machines</th>
<th>Casinos</th>
<th>New Zealand Racing Board</th>
<th>Lotteries Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector levy rates (%) (collected over 33 months)</td>
<td>1.23</td>
<td>0.60</td>
<td>0.66</td>
<td>0.16</td>
</tr>
</tbody>
</table>

**Table 19: Proposed problem gambling levy rates (36 months) – for comparison purposes only**

<table>
<thead>
<tr>
<th>Collection period starts 1 July 2004</th>
<th>Non-casino gaming machines</th>
<th>Casinos</th>
<th>New Zealand Racing Board</th>
<th>Lotteries Commission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sector levy rates (%) (collected over 36 months)</td>
<td>1.13</td>
<td>0.55</td>
<td>0.60</td>
<td>0.15</td>
</tr>
</tbody>
</table>