

**The Problem Gambling Committee of New Zealand
in association with
The Gambling Studies Institute of New Zealand**

GAMBLING, HARM AND HEALTH



**Two perspectives on ways to minimise harm
and maximise health with regard to gambling in
New Zealand**

**Robert Brown, PhD
John Raeburn, PhD**

April 2001

GAMBLING, HARM AND HEALTH

TWO COMPLEMENTARY PERSPECTIVES ON MINIMISING HARM AND INCREASING COMMUNITY RESILIENCE WITH REGARD TO GAMBLING

In November 2000, the Problem Gambling Committee of New Zealand commissioned two documents from the Gambling Studies Institute of New Zealand to develop discussion documents relating to national policies in the areas of harm minimisation and public health/health promotion, as these relate to gambling in New Zealand. The two documents reached their final form in April, 2001, and are as follows:

Harm minimisation:

Robert Brown, PhD (2001): The harm minimisation strategy: A proposed national responsible gambling policy for New Zealand.

Public health/health promotion:

John Raeburn, PhD (2001): Towards healthy gambling: A health promotion approach to gambling in New Zealand.

These two documents are seen as addressing the same broad areas of concern – that is, how best to reduce the harm done by gambling in society, and to strengthen the community in terms of how gambling impacts on them. There is no question that gambling, given its huge growth over the last decade, has had a major impact on the lives of ordinary people in New Zealand, and this is likely to grow. Many of these impacts have not been positive, and there are clearly significant and growing costs associated with gambling in terms of social, health, economic and other domains of life. There is urgent need for government to address this reality, and to have cogent policies in place to serve us now and in the future. These policies are seen as being especially along the lines of those outlined in these two documents – one which emphasises appropriate regulation and treatment (harm minimisation), and one which emphasises the community dimension, in terms of building community resilience – that is knowledge, skills, and sense of control – with regard to gambling activities and issues (health promotion). Harm minimisation tends to be focused on the more immediate issues of containing and ameliorating damage. Health promotion has a longer term, developmental perspective, of building community capacity. **Both perspectives are seen as vital to a balanced approach to the issue of reducing the damage done by gambling in society, and strengthening community health and wellbeing with regard to gambling.**

This work has been undertaken within the context of the New Zealand Government's announcement of a major review of gambling as has happened in other jurisdictions around the world. Many countries in the western world are struggling to catch up with the impact of modern gambling on people and communities. The findings from these reviews being undertaken around the world, and in particular, the unequivocal findings of increasing harm from problem gambling associated with the expansion of high-intensity, continuous gambling products reported in the Australian Productivity Commission report, must have a significant effect on policy-makers.

Unlike previous reviews of 1995 and 1997 in New Zealand, the Problem Gambling Committee and the Government now wish for major reform in gambling policy and legislation. The Government has signalled that in this review there will be wide-ranging consultation and the opportunity for community input leading to comprehensive revision and reforms. To this end the Problem Gambling Committee has commissioned these documents to provide a basis for informed discussion of the issues surrounding the expansion of gambling in New Zealand and potential strategies for addressing these issues.

These documents together represent a balanced approach – both are necessary. We believe the perspectives and ideas they present are innovative, important and sensible. We believe they represent a good appraisal of what is urgently needed in terms of government and community action to contain a phenomenon that could challenge the whole underpinning of the wellbeing of our society. An illustration of the scale of gambling as a societal issue is that it is estimated that on present trends, by 2005 the turnover from gambling could equal the value of whole of New Zealand's export trade.

It is time for action. We trust these documents will help to make that action intelligent and of value to this country.

Robert A Brown

John Raeburn

Problem Gambling Committee

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THE HARM MINIMISATION STRATEGY

**A Proposed National Responsible Gambling Policy for
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TOWARDS HEALTHY GAMBLING

**A Health Promotion Approach to Gambling in New
Zealand**

John Raeburn, PhD

Problem Gambling Committee

Commission Documents

National Responsible Gambling Policy

THE HARM MINIMISATION STRATEGY

**A Proposed National Responsible Gambling Policy
for New Zealand**

POLICY OVERVIEW - Dr Robert Brown

**A harm minimisation policy proposal designed to incorporate
a health promotion approach.**

Based upon the existing national drug policy template

**Proposed to be owned and monitored by the Social Policy
and Health Cabinet Committee chaired by Hon Steve Maharey**

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Proposed National Policy on Responsible Gambling

The policy aims to develop responsible gambling that maximises the benefits and minimises the harms of gambling in a way that establishes a level of gambling that is economically and socially sustainable

EXECUTIVE SUMMARY

Introduction

New Zealand has a proud tradition of being in the forefront of nations that take positive action to protect and improve both the physical health and the mental well being of its citizens.

This submission to Government seeks to follow in this proud tradition of protecting New Zealanders' well being by proposing a national policy to minimise harm from gambling.

The proposed policy is designed to minimise harm and retain the benefits of gambling by promoting responsible gambling at a level that is economically and socially sustainable for individuals, communities, and New Zealand.

Harm from gambling

In some form or other, gambling is engaged in by more than 90% of the adult population in New Zealand. As with other potentially addictive products (eg alcohol, drugs) major harms can arise from problem gambling resulting in costs that are borne by problem gamblers, their families and the wider community.

Harm that results from gambling includes harm to health, as well as crime and social disruption.

The full extent of harm to New Zealanders resulting from gambling is currently unknown. Some indication is provided by the 5767 people presenting for help at specialist treatment agencies such as the Compulsive Gambling Society, the Problem Gambling Helpline and the Oasis Centre during 1999 (Problem Gambling Committee, 2000), the high level of suicide attempts among problem gamblers (Sullivan et al, 1994) and the 24% of people in prison who have gambling problems (Brown et al, 2000).

Responsible gambling

Responsible gambling occurs in a regulated environment where the potential for harm associated with gambling is minimised and people make informed decisions about their participation in gambling.

Responsible gambling occurs as a result of the collective actions and shared ownership by individuals, communities, the gambling industry and Government, to achieve outcomes that are socially responsible and responsive to community concerns.

The proposed **National Policy on Responsible Gambling** recognises a continuum of harm associated with gambling. No single approach can adequately address the range of harm. The proposed policy accommodates complementary approaches, targeting the range of gambling and continuum of harm. The policy aims to prevent harm from occurring through measures that on one hand control the availability of gambling and on the other reduce individual demand for gambling. These supply control and demand reduction measures complement more traditional problem limitation approaches wherein treatment and counselling are provided for those persons experiencing gambling problems.

In outlining this Policy on Responsible Gambling for Government our aim is not to prevent gambling, nor to reduce the enjoyment experienced by those who gamble responsibly but rather to minimise the harm that is associated with problem gambling, and thereby to set the scene for a level of gambling in New Zealand that is both economically and socially sustainable.

Vision

Our vision is of a society that is healthy, well adjusted, informed, and chooses to gamble responsibly in a way that is sustainable for the community. Gambling blends into the social and cultural context of society at levels that are safe for the individual, their family and the community.

For the vision to be realised it is necessary that:

- Government develops a coherent responsible gambling policy that defines the role of gambling and recognises and addresses adequately the issue of harm arising from problem gambling.
- Gambling providers promote responsible gambling practices, which minimise the harm to problem gamblers, their families and the community.
- The public and gambling consumers are well informed about the risks of problem gambling.
- Communities have input through their local authority into local gambling provision and into distribution of community benefit funds.

It is our belief that our vision of responsible, sustainable gambling can be achieved through appropriate harm minimisation, health promotion and rehabilitation strategies. Together these strategies will regulate the supply, moderate consumer demand, and limit problems associated with gambling.

Principles for policy development

Development of any social policy must be underpinned by a number of important principles relating to social justice and effectiveness.

Development of the responsible gambling policy is underpinned by policy principles of cultural appropriateness, effectiveness and efficiency in reducing harm, empowerment that enables people and communities to assume control and behave responsibly, and equity in addressing disproportionate levels of harm among vulnerable groups. Further, in accord with the principles underlying the Treaty of Waitangi it is proposed that Maori be encouraged to identify their own needs and determine appropriate and effective approaches for reducing the disproportionate harm experienced by Maori.

Policy objectives

Identifying national objectives helps to provide a focus for co-ordinating a range of different strategies, programmes and activities to achieve the overall goal of the policy on responsible gambling.

The objectives proposed for the first five years of the national policy on responsible gambling are:

1. To enable New Zealanders to increase control over and improve their well being by limiting the harms and hazards associated with gambling.
2. To reduce the prevalence of problem and pathological gambling.
3. To reduce the health risks, crime and economic and social disruption associated with excessive gambling by promoting responsible gambling.

Outcomes and indicators

The proposed policy on responsible gambling aims to provide a basis for making measurable progress toward achieving the priority policy objectives. For each priority, a set of desired outcomes has been defined.

Measurable progress towards these desired outcomes would indicate that the priority is being achieved. In some cases there are existing indicators to show whether the strategies being implemented and resources being deployed have made a difference. In other cases, the first step will be to develop indicators and capture baseline data. Targets will be set so that progress towards each outcome can be assessed. It is proposed that each relevant government agency will be responsible for including such performance indicators in their detailed implementation plans.

Future directions

Any proposed policy, which extends over five years, must have the capacity to be flexible over time. Strategies that work towards achieving the desired outcomes of

the National Policy on Responsible Gambling will thus be adjusted as necessary, and as further information becomes available. These strategies will be cost-effective and should be consistent with the Government's overall strategic goals of "*building a better society by promoting opportunity for all*," (Hon. Steve Maharey, December 2000) and increasing "*social equity*" (Hon. Helen Clark, February, 2001) while taking account of the fiscal constraints under which it is operating.

Strategies

We recognise that there is a continuum of harm associated with gambling, and that no single approach or limited set of strategies can adequately address the possible range of harms. Strategies need to take account of the three interacting components of gamblers, the gambling product and the gambling environment. Different strategies are required to target different population groups, different gambling products and different gambling environments.

The National Policy on Responsible Gambling seeks to minimise the harmful effects of gambling by using a balance of supply control, demand reduction and problem limitation strategies.

- Supply control strategies prevent gambling-related harm by placing restrictions on the availability of gambling and controlling the manner and environment in which gambling occurs.
- Demand reduction strategies are designed to prevent harm by moderating demand and ensuring that those who gamble do so responsibly.
- Traditionally, problem limitation strategies mean providing ready access to effective assessment and treatment services. Even with supply control and demand reduction strategies in place, some people will still require help for problems with their gambling.

Government ownership of policy

We believe that Government carries the primary responsibility for development and implementation of a responsible gambling policy, for two reasons:

- First, ultimately any social policy response is shaped by an enabling and controlling legislative framework and only government can establish this framework
- Secondly, Government has a responsibility to protect and act in the best interests of its citizens, hence it is appropriate that Government take the initiative in establishing the Social Policy Response framework and for ensuring its implementation

There are a number of critical requirements of Government that must be fulfilled as necessary prerequisites to implementing policy to encourage responsible gambling, ensure harm minimisation and establish a sustainable level of gambling:

- Government must lead with policy and legislation
- Gambling policy must accord with Government strategic objectives
- Government must establish an independent regulatory agency
- Government must require online monitoring of machines
- Government must provide for review of policy implementation
- Government must sponsor relevant research and evaluation

Specific recommendations

A more extensive series of recommendations to minimise harm and facilitate responsible gambling as part of the development of the National Policy on Responsible Gambling is presented following this summary.

RECOMMENDATIONS

Our long-term vision is of a society that is healthy, well adjusted, informed, and chooses to gamble responsibly in a way that is sustainable for the community. Gambling blends into the social and cultural context of society at levels that are safe for the individual, their family and the community.

Development of a well-defined National Policy on Responsible Gambling within a comprehensive regulatory framework will enable Government to manage gambling in a sustainable manner, to minimize the harm from problem gambling, and to promote responsible gambling among New Zealand communities.

It is our belief that our vision of responsible, sustainable gambling can be achieved through a balanced combination of treatment, harm minimisation and health promotion strategies. Together these will regulate the supply, moderate consumer demand, and limit the problems associated with gambling.

In order to attain the vision it is recommended that:

1. Government places a freeze on any further expansion of gambling until we have satisfactory policy and appropriate legislation in place. This means an indefinite moratorium on any further gambling products, including casinos, additional gambling machines and any new forms of gambling, including Internet and interactive television gambling.
2. Government commissions appropriate studies that validly measure the social and economic impacts of gambling and problem gambling. We determine what is a sustainable level of gambling in New Zealand.
3. Government commissions investigation of legislative and policy “*best practice*” models for responsible and sustainable gambling in Australia, North America, Britain and Europe.
4. Government develops a responsible gambling policy (incorporating treatment, harm minimisation and health promotion) that will result in responsible gambling that is sustainable for New Zealand. This approach will provide:
 - Treatment and rehabilitation based upon “*best practice*” for people already experiencing gambling problems
 - Harm minimisation protection measures for those groups who are vulnerable or at immediate risk of developing gambling problems
 - Health promotion initiatives that contribute to healthy communities and development of responsible gambling appropriate for each community.
5. Government develops legislation and regulations covering all forms of gambling within an all-encompassing framework designed to encourage responsible gambling in all modes and venues where gambling occurs.

6. Government establishes an independent Gambling Commission to oversee regulation across all gambling modes with principal operating criteria of consumer protection and the public interest.¹
7. Government co-ordinates inter-sectorial strategies across a range of government departments, gambling providers and treatment service providers, local authority and community groups. Foremost among government departments to be involved in developing initiatives will be:
 - Health
 - Internal Affairs
 - Social Services
 - Corrections
 - Consumer Affairs
 - Education
 - Gambling Commission (to be established)
8. Government establishes on-line monitoring of gaming machines to ensure proceeds are channelled into legitimate community and government bodies as specified in legislation.
9. Government provides for monitoring and periodic review of responsible gambling policy implementation and its effectiveness.
10. Government sponsors research and evaluation program relevant to problem gambling and responsible gambling policy.
11. Government imposes an additional tax on the gambling industry to cover all costs of addressing harm from gambling
12. A duty of care to consumers on the part of gambling providers is enshrined in statute.
13. All gambling providers are required to implement host responsibility and problem gambling prevention practices, which minimise the harm to problem gamblers and their families/whanau.
14. Gaming venues are re-designed to be safer for gamblers, with for example, clocks and natural lighting to denote passage of time and prohibition of ATMs, cheques cashing, or credit facilities.
15. Gaming products are modified to be safer for gambler, with for example, gaming machines having a limitation on rate of loss with prohibition of bill acceptors, linked jackpots and large cash payouts.
16. Readily understandable product information explaining how the game works, the odds of winning, and the cost of playing are displayed clearly on all gaming products.

¹ The increasing importance of gambling in New Zealand may justify the appointment of a “*Minister of Gaming*” with responsibility for all aspects of gambling in New Zealand.

17. The legislative code ensures that advertising and promotion of gambling is neither misleading nor exploitative. All advertising contains a warning about the risk of harm from gambling.
18. The public and gambling consumers are well informed about true costs of gambling and the risks of problem gambling through government-sponsored, population-based public health information campaigns, targeted awareness programs for high-risk groups, and educational programs.
19. Public and consumers are encouraged to have input into decisions about local gambling provision and into distribution of community benefit funds through public consultation, surveys and local authority input.
20. Local communities are empowered in making decisions about the extent and nature of gambling to be made available.
21. Local communities are empowered in determining how and where profits from gambling in their community are applied to community causes.
22. Nationwide high quality treatment services are available for problem gamblers and their families at no charge.
23. Gambling issues are integrated into health and social policies and their related services.

INTRODUCTION

New Zealand has a proud tradition of being in the forefront of nations that take positive action to protect and improve both the physical health and the mental wellbeing of its citizens.

As early as 1994, Government had released its National Mental Health Strategy. As part of this strategy Government published a National Drug Policy in 1998. The document set out clearly its policy for improving the health and wellbeing of all New Zealanders by minimising harm caused by tobacco, alcohol and other illicit drugs to both individuals and the community.

The National Drug Policy emphasised the need for a coordinated approach that includes appropriate legislation and enforcement to control the supply of drugs, credible information about drug-related harm to reduce the demand for drugs, and effective intervention services to manage drug problems that still occur.

This inter-sectorial policy relies upon the efforts of different government and non-government agencies. It is in line with the *balanced* approach recommended by the United Nations and World Health Organization. The policy recognises the need for communities to be able to address drug-related issues at a local level and provides for a partnership between Government and community in minimising drug-related harm.

The role of Government is to encourage and support community involvement by providing leadership, information and resources within the appropriate legislative environment, and by ensuring that both community and governments efforts remain focused on a common goal and set of priorities.

This submission to Government seeks to follow in this proud tradition of protecting New Zealanders' wellbeing by proposing a national policy to minimise harm from gambling.

This policy is designed to minimise harm and retain the benefits of gambling by promoting responsible gambling at a level that is economically and socially sustainable for individuals, communities, and New Zealand.

RESPONSIBLE GAMBLING

Responsible gambling occurs in a regulated environment where the potential for harm associated with gambling is minimised and people make informed decisions about their participation in gambling.

Responsible gambling occurs as a result of the collective actions and shared ownership by individuals, communities, the gambling industry and Government, to achieve outcomes that are socially responsible and responsive to community concerns.

Problem gambling exists when gambling activity results in a range of adverse consequences where:

- the safety and well-being of gambling customers and /or their families and friends are placed at risk; and
- negative impacts extend to the broader community.

The proposed **National Policy on Responsible Gambling** recognises a continuum of harm associated with gambling. No single approach can adequately address the range of harm. The proposed policy accommodates complementary approaches, targeting the range of gambling and continuum of harm. The policy aims to prevent harm from occurring through measures that on one hand control the availability of gambling and on the other reduce individual demand for gambling. These supply control and demand reduction measures complement more traditional problem limitation approaches wherein treatment and counselling are provided for those persons experiencing gambling problems.

The format and structure of the responsible gambling policy relies heavily on that developed for the National Drug Policy (1998). However in addition it incorporates a strong health promotion component that is made explicit in Professor Raeburn's paper. The overall aim of the policy is to minimise gambling-related harm and develop responsible gambling to such an extent that gambling is maintained at a sustainable level.

From the gambling provider perspective, we are convinced that for New Zealand to retain a viable and sustainable gambling industry in the long-term, Government must develop a coherent responsible gambling policy that defines the role of gambling and recognises and addresses adequately the issue of harm arising from problem gambling.

Ownership of the Responsible Gambling Policy by the Health and Social Policy Cabinet Committee will provide the "*whole of government*" approach necessary to ensure its effectiveness. In these circumstances, we believe that the Prime Minister's Department best undertakes the day-by-day direction and monitoring of the policy.

VISION

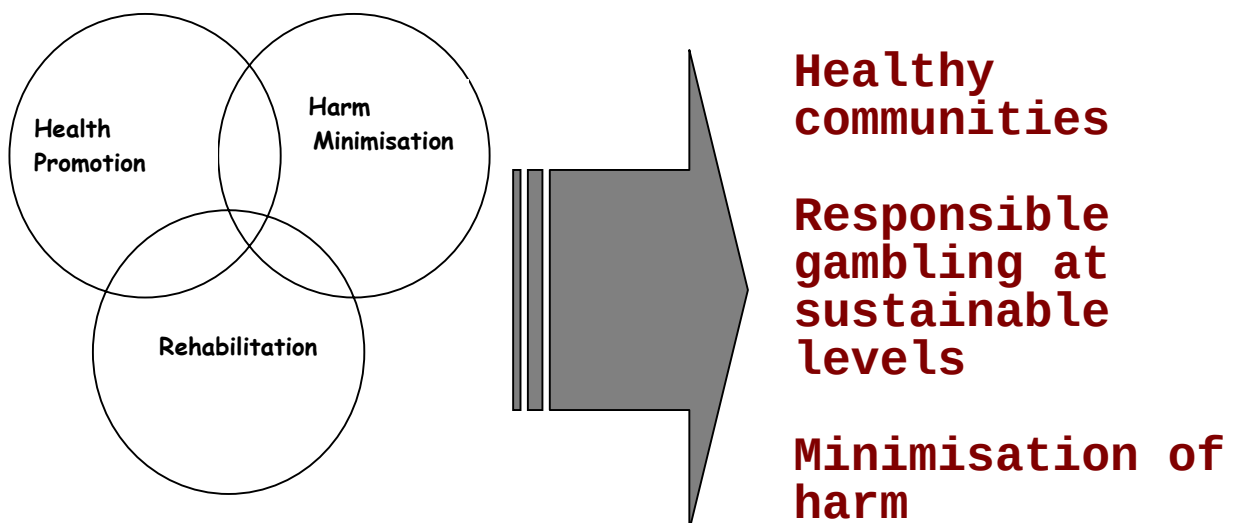
Our vision is of a society that is healthy, well adjusted, informed, and chooses to gamble responsibly in a way that is sustainable for the community.

Gambling blends into the social and cultural context of society at levels that are safe for the individual, their family and the community.

For the vision to be realised it is necessary that:

- Government develops a coherent responsible gambling policy that defines the role of gambling and recognises and addresses adequately the issue of harm arising from problem gambling.
- Gambling providers promote responsible gambling practices, which minimise the harm to problem gamblers, their families and the community.
- The public and gambling consumers are well informed about the risks of problem gambling.
- Communities have input through their local authority into local gambling provision and into distribution of community benefit funds (eg as in Hillary Commission or Creative Community Boards).

It is our belief that our vision of responsible, sustainable gambling can be achieved through appropriate harm minimisation, health promotion and rehabilitation strategies. Together these strategies will regulate the supply, moderate consumer demand, and limit problems associated with gambling.



HARM FROM GAMBLING

In some form or other, gambling is engaged in by more than 90% of the adult population in New Zealand. When engaged in responsibly in non-hazardous situations, gambling provides enjoyment and entertainment for many consumers. As with other potentially addictive products (eg alcohol, drugs) major harms can arise from problem gambling resulting in costs that are borne by problem gamblers, their families and the wider community.

Harm that results from gambling includes harm to health, as well as crime and social disruption.

- **Harm to health:** Problem gamblers pose serious risks to their own health, through alcohol or drug abuse associated with their gambling, depression and even suicide. Injury from accidents and physical illness resulting from poor health care is common among those with serious gambling problems, and even malnutrition may occur among problem gamblers and their dependents, as a consequence of gambling losses.
- **Crime:** Crime is associated with problem gambling and this is reflected in the significant proportion of sentenced prisoners reporting histories of problem gambling. Problem gamblers frequently commit crimes to support their gambling habits. These crimes, ranging from theft to murder, harm other members of the community, and impose costs on the community for police, prosecution and corrections costs.
- **Social disruption:** Gambling problems affect the life of the family and the community in which the individual lives, as well as the gambler *per se*. Excessive gambling leads to reduced social functioning at home, with dysfunctional behaviour affecting the behaviour of other members of the family at school, at work, and in the community generally.

The full extent of harm to New Zealanders resulting from gambling is currently unknown. Some indication is provided by the 5767 people presenting for help at specialist treatment agencies such as the Compulsive Gambling Society, the Problem Gambling Helpline and the Oasis Centre during 1999 (Problem Gambling Committee, 2000), the high level of suicide attempts among problem gamblers (Sullivan et al, 1994) and the 24% of people in prison who have gambling problems (Brown et al, 2000).

In outlining this Policy on Responsible Gambling for Government our aim is not to prevent gambling, nor to reduce the enjoyment experienced by those who gamble responsibly but rather to minimise the harm that is associated with problem gambling, and thereby to set the scene for a level of gambling in New Zealand that is both economically and socially sustainable.

PRINCIPLES FOR POLICY DEVELOPMENT

Development of any social policy must be underpinned by a number of important principles relating to social justice and effectiveness.

Development of the responsible gambling policy is underpinned by policy principles of cultural appropriateness, effectiveness and efficiency in reducing harm, empowerment that enables people and communities to assume control and behave responsibly, and equity in addressing disproportionate levels of harm among vulnerable groups. Further, in accord with the principles underlying the Treaty of Waitangi it is proposed that Maori be encouraged to identify their own needs and determine appropriate and effective approaches for reducing the disproportionate harm experienced by Maori.

Appropriateness

Appropriateness means developing strategies that are consistent with people's culture, values and behaviour. Thus it is important to develop strategies that are consistent with Maori norms, values and beliefs and recognise Maori realities. In the case of Maori this requirement is enshrined in the Treaty. Likewise, although no comparable treaty rights exist, it is appropriate that strategies consistent with their culture are developed for Pacific and Asian people.

Effectiveness

Effectiveness is achieved by employing strategies believed most likely to reduce harm associated with gambling. Effective strategies are those that are targeted, employ evidence-based practice, and have been soundly evaluated. Effectiveness may mean using alternative strategies to produce a reduction in gambling-related harm to non-mainstream groups, such as Maori, Pacific and Asian peoples.

Efficiency

Efficiency recognises that resources are limited and that choices have to be made, based upon careful examination of costs and benefits. Thus the national priorities selected reflect evidence of where the most costly areas of harm can be effectively reduced with available resources.

Where research or evidence about the most cost effective strategies, or even the extent of harm is lacking, the policy recommends further research or evaluation programmes before policy decisions are made.

Empowerment

Empowerment involves resourcing people in a way that enables them to assume greater control over their health and wellbeing. Empowering people enables them to behave more responsibly in their consumption and control of gambling. Often providing relevant information about gambling and its consequences will enable

people to behave more responsibly. Generally, to be empowering, those at whom the strategies are targeted must have some input into their design.

Equity

Equity means fairness. Equity may mean giving priority to reducing the disproportionate levels of gambling-related harm in particular groups and communities (eg those at risk of suicide if they can be identified and those in populations with a high incidence of problem gambling, such as Maori and Pacific people). This may mean allocating resources so that services are readily accessible to everyone in need while directing more resources to areas of greatest need so that no one group suffers a disproportionate amount of gambling-related harm

Sustainable level of gambling

To achieve a sustainable level of gambling requires that the contingent economic and social benefits are not exceeded by the harm and costs arising from gambling.

The Australian Productivity Commission (2000) identified that the net production-side benefits of gambling are relatively small when account is taken of substitution effects and the alternatives available for gambling spending. Benefits in terms of employment and activity in the gambling industries are largely offset by declines in industries that lose consumer dollars to gambling.

The major benefit lies in the enjoyment that consumers derive from gambling and this in turn must be offset against the costs associated with problem gambling. The Commission found that problem gamblers comprise 15% of regular (non-lottery) gamblers and account for approximately one-third of gambling expenditure. The costs associated with problem gambling include the negative health, financial and emotional impacts on gamblers and others, with at least five other people negatively affected by each problem gambler.

As with the consumption of other harmful products such as tobacco, the costs and negative social consequences of gambling tend to develop slowly over time, in contrast to immediately available benefits such as consumer enjoyment. Policy approaches for gambling need to be directed at reducing the extent and costs of gambling problems, through harm minimisation and prevention measures, while retaining as much of the benefit to recreational gamblers as possible.

Treaty of Waitangi principles

Under the Treaty, Government has a particular responsibility to address the health needs of Maori. This principle establishes that Maori should have the opportunity to enjoy at least the same level of health as non-Maori.

Maori are known to be suffering disproportionate harm from gambling and strategies designed for the general population have to date had limited success in reducing harm among Maori. Gambling harm in Maori communities may be addressed more effectively when targeted approaches are developed by and for Maori. This is because of the need for in-depth knowledge of the Maori community, and of

acceptable and effective approaches to use when advocating changes in behaviour and lifestyle.

It is important therefore to include specific desired outcomes for Maori within the National Policy on Responsible Gambling and to have Maori identify their own needs, and the most appropriate and effective interventions to reduce harm

Harm prevention and harm reduction strategies

Harm minimisation allows for different approaches to be used. An effective national policy must do two things:

- Prevent harm from occurring, by preventing harmful use of gambling.
- Reduce harm that is already occurring.

Health promotion programmes that encourage people to gamble responsibly or not gamble at all are examples of harm prevention. Treatment services for existing problem gamblers are designed to reduce harm. Host responsibility codes that assist people gamble responsibly and refer gamblers experiencing problems to treatment agencies incorporate both prevention and reduction strategies as means for minimising harm from gambling.

Working together and whole of government approach

Responding effectively to gambling-related harm requires a co-ordinated approach involving a range of participants.² The primary “*players*” who must each act responsibly for a national policy on responsible gambling to be effective are the Government, the regulatory agency, members of the gambling industry, communities and individual gambling consumers. Empowerment of communities and consumers to enable them to act responsibly is dependent upon responsible action by government, regulator and industry. Government in particular, has a responsibility for the effectiveness and ultimate success of the policy. It must frame the policy legislation, ensure the participation of the other players and make certain the policy is developed and implemented across all government departments rather than as a piecemeal exercise occurring within those few agencies that choose to participate.

In addition to legislators and regulators, workers in government and non-government agencies, in the gambling and related industries, together with communities and cultural groups must cooperate in developing, implementing and monitoring effective strategies if we are to minimise harm and establish responsible gambling at a level that is economically and socially sustainable for New Zealand.

² See Meirs (1998) “*Responsible gambling is a game for 4 or more players*”

POLICY OBJECTIVES

Identifying national objectives helps to provide a focus for co-ordinating a range of different strategies, programmes and activities to achieve the overall goal of the policy on responsible gambling.

The objectives proposed for the first five years of the national policy on responsible gambling are:

- | | |
|------------------------------|--|
| Priority objective 1: | To enable New Zealanders to increase control over and improve their wellbeing by limiting the harms and hazards associated with gambling. |
| Priority objective 2: | To reduce the prevalence of problem and pathological gambling. ³ |
| Priority objective 3: | To reduce the health risks, crime and economic and social disruption associated with excessive gambling by promoting responsible gambling. |

Priority objective 1

To enable New Zealanders to increase control over and improve their wellbeing by limiting the harms and hazards associated with gambling.

Desired outcomes are:

- Acceptance by government agency staff of harm minimisation as an effective approach to reducing gambling-related harm; and ongoing co-operation and collaboration among agencies involved in gambling issues.
- Increased involvement of the community, and particular subgroups in the community in reducing gambling-related harm.
- More effective school policies and education in the school setting about gambling-related harm and responsible gambling.
- Reduction in loss of productivity in the workplace linked to gambling.
- Improved range, quality and accessibility of effective treatment options for people with gambling problems and their significant others.
- Improved expertise of workers in the problem gambling field.

³ Use of the term problem gamblers includes those who are classified as pathological gamblers

Priority objective 2

To reduce the prevalence of problem and pathological gambling.

Desired outcomes are:

- Reduction in the prevalence of problem gambling in the general population as measured by presentation rates.
- Reduction in the prevalence of problem gambling among young people as measured by presentation rates.
- Reduction in the prevalence of problem gambling among Maori as measured by presentation rates.
- Reduction in the prevalence of problem gambling among ethnic minorities as measured by presentation rates.

Priority objective 3

To reduce the health risks, crime and economic and social disruption associated with excessive gambling by increasing responsible gambling.

Desired outcomes are:

- Increase in the proportion of the population who gamble responsibly or do not gamble.
- Reduction in the prevalence of problem gamblers among those committing or attempting suicide.
- Reduction in the prevalence of problem gamblers among those presenting with drug or alcohol problems.
- Reduction in the prevalence of problem gamblers among those presenting with other mental health problems.
- Reduction in the prevalence of problem gamblers among those convicted of criminal offences.
- Reduction in the number of job losses and bankruptcies that involve problem gambling.
- Reduction in the prevalence of family break-ups involving problem gamblers.

Outcomes and indicators

The proposed policy on responsible gambling aims to provide a basis for making measurable progress toward achieving the priority policy objectives. For each priority, a set of desired outcomes has been listed.

Measurable progress towards these desired outcomes would indicate that the priority is being achieved. In some cases there are existing indicators to show whether the strategies being implemented and resources being deployed have made a difference. In other cases, the first step will be to develop indicators and capture baseline data. Targets will be set so that progress towards each outcome can be assessed. It is proposed that each relevant government agency will be responsible for including such performance indicators in their detailed implementation plans.

Future directions

Any proposed policy, which extends over five years, must have the capacity to be flexible over time. Strategies that work towards achieving the desired outcomes of the National Policy on Responsible Gambling will thus be adjusted as necessary, and as further information becomes available. These strategies will be cost-effective and should be consistent with the Government's overall strategic goal of *"building a better society by promoting opportunity for all,"* (Hon. Steve Maharey, December 2000) and increasing *"social equity"* (Hon. Helen Clark, February, 2001) while taking account of the fiscal constraints under which it is operating.

STRATEGIES

We recognise that there is a continuum of harm associated with gambling, and that no single approach or limited set of strategies can adequately address the possible range of harms. Strategies need to take account of the three interacting components of gamblers, the gambling product and the gambling environment. Different strategies are required to target different population groups, different gambling products and different gambling environments.

The National Policy on Responsible Gambling seeks to minimise the harmful effects of gambling by using a balance of supply control, demand reduction and problem limitation strategies.

Harm minimisation strategies need to take account of three interacting components of:

- Characteristics of gamblers (for example, age, gender, and ethnicity).
- Environments in which gambling occurs (for example, physical, social, and economic context).
- Characteristics of the gambling product (for example, its availability, continuous or discontinuous nature, its “*addiction*” potential).

Clearly, different strategies are needed to target:

- The whole population, or particular at-risk groups.
- All gambling, or specific gambling products such as gaming machines or Internet gambling.
- All settings, or particular environments where misuse occurs.

In the harm minimisation approach, strategies are required to operate in the three different areas of:

- Supply control (regulating the supply of gambling).
- Demand reduction (moderating individual demand for gambling).
- Problem limitation (limiting problems arising from consumption).

SUPPLY CONTROL STRATEGIES

Supply control strategies prevent gambling-related harm by placing restrictions on the availability of gambling and controlling the manner and environment in which gambling occurs.

Restricting or prohibiting a potentially harmful product is often seen as the most obvious way of preventing harm. However, attempts to prohibit alcohol and use of illicit drugs have shown that supply control strategies may not be effective if used without accompanying demand reduction and problem limitation strategies.

Policy and legislative development

Regulatory intervention is a powerful tool for setting a framework and for controlling the environment within which gambling occurs

For example, legislation can control the supply of gambling by prohibiting it altogether, or prohibiting it for some people (for example, those under a certain age) or for some people in some environments (for example, those with a criminal record on racecourses). Legislation can also be used in a more sophisticated way to protect the consumer than by blanket prohibitions as, for example, in the primary objective of the Sale of Liquor Act 1989 being expressed as:

“...to establish a reasonable system of control over the sale and supply of liquor to the public with the aim of contributing to the reduction of liquor abuse, so far as this can be achieved by legislative means.”

It is important to review the legislative framework for any policy from time to time, to ensure that it is working as intended and to identify amendments that could improve it. This is especially the case in the gambling area where currently the legislation is unsatisfactory and ineffective.

As the Minister of Internal Affairs noted in releasing terms of reference for the review of gaming and gambling (5 November 2000)

“Existing gaming legislation has grown over the years on a piecemeal basis as new objectives and gaming activities have been recognised. As a result there are inconsistencies, both within specific statutes and between them”

“The gaming sector currently operates under a disparate regulatory structure. This structure has grown in an ad hoc fashion, in response to concerns arising at different times and in different parts of the gambling industry. There is little consistency between the different statutes which regulate the different sectors of gaming, and a variety of different bodies exercise regulatory and administrative functions, each with a different focus and different objectives. Moreover, different sectors of the industry are treated differently for tax purposes and make different contributions to the community.”

“As a result (of this and other factors of Government ownership and technological advances), there is a need to establish a clear view of the role of gaming in society and the role of the Government in regulating it.”

This submission is a part of the whole policy development process designed to establish a more relevant and more effective legislative framework and national policy aimed at developing a culture of responsible gambling which minimises harm and is conducive to maintaining a sustainable level of gambling in New Zealand. As the primary player with both ownership and other interests in gambling (eg, Lotteries Commission, Lottery Grants Board and Casino Control Authority) Government has a responsibility to ascertain how New Zealanders want gaming activities to be run and to ensure that new legislation meets those expectations (Minister of Internal Affairs, Gaming Review Terms of Reference, 5 November 2000)

Enforcement

Enforcement is an important part of the overall policy. Currently there are a number of different agencies, including the Department of Internal Affairs (DIA), Lotteries Commission, Racing Industry Board and Casino Control Authority, each of which has responsibility for administering or enforcing different pieces of gambling legislation. As the Minister of Internal Affairs has pointed out, there is little consistency among the different statutes that regulate the different sectors as administered and regulated by these agencies. The ineffectiveness of current enforcement procedures that confuse regulatory and enforcement responsibilities, for example in the case of the DIA its ineffectiveness in regulating and enforcing non-casino gaming machine operators, has been highlighted by:

- A lack of information about the ownership, location and operation of gaming machines outside of casinos
- A lack of electronic online monitoring of the operation and cash flows of gaming machines
- A lack of control and enforcement for non-compliance by gaming machine operators by the DIA evidenced by the approximately 79% of gaming machine operators found to be in breach of existing regulations (DIA report, November 2000).

It is proposed that New Zealand adopt the regulatory model described by the Australian Productivity Commission in its report last year (APC, 2000). This model presents a coherent regulatory structure that displays consistency across gambling sectors and provides for clear separation of policy-making, control and enforcement functions.

DEMAND REDUCTION STRATEGIES

Demand reduction strategies are designed to prevent harm by moderating demand and ensuring that those who gamble do so responsibly.

These strategies include the provision of accurate information on the hazards and harms of gambling, and education programmes to encourage moderate and responsible consumption. Demand reduction strategies may also include initiatives to encourage responsible promotion and advertising of gambling, monitoring of new marketing strategies, and tax and pricing adjustments designed to moderate demand for the product

Consumer Information

People need reliable information to develop the knowledge and skills they require for making responsible decisions about their use of gambling. They need to know for example, the consequences of excessive gambling upon their health and well being, to what extent it will affect their relationships with significant others in their life, and what safeguards they can employ to ensure they can gamble safely under varying circumstances.

Health Promotion

Health promotion strategies cover a wide variety of interventions designed to facilitate change and improve the health and well being of the whole community and particular groups within it.

In the broadest sense health promotion strategies may include changes to pricing policy, tax rates, legislation, advertising and marketing of products, building of supportive and healthy environments, developing healthy public policy, community development, social marketing and education. Indeed any approach that encourages communities and individuals to improve their well being and responsible use of gambling might be included within a health promotion initiative.

Effective health promotion strategies usually include a combination of interventions from several of the areas described, introduced and implemented in an integrated manner, in order to achieve the desired goals.

Increasingly, health promotion is being initiated by and will be responsive to the needs of local communities and specific cultural and interest groups. To be effective health promotion strategies must be consistent with people's cultures, realities and behaviours, and those for whom the strategies are designed must have some input into their design. The *Ottawa Charter for Health Promotion* (1986) recognises strengthening community action as a major contributor to achieving *equity*. Different groups will address gambling related-harm differently, and will identify different priorities for action.

Effective health promotion will increase the resilience of the community in that individuals within the community behave more responsibly in respect of gambling and can better resist or avoid the potential hazards of problem gambling. Ultimately, effective health promotion may reduce the potential harm from gambling to a level that obviates the need for more traditional harm minimisation measures.

Within the responsible gambling policy arena, health promotion initiatives in the next five years will likely include, for example:

- Inclusion of hazard warnings and information on gambling products such as gaming machines.
- Mass media education campaigns, including:
 - Information about hazards and harms of gambling.
 - Information about responsible gambling campaign.
 - Self-identification of problem gambling campaign.
 - Information about intervention and helping agencies available for problem gamblers and significant others.
- Health promotion in schools which more closely meets the need of particular school communities.
- Targeted health promotion for at-risk and special interest groups such as:
 - Maori.
 - Pacific peoples.
 - Asian peoples.
 - Prison inmates.
 - Young people.
 - Older people.
- Provision of host responsibility training for operators and people working in gambling venues.
- Community development projects focused on preventing or minimising gambling-related harm.
- Provision of training opportunities for health promotion workers.

Responsible marketing

Unlike other entertainment (eg films) that it is often compared with, gambling has the capacity to cause consumers considerable harm. For this reason it is important that gambling is marketed responsibly and with an appreciation of its harm potential.

Promotion and marketing of gambling is generally designed to attract new consumers or to maintain or increase the frequency of gambling by existing consumers. Particular concern must be aroused by promotions that target vulnerable groups, such as young people and others who have had little opportunity to develop realistic expectations of the likelihood of their winning or losing. Of concern also are promotions that target high-risk groups, such as those who are already heavy gamblers or those who drink heavily when they gamble.

Persuasive advertising may present misleading information or set unrealistic expectations in naïve consumers who are relatively unaware of the potential costs and harm that may result from their engaging in uncontrolled gambling.

The presence of effective point of sale promotions, such as loyalty schemes and inducements to gamble, along with the ready availability of cash or credit through

conveniently located ATMs add to the risk of gambling more than planned for both inexperienced and regular gamblers.

The Australian Productivity Commission (2000) reported that problem gamblers account for around one-third of total gambling expenditure. This has important policy implications because responsible gambling providers face mixed incentives for marketing to problem gamblers. Those providers who try to limit their marketing so as to minimise harm (eg to problem gamblers) may lose revenue as well as losing market share relative to those providers who engage in less responsible promotion and marketing. This issue may necessitate external regulation to ensure that consumers are protected from misleading advertising and harmful promotions.

Taxation and pricing

Pricing has been shown to be an important influence on consumption patterns of other potentially harmful products such as alcohol. Other things being equal, a rise in price tends to lead to a drop in consumption. Hence price and taxation may have the potential to moderate the extent of consumption by individual consumers and thereby reduce harm from gambling. Currently consumers are poorly informed about the cost of gambling in terms, for example, of the likelihood of their winning or the hourly rate of expenditure required to play gaming machines.

Higher gambling prices (and taxes) along with clear allocation of costs and meaningful pricing schedules for each form of gambling would reduce demand and harm from gambling.

A secondary benefit from increasing excise tax on gambling is that the tax revenue can be applied to offset some of the costs of harm from gambling.

PROBLEM LIMITATION STRATEGIES

The concept of problem limitation acknowledges that gambling is increasingly a part of many people's lives and that strategies are needed to reduce problems that can result from its misuse.

Traditionally, problem limitation strategies mean providing ready access to effective assessment and treatment services. Even with supply control and demand reduction strategies in place, some people will still require help for problems with their gambling.

In its wider sense, problem limitation may overlap with demand reduction strategies in encouraging those promoting and providing gambling products to do so responsibly, for example through introduction of host responsibility programs and safer gambling products. It also means ensuring that gambling environments, especially those known to be linked with gambling-related harm, are made as safe as possible.

Assessment, advice and treatment

Treatment interventions are vital to limit the problems arising from gambling. This policy on responsible gambling emphasises the need for a variety of treatment services.

The current focus tends to be on specialist assessment and treatment services purchased by the Problem Gambling Committee and provided by a limited number of non-governmental agencies, specifically the Compulsive Gambling Society (CGS) and the Salvation Army, together with the voluntary self-help group Gamblers Anonymous. A Gambling Problem Helpline offers callers information and a first point of contact for advice and referral to treatment agencies.

- There needs to be a greater emphasis on primary care, with the screening and diagnosis of gambling problems occurring at an earlier stage and more advice and assistance on promotion of healthier lifestyles and development of responsible gambling practices by primary healthcare professionals and other primary care workers who need to be trained in detection and early intervention.
- There may be a rationale for incorporating gambling assessment and treatment services into existing alcohol and drug treatment services. In this case existing specialist problem gambling agencies such as CGS could provide training, quality assurance and consultative services to these agencies, which could then offer integrated alcohol, drug and problem gambling intervention services. Alternatively, existing problem gambling treatment agencies such as CGS could offer alcohol and drug treatment services to complement their problem gambling services.
- Specialist treatment programmes need to be further developed and provided for target groups that are proving difficult to access and treat within existing mainstream problem gambling services. In the next five years, assessment, advice and treatment services will, *inter alia*, focus on, for example:
 - Young people
 - Maori

- Pacific peoples
- Asian peoples
- People with co-existing alcohol or drug problems
- People with co-existing mental health problems
- Justice system clients.

Development of specialist programmes in several of these areas is currently being investigated or already successfully underway, for example in the areas of services for young people and justice system clients and for Asian peoples respectively, through the efforts of management and staff at CGS.

There is also increasing need for:

- Advice and brief intervention by primary healthcare workers and other community workers especially for people with emerging gambling problems.
- Training for service providers with a focus on:
 - Training for primary health workers and community workers in brief assessment and intervention.
 - Training for mental health service workers in assessment and management of gambling problems.
 - Training for alcohol and drug specialist workers in assessment and management of gambling problems.
 - Training for community workers and school personnel in recognition of gambling-related problems, and how to manage and refer people at risk of harm.

Environment and product safety

To develop safer gambling environments requires that members of the gambling industry, as with promotion and marketing, act responsibly in their provision of gambling and in their design and operation of gambling products and the environments in which they provide gambling. This entails developing and promoting **host responsibility programs** that include, for example, the following:

- Providing meaningful information about gambling products to consumers, for example, about:
 - The cost of playing gaming machines.
 - The odds of winning.
 - How the game works.
 - The amount spent in the session to date and in the last hour.
- Serving alcohol with care and responsibility.
- Identifying and taking responsible action in respect of gamblers displaying problem behaviour, including:
 - Referring problem gamblers to helping agencies wherever appropriate.
 - Supporting and maintaining self-exclusion by problem gamblers.
 - Ensuring all staff are aware and trained in host responsibility.

- Providing clocks and windows in gambling environments to denote passage of time.
- Prohibiting ATMs, EFTPOS and cheque cashing or credit facilities in gambling venues.
- Modifying gaming machines to limit the rate of loss.
- Removing bill acceptors from gaming machines.
- Prohibiting linked jackpots.
- Making payouts of over \$250 by cheque.

GOVERNMENT OWNERSHIP OF POLICY

There are a number of critical requirements of Government that must be fulfilled as necessary prerequisites to implementing policy to encourage responsible gambling, ensure harm minimisation and establish a sustainable level of gambling

We believe that Government carries the primary responsibility for development and implementation of a responsible gambling policy, for two reasons:

- First, ultimately any social policy response is shaped by an enabling and controlling legislative framework and only government can set this framework and define the roles of the other players, including the role of the independent regulator.
- Secondly, Government has profited from and continues to profit from gambling. Yet Government has a responsibility to protect and act in the best interests of its citizens, hence it is appropriate that Government take the initiative in establishing the Social Policy Response framework and for ensuring its implementation. This is why we propose that implementation of the responsible gambling policy is undertaken as a whole of government initiative across all sectors and is monitored by the powerful Social Policy and Health Cabinet Committee that extends across all the relevant sectors.

Government must lead with policy and legislation

Government must legislate to ensure that a duty of care to consumers by providers is enshrined in statute. As a first stage it is essential that Government take this opportunity to introduce legislation establishing a stronger consumer protection-oriented regulatory environment in respect of gambling, as per the **Victorian Responsible Gambling Bill 2000** designed to develop responsible gambling by, for example:

- Freezing the number of gaming machines in New Zealand.
- Making provision for local councils to have a say in number and placement of machines in their area.
- Limiting numbers of 24 hour gaming venues.
- Compelling gaming operators to provide meaningful information to players.
- Imposing standards and limits on advertising.
- Establishing independent panel to oversee research into gambling matters.
- Increase independence of the regulatory control authority.

Or as per the **NSW Liquor Amendment (Responsible Gambling) Regulation 2000** that establishes a set of initiatives to foster responsible gambling, as follows:

- Requires hoteliers to provide information to patrons on:

- The use and operation of gaming machines.
 - The chances of winning and the problems caused from excessive gambling.
 - Availability of counselling services.
- Limits the cashing of cheques.
- Places limitations on the payment of prizes by cash.
- Requires cash dispensing facilities to be located away from gaming machine areas.
- Places limitations on gambling-related advertising.
- Prohibits the offering of inducements to gamble.
- Requires hoteliers and certain employees to undertake approved training in the responsible conduct of gambling (RGC).
- Specifies the minimum requirement for self-exclusion schemes.
- Makes other miscellaneous controls.

There are also recent Queensland and Canadian initiatives (circa 2000) to foster responsible gambling and thereby minimise harm and develop economically and socially sustainable gambling in their jurisdictions. Currently New Zealand lags far behind in enacting responsible gambling legislation and putting in place appropriate policies. We believe that this is what New Zealand should be aiming toward, with leadership and direction from Government through a coherent soundly-based social policy and establishment of an effective and transparent regulatory framework.

Policy must accord with Government strategic objectives

We emphasise that policy objectives and strategies must be consistent with Government's overall strategic objectives and accord with the fundamental principles underpinning these.

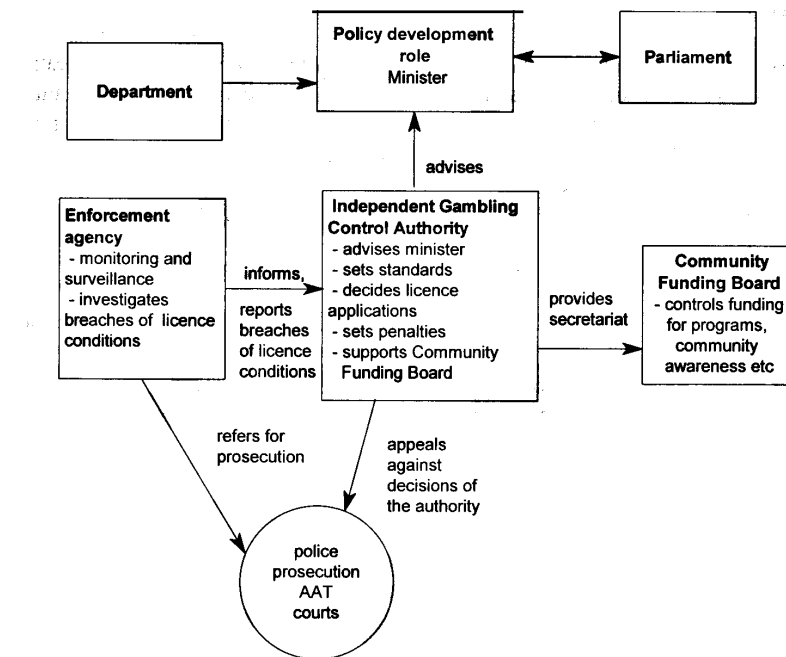
The Minister of Health has recently (21 December 2000) launched the New Zealand Health Strategy, which identifies seven fundamental principles and objectives designed to improve the overall health status of New Zealanders and reduce health inequalities of the population. Most pertinent here are the principles of:

- Good health and wellbeing for all New Zealanders throughout their lives.
- Collaborative health promotion and disease and injury prevention by all sectors.
- Active involvement of consumers and communities at all levels.

The Minister notes that, *"we must work across sectors, including health, education, housing and social welfare, in terms of health promotion and disease and injury prevention, if New Zealand is to become a healthier country."*

Government must establish independent regulatory agency

For the responsible gambling policy to be effective, Government must establish an independent regulatory agency, a Gambling Control Commission along the lines of the Australian Productivity Commission (2000) proposal with clear separation of policy-making, control and enforcement functions. This transparency and separation of functions will ensure a high standard of consumer protection within a regulatory process that is well informed, receptive to community input and fully aligned with the public interest.



Reproduced from Australian Productivity Commission document, 2000

Government must require online monitoring of machines

For effective enforcement of regulations, Government must ensure that there is online electronic monitoring of all gaming machines by the enforcement agency, whether the machines are in Casinos or in pubs or clubs throughout New Zealand:

- This will reduce the opportunity for misappropriation of community and government revenue by gaming machine operators and provide the basis for more effective enforcement of regulations in this area. Currently non-compliance may be as high as 79% (DIA report to Parliament, November, 2000).
- This will provide an essential up-to-date record of number, ownership and cash flow of all gaming machines in New Zealand. This information is critical to effective implementation of any harm minimisation policy and is, sadly lacking under present regulation.

Government must provide for review of policy implementation

Systems for collecting information needed to monitor and gauge the success of this policy have yet to be developed. Following collection of baseline information, implementation will be monitored through periodic review of progress within the priority areas in the following ways:

- Twice yearly review of progress by the Social Policy and Health Cabinet Committee which is chaired by the Minister for Social Services and includes the Ministers for Health, Economic Development, Finance, Local Government, Maori Affairs, Education, Justice, Corrections, Courts, Police, Pacific Island Affairs, Women's and Youth Affairs, and Consumer Affairs. This Cabinet Committee will decide which new policy initiatives should be recommended to the Government.
- A monitoring group, chaired by an official of the Prime Minister's Department and including representatives of the Ministries Finance, Economic Development, Education, Health, Justice, Local Government, Maori Affairs, Corrections, Courts, Police, Pacific Island Affairs, Women's and Youth Affairs, Consumer Affairs, the independent regulatory agency and the restructured Problem Gambling Committee will ensure that policies and programmes throughout Government, gambling industry, community and treatment agencies are consistent and mutually supportive. This monitoring group will receive reports from individual government agencies on progress made in implementing the policy, and will make recommendations to the Cabinet Committee on new policy initiatives. It will seek representations from other agencies and individuals, as it considers appropriate.
- Government agencies with responsibilities for policy initiatives in the harm minimisation and responsible gambling area will present six-monthly progress reports which outline progress within their areas of responsibility, provide an update of resources allocated to the area, and report on any other strategies or interventions developed to impact on the national priorities and desired outcomes.

Government must sponsor relevant research and evaluation

In the next five years, research and evaluation will include emphasis on, eg:

- Accurately assessing prevalence of problem gambling, particularly in at-risk groups as existing telephone survey estimates are considered to be unreliable.
- More accurately determining the exact extent of harm to individuals, families and communities arising from gambling in New Zealand (see Australian Productivity Commission Report, 2000).
- Assessing environmental and predisposing factors to problem gambling.
- Assessing impact of legislative change.
- Assessing impact of law enforcement interventions.

- Developing evaluation techniques and performance indicators for service providers.

This research and evaluation program must be sponsored by Government. It is proposed that a Professorial Chair and a Centre for Gambling Studies be established within the Discipline of Applied Behavioural Science at the University of Auckland School of Medicine and charged with the brief of undertaking and updating the research programme outlined here.

Specific recommendations

A more extensive series of recommendations to minimise harm and facilitate responsible gambling as part of the development of the National Policy on Responsible Gambling is presented following the conclusion.

CONCLUSION

This draft National Policy on Responsible Gambling represents an important first step in the co-ordination of gambling policies and strategies across many government agencies that share responsibilities in the gambling field. It is expected that each agency will implement and manage the policies and programmes within its area of responsibility, although in some cases this area of responsibility may require clearer definition. This policy aims to set an overall direction, providing a framework for this work, and for resource allocation and co-ordination among government agencies.

To be successful, this policy needs to be owned and promoted by the Government and to obtain the active support and collaboration of the “*whole of government*” departments and agencies, in particular the independent agency responsible for regulation of gambling. The policy also needs the support and participation of non-governmental organizations, including local and voluntary groups, service providers, individuals, employer and industry groups, and the community at large. It is hoped that, by establishing a framework and a direction, this policy will assist them to participate in a coherent and comprehensive Government-led approach to minimising gambling-related harm. The policy is intended to reinforce and further develop strong inter-sectoral linkages at both a national and local level.

Given the requirement for wide-reaching participation across many sectors, in particular in the health, education, social policy and criminal justice areas, it seems appropriate that ownership and monitoring of the policy and its implementation reside with the Health and Social Policy Cabinet Committee chaired by the Hon. Steve Maharey. Ownership by the Health and Social Policy Cabinet Committee will ensure a “*whole of government*” approach and increase the effectiveness of the policy.

RECOMMENDATIONS

Our long-term vision is of a society that is healthy, well adjusted, informed, and chooses to gamble responsibly in a way that is sustainable for the community. Gambling blends into the social and cultural context of society at levels that are safe for the individual, their family and the community.

Development of a well-defined National Policy on Responsible Gambling within a comprehensive regulatory framework will enable Government to manage gambling in a sustainable manner, to minimize the harm from problem gambling, and to promote responsible gambling among New Zealand communities.

It is our belief that our vision of responsible, sustainable gambling can be achieved through a balanced combination of treatment, harm minimisation and health promotion strategies. Together these will regulate the supply, moderate consumer demand, and limit the problems associated with gambling.

In order to attain the vision it is recommended that:

1. Government places a freeze on any further expansion of gambling until we have satisfactory policy and appropriate legislation in place. This means an indefinite moratorium on any further gambling products, including casinos, additional gambling machines and any new forms of gambling, including Internet and interactive television gambling.
2. Government commissions appropriate studies that validly measure the social and economic impacts of gambling and problem gambling. We determine what is a sustainable level of gambling in New Zealand.
3. Government commissions investigation of legislative and policy “*best practice*” models for responsible and sustainable gambling in Australia, North America, Britain and Europe.
4. Government develops a responsible gambling policy (incorporating treatment, harm minimisation and health promotion) that will result in responsible gambling that is sustainable for New Zealand. This approach will provide:
 - Treatment and rehabilitation based upon “*best practice*” for people already experiencing gambling problems
 - Harm minimisation protection measures for those groups who are vulnerable or at immediate risk of developing gambling problems
 - Health promotion initiatives that contribute to healthy communities and development of responsible gambling appropriate for each community.
5. Government develops legislation and regulations covering all forms of gambling within an all-encompassing framework designed to encourage responsible gambling in all modes and venues where gambling occurs.

6. Government establishes an independent Gambling Commission to oversee regulation across all gambling modes with principal operating criteria of consumer protection and the public interest.⁴
7. Government co-ordinates inter-sectorial strategies across a range of government departments, gambling providers and treatment service providers, local authority and community groups. Foremost among government departments to be involved in developing initiatives will be:
 - Health
 - Internal Affairs
 - Social Services
 - Corrections
 - Consumer Affairs
 - Education
 - Gambling Commission (to be established)
8. Government establishes on-line monitoring of gaming machines to ensure proceeds are channelled into legitimate community and government bodies as specified in legislation.
9. Government provides for monitoring and periodic review of responsible gambling policy implementation and its effectiveness.
10. Government sponsors research and evaluation program relevant to problem gambling and responsible gambling policy.
11. Government imposes an additional tax on the gambling industry to cover all costs of addressing harm from gambling
12. A duty of care to consumers on the part of gambling providers is enshrined in statute.
13. All gambling providers are required to implement host responsibility and problem gambling prevention practices, which minimise the harm to problem gamblers and their families/whanau.
14. Gaming venues are re-designed to be safer for gamblers, with for example clocks and natural lighting to denote passage of time and prohibition of ATMs, cheques cashing, or credit facilities.
15. Gaming products are modified to be safer for gambler, with for example gaming machines having a limitation on rate of loss with prohibition of bill acceptors, linked jackpots and large cash payouts.
16. Readily understandable product information explaining how the game works, the odds of winning, and the cost of playing are displayed clearly on all gaming products.

⁴ The increasing importance of gambling in New Zealand may justify the appointment of a “*Minister of Gaming*” with responsibility for all aspects of gambling in New Zealand.

17. The legislative code ensures that advertising and promotion of gambling is neither misleading nor exploitative. All advertising contains a warning about the risk of harm from gambling.
18. The public and gambling consumers are well informed about true costs of gambling and the risks of problem gambling through government-sponsored, population-based public health information campaigns, targeted awareness programs for high-risk groups, and educational programs.
19. Public and consumers are encouraged to have input into decisions about local gambling provision and into distribution of community benefit funds through public consultation, surveys and local authority input.
20. Local communities are empowered in making decisions about the extent and nature of gambling to be made available.
21. Local communities are empowered in determining how and where profits from gambling in their community are applied to community causes.
22. Nationwide high quality treatment services are available for problem gamblers and their families at no charge.
23. Gambling issues are integrated into health and social policies and their related services

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Problem Gambling Committee

Commission Documents

TOWARDS HEALTHY GAMBLING

A HEALTH PROMOTION APPROACH TO GAMBLING IN NEW ZEALAND

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EXECUTIVE SUMMARY

The aim of this document is to make the case that gambling needs to be seen and dealt with, at least in part, as a public health issue. Once having made the case for public health, we suggest that the best way to create a 'healthy' situation with regard to gambling is by the domain of activity called 'health promotion', also called 'the new public health'. We describe what this is, then present a community-based strategy consonant with this perspective, and discuss the implications.

Gambling as a public health issue

Public health takes an overall societal view of health and illness issues. It is especially interested in whole populations and demographic groups, and in social and policy factors in health and wellbeing.

Increase in gambling

In line with international trends, gambling in New Zealand has increased exponentially over the past decade, having quadrupled in the past 10 years. Gambling problems have also increased. Here, electronic gaming machines (EGMs) are the most damaging in terms of their effect on people, and New Zealand's EGMs are currently increasing at the highest rate in the world. Worse is likely to come with the imminent advent of internet and interactive TV gambling, and youth will be especially affected by these new technologies.

The social and health impacts of gambling

Both the international and New Zealand literature show that gambling has far reaching negative effects on the health, wellbeing and quality of life of individuals, families and communities. A recent Internal Affairs survey suggests the level of gambling problems in New Zealand is only 2-3% of the adult population. We argue here that these figures are an underestimate, and that basing the discussion of the negative health effects of gambling on self-confessed problem gamblers alone is misleading in terms of overall societal impact. More realistic estimates of the negative effect could be more like 20-30% of the total population, or higher. The costs to the New Zealand taxpayer of providing services for this damage could be in the range of \$438 million to \$1.36 billion, which is in excess of the tax and duty income from gambling. Furthermore, these figures do not take into account other monetary costs to society, such as loss of productivity.

The ill effects of gambling are not equitably distributed. Disadvantaged groups are further disadvantaged by expenditures on gambling. The fabric of at least some communities is changing in negative directions. Some groups, such as Maori, Pacific people, children and the elderly are disproportionately affected. Youth are of special concern. While there is no relevant New Zealand research, in Alberta it is shown that 8% of adolescents are considered to be problem gamblers, and 15% are considered at risk of problem gambling.

Gambling is especially associated with distress of family and parents, child neglect, depression and suicide, marital breakup and divorce, job loss, financial loss, theft, and violence. There are direct effects on physical health, such as increased

smoking, high alcohol intake, and a variety of somatic disorders, including hypertension and back problems. The social cohesion of communities is being affected. In countries where public attitude research is done, it appears that although gambling is generally tolerated, about 70% of adults think that it does more harm than good, and up to 90% want no increase in gambling in their communities.

The public health perspective

In both New Zealand and overseas, there is growing usage among politicians and experts of the concept of public health with regard to gambling. This is partly because of the explicit links of gambling with health, both physical and mental. But it is also that the public health model is useful for considering the effects of gambling on people in society, with its population perspective, its use of methods such as epidemiology and social surveys, its emphasis on community, an awareness of health and wellbeing related to social determinants, an awareness of equity issues, a concern with culture and bicultural perspectives, the setting up of monitoring and evaluation systems, and its concepts of prevention, protection and health promotion. However, to date, the New Zealand Ministry of Health seems to have resisted the idea of being involved with gambling

Health Promotion applied to gambling

Principles of health promotion

Health promotion (HP) has been called 'the new public health'. Its modern form is derived from the 1986 international consensus document, the **Ottawa Charter for Health Promotion**, which represents what is called the 'social model' of HP – one which is concerned with the broad social determinants of health. It defines HP as having to do with people in the community getting more control over their health and wellbeing, in a supportive environment. It sees this as requiring **five action streams** to do with **healthy public policy, supportive environments, community action, personal knowledge and skills, and orienting services in more of a HP direction**. It stresses concepts like enabling, empowerment, and equity. It has prevention goals, but equally, it is concerned with enhancing positive dimensions of life, such as resilience, wellbeing and quality of life. In New Zealand, the **Treaty of Waitangi**, with its principles of protection, partnership and participation, applying both to Maori and to the rest of the population, is also regarded as a key document for HP.

Health promotion applied to gambling

It is suggested that an optimal approach to HP applied to gambling issues (HPG) is one that emphasises three of the Ottawa Charter streams, leading to a **community+knowledge+policy approach**. That is one where, in the context of appropriate supportive, enabling and regulatory policy, communities become well informed about gambling and its impacts on them (through, say, a media campaign), and then take their own action on what is best for themselves at the community level, in partnership with government and the policy making process.

It is suggested that the aim of a HPG approach in New Zealand would be **'to enable people and communities to have more control over and enhance their health, wellbeing and quality of life related to gambling'**. It is asserted that active

participation by people and communities is the best way to achieve this, rather than 'top down' regulation, as important as that also is. The need for taking into account regional, community and cultural variation is stressed.

Examples are given of existing health promotion initiatives around the world, for example information and educational programmes, school programmes, healthy public policy, and an array of community initiatives. In New Zealand, the Compulsive Gambling Society has been responsible for most HPG to date. It has done an excellent job in the information area, and is now moving towards initiatives with a strong community and cultural orientation.

A proposed health promotion strategy for healthy gambling in New Zealand

A suggested practical strategy for community-based HPG in New Zealand is outlined. It incorporates many of the factors found to be optimal for such programmes, and is based on successful programmes addressing other HP issues in New Zealand. The procedures for this are described in **12 steps aimed at informing and mobilising local communities to take their own constructive action regarding the gambling in their midst**. The process involves a national media campaign for awareness raising, then soliciting for volunteer communities to take part in a trial, assisted by trained facilitators. Essentially, each of these communities would do its own needs assessment, and set up its own organisation to implement projects and policies around the gambling issue on a local basis. Such an approach is aimed at boosting a sense of community control, as well as bringing about many positive outcomes in the community. Once these processes have been set up, and evaluated as successful, then a national resource centre to disseminate this approach on a wider scale would be established. In addition, the skill and knowledge acquired by communities would be used in a policy development process involving local communities interacting nationally, and advising government on policy in a partnership way. Periodic outcome evaluations would assess the overall impacts, the aims being to contain and lower the rate of problems, to create resilience in individuals and communities relating to present and future gambling (since gambling is likely to increase greatly with the new technologies), and to have communities satisfied about the way gambling takes place in their own locality. Such processes are likely to involve local authorities, and perhaps local district health boards, as well as other local agencies, schools and central government.

Conclusion

It is concluded that the huge growth in gambling in modern society is having significant health, social and wellbeing impacts, and this is likely to increase in the future. It is argued that this justifies the introduction of the powerful set of principles and procedures which constitute modern public health. In particular, the perspective represented by the Ottawa Charter approach to health promotion, with its social view of the determinants of health and wellbeing, the principle of people getting more control over the important matters affecting their wellbeing, the emphasis on community, the role of the Treaty of Waitangi, plus the five systematic action streams to enhance health and wellbeing, seem to fit the requirements well for a positive approach to 'the gambling issue'. It is suggested that a community action strategy along the lines of that outlined here would have many positive effects, and indeed would go a long way to bring about the desired result – a society in which there is 'healthy gambling'.

KEY RECOMMENDATIONS

1. Lobby government to support a public health/health promotion approach to gambling

This could include:

- Encourage a 'whole of Government' response, by positioning the policy development for gambling with the Social Policy Committee, particularly with regard to its health, social welfare, education and community concerns, and with regard to the overall quality of life of the nation.
- Encourage the Ministry of Health to agree that gambling is, at least in part, a public health issue, and to act accordingly.
- Strengthen the Government's responsibilities implicit in their 'duty of care', by having them recognise its ethical responsibilities towards the current growth of gambling and its attendant problems.
- Have government look at its responsibility to Maori, one of the groups in New Zealand most disadvantaged by gambling, in terms of the Treaty of Waitangi, and its principles of protection, partnership and participation, which are applicable not only to Maori, but to the whole population.
- Have the Minister of Health take action on her promises to have gambling dealt with as a public health issue, and to have this process steered through parliament as she indicated she would.
- Have government question the conflict of interest implicit in its role as both a provider and promoter of gambling in society, while also being its chief regulator.
- Persuade government that its persistent attempts to describe the 'impacts' of gambling on communities and people as beneficial are inappropriate and false, and that it should stop 'selling' gambling purely on its economic benefits, especially since these seem marginal or even negative
- Persuade government to sanction a health promotion approach to gambling by providing enabling legislation that allows and protects the community health promotion processes outlined in this document. Implicit in this is the requirement that sufficient funds be available from gambling levies, taxes, duties and profits to fund these activities.
- Persuade government that appropriate powers should be available to allow local authorities and district health boards to be involved in gambling issues – for example, to have the licensing of EGM outlets be the responsibility of community trusts like liquor trusts.
- Persuade government of the wisdom of having policy development for healthy gambling a partnership process with communities and iwi, which would both honour the obligations of the Treaty of Waitangi, and be a wise way to proceed with gambling as a community and public health issue.

2. Set up an organisational structure with the mission of overseeing the development of a health promotion approach to gambling in New Zealand

This could be part of the Problem Gambling Committee or the new Centre for Gambling Studies, or be an independent NGO, Trust, or other such body.

This could involve health promotion issues with regard to gambling such as:

- Development of healthy policy
- Media campaigns
- School programmes
- Cultural programmes
- Community projects
- Self-help information and resources
- Web-based programmes
- Support groups
- Needs assessments
- Facilitation of community development processes

3. Support the proposal presented in this document for a community-based demonstration project based on health promotion principles

This could be part of the above mentioned health promotion centre's activities, part of the new Centre for Gambling Studies at the University of Auckland, or independent. It would require a dedicated staff, and skilled community facilitators. Resource development would be part of its activities, including access to the best and most representative international and national information, plus it could develop a national network of people and communities who participate in the project. In due course, if the demonstration phase is successful, it would be intended to develop this strategy into a nationwide enterprise, which will then increase the need for good coordination and resourcing.

Relevant activities would include:

- A comprehensive national media campaign to raise community awareness and knowledge with regard to gambling.
- Training systems for community facilitators.
- Setting up policy development systems at the community level for dialogue with government, and interchange with individual community groups, local authorities, district health boards, etc.
- A national resource centre, perhaps based at the Centre for Gambling Studies, aimed at developing the resources and skills to facilitate community knowledge development, needs assessment, organisational structures, etc.
- The undertaking of a two to three year trial demonstration project, involving perhaps three or four communities, e.g. urban, rural, Maori, Asian.
- Assessment of the impact on health and wellbeing of communities of this system, its influence on patterns of gambling, and the effects on the safety of vulnerable groups.

- Deciding on the future of this system in the light of this pilot work, and proceeding to set up a wide scale implementation of the system throughout New Zealand.
- Undertaking other such demonstration projects as indicated.

4. Support the setting up of the Centre for Gambling Studies, and encourage it and other centres to undertake relevant research

Some of the research areas requiring attention are as follows:

Information-gathering:

We urgently need more information in the area of the impact of gambling on the quality of life of New Zealanders. Issues addressed would include:

- What is the true usage of gambling in New Zealand, and how does this impact on different groups in society?
- What is the range and scale of both negative and positive effects of gambling on New Zealanders? What is health-related and what belongs in other sectors? What is the true proportion of people adversely affected by gambling? How can different categories of effect be classified? Are there positive effects of gambling on people? Are there regional variations in this? What is the demography of the recorded impacts (age, gender, ethnicity, etc).
- What is the role of gambling in youth in New Zealand?
- What are New Zealanders' attitudes toward gambling and where it is going? Do we approve of gambling as a society? Do we want expansion? What do people think should be done in terms of regulation, treatment, education, community action, etc?
- What are the community impacts of gambling from a social, economic and health perspective? What are the benefits? What is the downside? How do communities vary on these dimensions and why? How are different groups affected? Are there urban and rural differences? What are the most benign and most damaging forms of gambling from a local community perspective? What are attitudes in those communities in proximity to major casinos? What is the impact of non-casino EGMs on community recreation patterns and preferences? Are jobs being affected? What is the impact on family life? What are community needs and wishes when these are systematically assessed on a representative basis?
- What will be the impact of the new technologies currently arriving? In particular, what about internet and interactive TV gambling?

Policy development research

This involves considerations such as the following:

- What kind of policies are best for the health and wellbeing of New Zealanders with regard to gambling? What is the correct balance of regulation and self-determination?
- What policies seem to work best overseas?
- What is the role and responsibility of different sectors regarding policy? e.g. central government, local government, district health boards, licensing trusts, the industry, citizens groups, lobby groups, etc.
- How can the 'ideal' of partnership policy development with regard to gambling and the community best be accomplished?
- What is the role of the Treaty of Waitangi in these considerations?
- What kinds of policies would best enable, support and protect the community development processes on which a community-based health promotion strategy relies (but which can be quite fragile initially)?

Develop data bases and monitoring systems:

This is the most basic kind of research, and should probably be the responsibility of government. But it could be contracted to a research agency, and is probably best designed by such an agency.

Some of the purposes served by such data and monitoring systems would be:

- To determine usage patterns of EGMs and other forms of gambling, turnover, payouts, etc., perhaps by point of sale monitoring systems
- To determine demographic patterns of usage.
- To ensure that regulations are being properly adhered to by providers.
- To have exact accountability regarding distribution of gambling profits in communities.
- To know exactly the usage and costs of services which deal with gambling problems and 'fallout', not just related to problem gambling services as such, but including other services such as general practice, social agencies, etc
- To determine the 'true costs' of gambling in society, from a quality of life and social services perspective, akin to the costing in the Australian Productivity report, and based on empirical data gathering.

5. Generally, to advocate for, and support, the concept of the relevance of a public health approach to gambling, and the value of a health promotion perspective, especially one that is community-driven.

PART 1: GAMBLING: A PUBLIC HEALTH ISSUE?

This document has two aims. The first is to make the case that gambling needs to be seen, at least in part, as a public health issue. The second aim is to show that a widely accepted public health approach, that of health promotion, is an optimal one for dealing with the long-term negative impacts of gambling on New Zealand society, and for making gambling a healthy activity rather than a damaging one.

In Part 1, we make the case that gambling is a public health issue. In Part 2, health promotion is introduced as a concept, and its relevance to gambling described. In Part 3, a possible community based health promotion strategy for New Zealand is outlined. Part 4 is a brief conclusion.

The prevalence of gambling in the New Zealand population

Public health takes what is described as a 'population' perspective. That is, rather than just being concerned with the illnesses of individuals, it looks at the patterns of illness, health and wellbeing over the whole society, especially in terms of definable groups and localities, and the overall measures taken to deal with them, including services, prevention and health promotion. Consonant with this perspective, we first look briefly at the prevalence of gambling in New Zealand.

Virtually every document on gambling, whether international or local, tells us that gambling has increased greatly in the last decade. In New Zealand, this growth in gambling activity has **quadrupled** over this period. Current research shows that 94% of the adult New Zealand population now gamble to some extent, and 48% are estimated to be regular gamblers (Abbott and Volberg, 2000). The same research tells us that between 1.4% and 2.5% of the adult population are 'lifetime problem gamblers', with an additional 0.7% to 1.4% being 'lifetime probable pathological gamblers' (p. 13).

At first sight, these 'problem' figures might seem quite modest for such a widespread and potentially problematical activity. However, as we will see, not only are these figures almost certainly gross underestimates of the real levels of problem gambling in New Zealand society, but by concentrating only on problem gamblers as such, they ignore a much larger problem – that of families, communities, and vulnerable social groups who are negatively impacted upon by gambling activity. Research shows that there are many measurable negative health and wellbeing impacts directly and indirectly associated with gambling, including mental health problems, suicide, addictions, smoking, high blood pressure, ulcers, family breakdown, criminal behaviour, stress, and so on. (See later).

At present, the major damage from gambling is seen as coming from electronic gaming machines (EGMs) or 'pokies'. For example, in the latest available statistics on counselling services for gambling in New Zealand, between 80 and 86% of treated problems were associated with EGMs (Problem Gambling Committee, 2001). In New Zealand, we currently have a very large number of these machines - about 17,150 outside of casinos, plus another 2200 inside casinos (Department of Internal Affairs, 2000). Their increase has been rapid over a short period of time. For example, the number of EGMs has doubled in the last five years (Bunkle, 1998). Last year alone (2000), there was a 25% increase in expenditure on non-casino EGMs,

bringing the total spent on these in 2000 to \$450 million (Dominion, 2001). (Note: At the moment of completing this document, it was announced that in the first three months of 2001, EGMs had increased by another 971, which is said by Dr Peter Adams, Chair of the Compulsive Gambling Society, to be 'the fastest growth rate of licensed gaming machines per capita anywhere in the world' (Adams, 2001)). Overall, EGM numbers continue to grow rapidly in an unregulated way, so we may not have seen their true impact yet. Indeed, it is rumoured that the present government may allow the numbers to go to double their present rate, which could be little short of catastrophic.

Most EGMs, as can be seen, are outside casinos, in multiple small to medium size locations around the country. At the same time, casinos are increasingly having most of their trade via EGMs, and with 11 casinos, we have a higher number per capita than Australia, usually considered the west's most gambling prone country.

Although EGMs are currently associated with most identified gambling problems in New Zealand, there may be even more pernicious forms of gambling on the way, in particular internet and interactive television gambling. This will, as one Australian document says (McMillen and Grabosky, 1998), bring casinos into everyone's living room for 24 hours a day, and it will be very difficult to regulate them. This points to a need for an 'empowered community', where self-regulation based on good information, resilience in relation to gambling 'temptations', and a new culture of awareness around gambling issues is needed, akin to that which has developed around tobacco and drinking/driving issues in the past 50 years in the west.

What are the negative health and wellbeing impacts of gambling on society?

We begin this section by looking at overseas research. There is a great deal of this, so we limit the discussion to two countries considered quite similar to New Zealand, Australia and Canada. We then look at the New Zealand situation.

Australia

As mentioned, Australia has the dubious reputation of being the most gambling-oriented nation in the western world. At the same time, Australians appear to be well ahead of New Zealanders in acknowledging the ill-effects of gambling on their society. Indeed, in 1999, the Prime Minister of Australia, John Howard, entered the arena, and had this to say:

Excessive gambling blights the lives of thousands of Australians and their families every year. Problem gambling has become a major social concern.

He added:

I am particularly concerned by the finding of the [Productivity Commission's] report about the extent and severity of problem gambling. The report found that around 290,000 Australians are problem gamblers and account for over \$3 billion in losses annually. This is disastrous not only for these problem gamblers, but also for the estimated 1.5 million people they directly affect as a result of bankruptcy, divorce, suicide and lost time at work. (Howard, 1999)

The report being alluded to here, entitled Australia's Gambling Industries, was that commissioned by the Australian Productivity Commission (APC) (Australian Productivity Commission, Summary, 1999). The purpose of this was to look at the gambling industry in Australia, including 'social impacts.' As acknowledged at the beginning of the report summary, 'Even by Australian standards, the recent proliferation of gambling opportunities and the growth in the gambling industries have been remarkable.' (p. 5). At the same time, in spite of the gambling industry making claims for the economic benefits of gambling for Australian society, the APC found that 'net gains in jobs and economic activity are small when account is taken of the impact on other industries of the diversion of consumer spending to gambling.' (p. 2) Since jobs and the state of the economy are directly related to wellbeing in a society, such a finding is of public health significance.

As in New Zealand, the APC found that gaming machines ('pokies') are the most damaging form of gambling. Similar to the Internal Affairs report in New Zealand, the APC report's assessment of 'damage' is largely limited to a discussion of 'problem' and 'pathological' gamblers, a number they put at about 2% of the population, similar to what was found by Abbott and Volberg (2000) in New Zealand. However, it is our assertion that this focus on 2% is probably a gross underestimate both of problem/pathological gambling as such (hereafter combined into the term 'problem gambling'), and of the overall negative impact of gambling on Australian (and New Zealand) society. Indeed, in the New Zealand Internal Affairs report, it says that other research suggests the Australian rate of problem gambling is more like 6% (Abbott and Volberg, 2000, p 15). And as John Howard said, there are five people negatively affected for every identified problem gambler, so the 'problem' of gambling from a societal perspective becomes considerably larger.

One of the reasons to suspect the figures which give a result of only about 2% problem gambling in the population is that these figures are based on telephone and other such surveys, using psychiatric or other self-report measures. It is quite clear that many, if not the majority, of those with gambling problems, are not going to own up to them to an anonymous interviewer, especially if that person is seen as a representative of the state, since so many gambling problems are associated with tax avoidance, theft and other crime, social shame, and so on. Many people with a problem may not acknowledge they have a problem. The argument that there is under-reporting in such surveys is supported by a finding in the APC report, which says: 'Many people are understandably reluctant to give honest answers to an interviewer about their gambling problems' (p. 22). It then goes on to cite a survey of those in counselling for gambling problems, **which showed that only 29% would have been prepared to admit to the 'true nature of their problems' prior to coming for help. (p. 23).** This figure of approximately 'one third' who are prepared to admit to a gambling problem gybes with the other research that shows that the 'true' rate of gambling problems in Australia is probably more like 6% (not 2%).

In terms of assessing the true cost of gambling on society, the APC provides a valuable breakdown of the estimated costs to the Australian taxpayer of providing services to deal with gambling associated problems. These are as follows:

	Low (A\$m)	High (A\$m)
• Distress of family and parents	756	2933
• Depression and suicide	502	1230
• Breakup, divorce and separation	417	1120
• Job change	59	59
• Productivity loss	28	200
• Gambling counselling services	20	20
• Police, court and jail	14	14
• Violence	2.8	8.3
• Bankruptcy	1.3	1.3

(p.32)

Overall, these total cost estimates to the public purse of the negative health and social impacts of gambling in Australia range from **a low of \$A1.8 billion to a high of \$A5.6 billion**. As can be seen, several of these cost areas fall into the general purview of health, to the extent that the term 'health' includes mental health and social wellbeing, which is how the concept of health is currently construed in most modern societies.

It is of interest to consider these cost estimates **translated into the New Zealand situation**. Australia is roughly five times the size of New Zealand, so if we divide the figures by five and convert into New Zealand dollars, **this range of health and social costs to the New Zealand taxpayer would be from \$NZ438 million to \$NZ1.36 billion**. This can then be contrasted with the New Zealand government's tax and duty income from gambling of about \$400 million in 1998 (Sullivan, 2001). It can be seen that to the extent that the New Zealand situation is similar to the Australian one, **the net benefit to the New Zealand taxpayer is at best zero, and at worst, there could be a net cost to the taxpayer of almost a billion dollars**. And this is only financial costs in terms of health and social services. It does not take into account other economic factors, such as loss of productivity, loss of spending power in other sectors, and loss of jobs, as shown in the Bendigo study below.

By way of summary, the report says the following about the adverse impacts on people of gambling:

The adverse impacts on individuals and the community, help explain the ambivalence of most Australians about the gambling industries, despite their widespread involvement:

- *about 70 per cent of people surveyed believed that gambling did more harm than good; and*
- *92 per cent did not want to see further expansion of gaming machines (p. 3)*

Apart from the Productivity Commission report, there is other recent Australian research which shows some of the impact of gambling on the wellbeing of people and communities. The Victorian Casino and Gaming Authority has looked at the impact of electronic gaming machines (EGMs) on individuals, families, and urban and rural communities (Anderson, 1997). In general, it was found that expenditure on gambling was 'regressive', in that it is disproportionately high among poor and disadvantaged groups. Those most negatively affected by gambling were people born outside Australia or of non-English speaking backgrounds, low income earners, the intellectually disabled, sole parents, the unemployed, the recently retrenched, and financially dependent women. For situations of problem gambling, the Victoria research showed the following:

Families and households, particularly children and partners....have been significantly adversely affected. The major impacts were in terms of family composition, living standards and family cohesion. Family and household hardships identified as linked to gaming were money, financial ruin, increasing reliance on welfare, stealing, lying, and deteriorating mental and physical health. (p. 9)

An inner city series of surveys relating to EGMs involved four municipalities in Victoria. These surveys found that '70% of respondents felt that 'gambling does more bad than good....and 40% said they knew someone whom they would describe as a problem gambler.' (Victorian Casino and Gaming Authority, 1996-7). In community service agencies, 'the common themes which related to gambling included individual depression, dependence on welfare (social security), family conflict, family breakdown and neglect of children.' (p. 4)

Other surveys looked at the impact of EGMs on rural Victorian communities. Here it was found that 'EGMs had changed the lifestyle of a significant section of the community and there had been changed entertainment patterns, which are attributable to the introduction of EGMs.'(p. 4) In telephone surveys in these rural communities, 89% of respondents 'indicated that they considered household expenditure was being redirected away from essentials towards EGMs,....and 78% felt that traditional entertainment venues without EGMs were experiencing difficulties.'(p. 5)

Another Victorian study in a regional setting by senior La Trobe University research economist Ian Pinge recently received considerable publicity. This involved the city of Bendigo (pop. 80,000). An abridgment of the The Australian newspaper's report on this research is as follows (Ellicot and Crawford, 2000):

The world's first study on the effect of poker machines on regional economies has found they are a blight on rural cities and towns. The study by La Trobe university found pokies cost the Bendigo economy a net annual loss of \$11 million....The report paints a bleak picture of a rural city where poker

machines are cleaning out a large part of the community without giving anything back. It found 72 per cent of the pokie players in Bendigo earned less than \$30,000 a year, paying for their losses in unpaid loans, wasted welfare or theft from employers, families or friends. If the millions lost annually by gamblers in Bendigo were spent in line with normal consumption the local economy would benefit by an additional \$5 million and an increase in employment by the equivalent of 237 full-time jobs, the study says. Author Ian Pinge said the model could be translated to most regional cities and towns where pokies have taken over local hotels and clubs. (p. 9)

The author of this research was recently in New Zealand, and stated that the gambling industry was one of the poorest performers in the overall Victorian economy, resulting in a net deficit contribution to the economy when its associated social and other costs are factored in (Pinge, 2001).

Canada

Canada appears to be a world leader in the quantity and quality of research it is doing in the area of gambling, and its health and social impacts. We can only mention a small amount of this research here.

One example is a recent national survey on public attitudes towards gambling, conducted by the Canada West Foundation in Calgary (Azmier, 2000). This involved a sample of 2202 people using a multi-provincial CATI (telephone) approach. (Gambling policy is a provincial jurisdiction in Canada). Over the whole sample, 63% agreed that 'gambling is an acceptable activity in (their province)', but a quarter (27%) said it was not, and the rest were ambivalent. This is interpreted by the report as a 'good barometer of public opinion on gambling in Canada', and concludes 'although the majority support the acceptability of gambling, this support is not strongly held.' (p. 21). There was an overall view that the poor are especially affected by gambling problems, and gambling is seen by some as 'a tax on the poor'. 60% of all Canadians agreed that 'gambling related problems in (province) have increased in the last three years.' (p. 24)

Especially relevant to the present document are the data on the perceived community impacts of gambling. The Canadian report says 'On balance, gambling is not seen as having a positive impact on communities', with 'only a small minority [9%] of Canadians [who] strongly favour gambling'. (p. 24). And of direct relevance to the concerns of health promotion is a question in the Canadian survey relating to the concept of 'quality of life'. The report says:

Perhaps the best overall measure of gambling's impact on the individual and communities relates to quality of life [which] can encapsulate both tangible... and intangible... factors in a single measure. [In response to the question whether] gambling has improved the quality of life in (province), two thirds (68%) say it has not, and only 14% say it has. This is in spite of the fact of much publicity about the community benefits of gambling. This was the most striking finding of the survey.... The stark nature of these data warrant careful consideration. (p. 28)

Elsewhere in Canada, the Alberta Alcohol and Drug Abuse Commission (AADAC) has been looking at gambling in the community, and has conducted a number of community research projects. One of their studies looked not so much at impacts as

at risks, especially among young people. A recent report by AADC quotes this important finding:

A 1995 telephone survey on a sample of 972 Albertans aged 12-17 years, found that 15% of Alberta adolescents are considered "at risk" for gambling problems and 8% of Alberta adolescents are considered problem gamblers. Furthermore, we found that most adolescent problem gamblers do not feel they have a gambling problem nor have they sought help for this condition. (AADC, 2001)

As can be seen, this is a higher rate than the 2% of adults generally considered to have gambling problems, and the 'at risk' figures are particularly concerning. It also suggests that people, whether young or old, can have a gambling problem, but not know it or admit to it.

New Zealand

We have already mentioned the major study of New Zealand gambling commissioned by the Department of Internal Affairs, and conducted by Abbott and Volberg (2000). Called Taking the Pulse on Gambling and Problem Gambling in New Zealand, it is based on a 1999 national telephone survey of 6452 adults aged 18 and over. This research used two time frames – one of lifetime prevalence, and one based on the six months preceding the survey.

Of particular interest for public health in this report is the demographic information as it relates to both participation in gambling and problems. Based on the six month data, it was found that those who gamble most are men, people aged 55-64, Maori, people without formal educational qualifications, employed people, and people with lower status occupations. Those with the most problems appear to be men, those aged 35-55, Pacific and Maori, and employed people, although the unemployed had the highest lifetime rate of problems (5.9%).

Based on the lifetime prevalence data, Maori and Pacific people seem to have rates of problems considerably higher than Europeans or Asians. For example, the lifetime prevalence of problems for Maori was reported at 7.1% (vs 1.9% European), and for Pacificans, it was 11%.

Asians are another group of special interest. It is often thought that they have high rates of gambling participation and problems. However, reported six month problems were 0%, and lifetime problems were 2.9%, with none falling into the 'pathological' category. These results run counter to the experience of those working in the problem gambling services, and suggest that the survey methodology failed to pick up the true rates.

On the basis of psychiatric measures, the overall rates of problem/pathological gambling in New Zealand are estimated as being between 2 and 3%. According to the report:

On the basis of the SOGS-R, it is estimated that between 38,300 (1.4%) and 68,600 (2.5%) New Zealanders aged 18 years and older can be classified as lifetime problem gamblers and that an additional 19,700 (0.7%) to 39,100 (1.4%) can be classified as lifetime probable pathological gamblers. (p. 13)

However, other researchers in New Zealand believe the figures in this survey relating to problems to be lower than the reality (e.g. Adams, 2000; Sullivan, 2001). This is attributed to the nature of the survey, where people were asked over the telephone to reveal their gambling problems to an researcher representing Internal Affairs. As argued above with regard to the Australian Productivity Commission findings on 'the 2%', such official surveys are likely to lead to these underestimates. The authors of the Internal Affairs report do concede the following:

For a variety of reasons discussed in the body of this report, it is considered that all of these estimates [of problems] are probably conservative and possibly highly conservative. (p. 14)

This is very important, because the findings from this report seem to be driving current government policy formation by the Department of Internal Affairs in New Zealand. One finding in the Abbott and Volberg research seems especially misleading. That is, in spite of the massive increase in gambling activity and promotion since 1991, when a similar population survey was done by the same authors, the following was found in 1999:

....a conservative conclusion is that there is no evidence of an increase in the prevalence of problem gambling and probable pathological gambling since 1991.... (p.17)

However, the authors do add with regard to this:

At this point, a cautionary note needs to be made concerning comparison of these and other findings from the 1991 and 1999 surveys. Although similar procedures and questionnaires were used, the methodologies and statistical treatment of the data from the two studies are not identical. (p. 17)

Thus, commonsense would suggest that it would be foolish to base policy decisions on this research.

Another source of New Zealand information are the annual reports of the Problem Gambling Committee (PGC) on the statistics gathered from the services who counsel problem gamblers. (The PGC is the body responsible for funding these services from a voluntary levy from the gambling industry). For example, in 1999 (Paton-Simpson, Gruys, Hannifin, 2000), the report showed that there had been a 30% increase in new clients seeking personal counselling for problem gambling in New Zealand, bringing the total to 2363 clients in 1999. These figures are made up of 1587 new clients, 695 'brought forward' clients and 81 'repeat admission clients' (p. 16). (Note: as this document was being completed, a draft of the report with the 2000 data was released. This showed that there were a total of 2473 clients, including 1942 new clients since 1999. In addition, there were 3690 new telephone hotline clients, and a total of 14,662 calls to the hotlines (PGC, 2001)).

According to Dr Sean Sullivan, a senior clinician and researcher working with the Compulsive Gambling Society, the principal provider of counselling services for gambling in New Zealand, only 3% to 10% of those with problems actually seek help. (Sullivan, 2001, personal communication). According to that estimate, based on the 1999 figures of those seeking personal counselling (we have not included the hotline numbers), there would in New Zealand be between 79,000 and 236,000 people with gambling problems requiring treatment.

Dr Sullivan's suggested figures make us ask **what are the true numbers of people negatively affected by gambling in New Zealand?** If we base this estimate on the approximate 2% of the adult population (over 18) claimed by the APC and the New Zealand Internal Affairs reports, then this number would be 56,000 people. (In June 2000, New Zealand adults over 18 numbered 2.53 million (Statistics New Zealand, 2001)).

However, if we say that the more likely figure for problem gambling is 5% of the adult population (still at the low end of some overseas estimates), this number grows to 126,500 people. Then we have Sullivan's suggestion of up to 236,000 people, which is 9% of the adult population. Although this seems high, it is not far from the 7% problem rate given for the UK (GamCare, 1998).

If we then throw the net wider, and factor in those directly affected by these gamblers, the numbers of those negatively impacted on starts to rise. For example, if we apply 'the rule of five' (i.e. the Productivity Commission's estimate that five people are negatively affected by each problem gambler), then even at the 2% level of problem gambling, we can add 280,000 people, making a total of 336,000 people in New Zealand negatively affected by problem gambling, which is almost 9% of the total population of 3.8 million.

If we apply 'the rule of five' to the 5% estimate, the total becomes 759,000 people negatively affected, or 20% of the total population. And at 9%, this becomes 1,416,000 people or 37% of the total population!

These hypothetical calculations are only based on identified problem gamblers and their close associates. There are obviously others negatively affected by gambling in society, for example those whose incomes are reduced greatly by gambling, or those whose communities have had an unwanted casino built in them.

Whatever, the true rate of people negatively affected by gambling in New Zealand, it is almost certainly higher than the 2-3% cited in the Internal Affairs report.

It is important to consider the social groups who are particularly at risk in terms of the damaging social, economic and other effects of gambling. For example, from a people/community perspective, based on New Zealand and overseas research, it is clear that the 'new gambling' puts at risk some significant groups in our society, notably youth, Maori, Pacific people, Asians, those on low incomes, the intellectually disabled, and the elderly.

Conclusions regarding impact

The international studies all have common themes – that while gambling is accepted as a reality of modern life, and enjoyed by many on an individual basis, it is not generally felt to be a 'good thing', and most want further expansion curtailed, especially in electronic gaming machines. A significant proportion of people beyond 'the 2%' usually identified as 'problem gamblers' are negatively affected by gambling, with realistic estimates being up to a fifth of the total population. Furthermore, it is the most vulnerable groups in society which bear the greatest burden. The social and health costs are high, both in terms of their impact on people, and the cost to the public purse.

Overall, it appears that serious problems associated with gambling are increasing. This is shown in New Zealand by the escalating rates of people seeking treatment.

With the unregulated growth of EGMs, the rate of the problems is expected to increase substantially. And this may only be the start, since the accepted predictions are that internet and interactive TV gambling are about to arrive, which may present us with the biggest gambling presence yet. Youth are seen as especially at risk. If the Alberta study is an indication of New Zealand youth gambling patterns at the present moment, then there already much higher rates of problems among youth than older groups, except that they have not yet been explicitly identified, because the research is lacking

In short, there is time for a whole new look at the issue of gambling in society - one which looks to the current reality of its impact on communities and people beyond the treatment or addiction model, and one which especially looks to what will happen in the future.

Specific links of gambling with health

What we have been discussing so far are general negative health and wellbeing impacts of gambling in society. This perspective is consonant with that of public health. In this section, we look briefly at more specific health effects which are associated with gambling.

First, there are undisputed **mental health impacts**. The Australian Productivity Commission's listing of the costs of services related to gambling harm showed the three most expensive categories involved mental health, namely distress of family and parents; depression and suicide; and breakup, divorce and separation. Gambling counselling services, violence, and the stress associated with criminal proceedings, bankruptcy, job loss and so on can also be factored in here. According to Sullivan and Penfold (2001), New Zealand Compulsive Gambling Society research shows that gambling often coexists with mental and physical disorders:

Problem gambling has been found to coexist with many mental health problems....In particular mood disorders are common (eg Major Depressive Episode, Dysthymic Disorder), medical conditions as a result of the stresses that occur once gambling has become excessive (hypertension, migraine, peptic ulcers), while personality disorders (ASPD, Narcissistic, BPD and Avoidant) are also commonly found amongst gamblers presenting for help.
(p.1)

Second, there are **physical health impacts**. It is well established that stress and physical health are intimately related, for example through the immune and endocrine systems (Sarafino, 1998), and it is clear that problems arising from gambling have multiple stressors associated with them. The above research by Sullivan and Penfold shows that there are psychosomatic physical disorders associated with gambling, for example hypertension (high blood pressure), migraine and peptic ulcers. Sullivan (2000) has also found musculoskeletal problems associated with gambling, such as back problems, presumably associated with tension, and with sitting in front of EGMs for extended periods. Also, it is clear that, as shown by the APC report, gambling has an impoverishing effect on already poor families, and the lack of use of health services by the poor because of cost is well documented by researchers such as Waldegrave in New Zealand (Health Promotion Forum, 1999). One Australian study found that up to 20% of the pretax income of low income families was going on gambling (Health Matters, 2000), which would leave little available for health care.

Other physical health impacts of gambling are associated with smoking, well established as the single most important risk factor many forms of ill-health, including heart disease. For example, gambling is associated with increased rates of smoking. In Victoria, Australia, one study showed that gamblers using EGMs spend twice as much on tobacco as non-players, and another study showed that women gamblers had deteriorating health associated with smoking. (Health Matters, 2000). In New Zealand, Sullivan (cited in Health Matters, 2000) found that gamblers presenting for treatment had a smoking rate of 64%, when the national average is about 25%. (p.6) Even for nonsmokers there are raised health risks, since environmental tobacco smoke (ETS), well known as damaging to health, is higher than normal in gaming areas (Health Matters, 2000).

Third, gambling is associated with **unhealthy alcohol and drug use**. Sullivan and Penfold (1999) state 'that there is strong evidence to suggest that misuse of alcohol and gambling problems coexist to a degree that is of clinical significance'. They go on to suggest that gambling and alcohol abuse are directly linked:

Many clients presenting at the Compulsive Gambling Society's (CGS) clinics report their binge behaviour with alcohol after gambling, and when access to gambling is inhibited....Thus gambling becomes intertwined with alcohol use as a part of the gambling problem, rather than a discrete and separate problem. (p. 2)

There are more general substance abuse and addiction issues here too. Sullivan and Penfold say that '47% of compulsive gamblers were addicted to a psychoactive substance at some stage in their lives....37 of 67 male pathological gamblers (55%) 'were alcoholics' and 50% of compulsive gamblers in treatment had substance abuse problems presently or in the past.' (p. 3). This is not to say that gambling has caused these problems, but there are certainly strong correlations.

Fourth, there are **unhealthy aspects of gambling environments, and of the activity itself**. We have mentioned tobacco smoke as one environmental hazard. In addition, most gambling takes place indoors, often with no natural light, and is very sedentary. It would be interesting to study the eating habits of gamblers, their exercise habits, their blood pressure levels, their weight, their cholesterol, and so forth. As mentioned, Sullivan (2000) has found a correlation between musculoskeletal problems and gambling (p. 16), and Sullivan and Penfold (1999) have found elevated blood pressures in problem gamblers in counselling. Time spent gambling is time away from other, perhaps more healthy, forms of recreation (e.g. sport). In summary, it is reasonable to suppose that long periods spent gambling, at least on EGMs, may not be very good for one's health!

Taking a public health perspective

This is not the place to go into a overview of the whole topic of public health. But there are some public health principles that are important to the present discussion.

The first is that public health is based on the science of **epidemiology**. This is concerned with the study of the distribution of health and illness patterns in society, and of prevalence and incidence rates. In short, we need good data on what is happening to make good policy decisions. The previously mentioned Abbott and Volberg (2000) studies, and the APC studies, are epidemiological in nature.

Second, public health is concerned with issues of **equity**. Equity has to do with the gap between the rich and poor in a nation, and other issues of social and cultural difference and disadvantage. It is well known that poverty is associated with poor health. More recent research shows that, at least in developed countries, it is not so much poverty as such which is associated with poor health, but the size of the gap between rich and poor (Wilkinson, 1998). New Zealand has, over the past two decades, become one of the most inequitable countries in the OECD, with some of the world's worst health and wellbeing indicators emerging over that time (e.g. reputedly the highest rate of youth suicide in the world, one of the highest homicide rates, and the re-emergence of 'third world' childhood diseases such as TB). There is the likelihood that gambling, with its socially regressive impact on incomes, will exacerbate this wealth gap, leading to even worse health and wellbeing outcomes than we have at present.

A third core public health concept is that of **community**. Community has to do with the locality in which we live, our culture, and the family, friends, workmates, neighbours, and others with whom we live, work and spend our spare time in everyday life. Much of our health and wellbeing is determined at this level. As will be seen, in this document we believe a community-based perspective for public health related to gambling is an optimal one to have.

A fourth central concept in public health is that of **culture**, since our life habits are very much a product of the cultural milieu in which we grow up and live. In New Zealand, the cultural dimension is one very much at the top of the social and health agendas, and it needs to be for gambling also. In particular, we need to be taking continuous account of the place of the Treaty of Waitangi in all health considerations, including gambling (TUHANZ, 1999).

A fifth concept is the primacy of **policy**. Obviously government and other policy on gambling, health and related issues have a major impact on how we operate societally, and much public health research and advocacy is aimed at informing healthy public policy.

Sixth, and finally, public health emphasises the need to work **intersectorally**. That is, in an area such as gambling, no one sector (government, community, the industry, etc) should have the responsibility. Rather, gambling is a complex issue affecting many sectors, and any wise action taken in the interests of public good and health have to be dealt with at this level. The current Problem Gambling Committee in New Zealand is a start in this direction, with its representation from the industry, the Department of Internal Affairs, and the helping services.

Growing recognition of the public health and gambling link

The international literature is increasingly beginning to reflect a public health perspective on gambling. For example, Professor Jan McMilen, Director of the Australian Institute for Gambling Research, recently presented a paper (McMilen, 2000) called 'When Gambling is a Problem – Implications for Public Health', in which she 'examines the recent emergence of problem gambling as [an] identifiable public health issue in Australia.' Her focus is on Victoria, and in her paper she presents

....a broad-ranging review of gambling from a public health perspective. It [the paper] argues that Victoria's strategy on problem gambling is more comprehensive than other jurisdictions, but that there is considerable room for improvement. Specifically, it argues for reorientation from the current reactive

responses to a preventative public health approach, which focuses not only on gamblers, but their material and social circumstances. (p. 1)

In doing this, she argues against the dominant 'medical model' approach to gambling problems, and instead looks at the wider social and political context – the hallmark of a public health approach.

In Canada, the Alberta Alcohol and Drug Abuse Commission (AADAC) also attempts to take a public health perspective on gambling problems, but from a more community perspective. They say:

...we take our mandate to prevent problems caused by the abuse of alcohol, other drugs and gambling...seriously....Those Albertans who experience negative effects from their gambling often experience personal problems in the areas of finances, health, and relationships. Problem gambling can also be seen as a public health issue as it affects families, friends, social groups, and the wider community.... We know that effective prevention of gambling-related problems must include a range of responses suited to the needs of specific communities. It is necessary and important that government agencies and community groups combine their efforts and resources.... (AADAC, 2001)

In **New Zealand**, in the public domain, there has been little official recognition of gambling as a public health issue. For example, in 1998, the Problem Gambling Committee (then called 'COPGM') had this to say (Klimister, 1998):

Government involvement [in problem gambling] is focused through and tends to be limited to the Department of Internal Affairs, through its administration of the gaming legislation and the secretariat provided to COPGM.

Notwithstanding, we are starting to see evidence of the concepts of gambling and public health being put together. In The Department of Internal Affairs Synopsis of Submissions to Gaming – A New Direction for New Zealand (1997), it says:

Thirty-seven submitters (5%) stated that the Government should actively address social problems associated with gaming. A number of these submitters noted that social problems created by gaming should be funded out of the Health Vote.

At the 1999 National Conference on Gambling in Auckland, it appeared that there was potential interest in political circles at bringing gambling into the public health fold. At that conference, which took place not long before the general election, Annette King, now Minister of Health, said in a keynote address:

Pathological gambling is a health issue.... There is a link between people with compulsive gambling and mental illness.... I say to you as Minister of Health in the next Labour Government, I am prepared to put together a comprehensive public health strategy to address pathological gambling. There is a need to take a prevention approach and I have given a specific commitment, commitment to a strategy, a strategy that will be driven through a cabinet and a caucus, and taken to the New Zealand Parliament.... (King, 1999, p20ff).

Unfortunately, we have not yet seen the Minister follow up on these promises.

At the same conference, John Alexander, Chief Executive of the Racing Industry Board of New Zealand, gave a paper entitled 'Problem Gambling a Health Issue and the Need for a Comprehensive and Coordinated Policy Response'. This makes a very strongly expressed case for a public health perspective, emphasising in particular the mental health impacts of gambling. He says of gambling in New Zealand:

The harsh reality is that we have opened the flood gates without taking stock of what the true consequences are likely to be....New Zealand in the new millennium must have a major rethink and a planned response based on accurate information...

The bottom line in mental health wellness must surely be the domain of the Ministry of Health and those engaged in the health professions.... Where is the investment in preventative education? Problem gambling as a mental health issue has now been well researched and chronicled in many peer reviewed journals over the last decade. We are yet to hear any cogent argument sustaining an exclusivity of problem gambling as a non health matter...

Serious issues of health policy credibility have developed as a result of the Ministry of Health refusing to include problem gambling within our mental health community responses....

Surely should not the thrust of our interventions be aimed at preventing the harm before it becomes reckless, progressive, hurtful and hugely expensive to address?...How is it that this disorder is to be excused from a public health policy?...[The current treatment services are] now requiring inclusion within mental health led by community education and recognised by health professionals generally. (Alexander, 1999, p160ff)

In a recent submission of a Funding Recommendation to the Problem Gambling Committee, the Compulsive Gambling Society (CGS, 2000) saw a need for 'mental health promotion', which is a public health issue. They say that there are three strategies required to broaden the present base of services, namely counselling services, harm minimisation and public awareness raising. With regard to the latter, they say:

Messages to develop responsible gambling behaviours would be welcomed by all. Mental health promotion in all its forms is now required to the minimal level of \$500,000 per annum if an impact on the incidence of problem gambling is to be realised. (pp 3-4)

From these kinds of statements, it would appear that gambling is, at least in part, being seen increasingly as a public health issue in New Zealand.

At this point, it is necessary to say that there are a number of conceptual issues that could be clarified with regard to the term 'public health'. The first is that public health has two meanings. One is that it is to do with all the **publicly funded services of a country**, as implied in the phrase 'public health system'. In particular, this tends to refer to treatment and illness services, such as hospitals. The second usage is a **broader one**, more along the lines of that used here. That is, it has to do with looking at the whole of society in a health sense, and includes **social factors, prevention and health promotion**.

Also relevant here is the issue of **the model of health and wellbeing** being used to look at public health issues. The professional health field, public or personal, has been dominated for the last century by what is synoptically referred to as '**the medical model**'. Similarly, gambling has been conceived, from a mental health perspective, by an analogy of the medical model, namely '**the addiction model**'. This is not the place to debate this issue, except to say that both these models tend to be limited to looking at 'pathology' – that is, to the most extreme 'illness' effects, typically in individual 'patients' or 'clients'. It should be clear by now that this document argues that there is much more to gambling than that, particularly in the social and economic area, and with regard to the impact of gambling on communities, families, etc. The danger of staying within a pathology model with regard to gambling is that it tends to ignore these wider social determinants, and to put the focus and often the blame solely on the 'addicted' person. This in turn tends to let government, the industry and others escape their responsibility to act in the interests of the overall public good. For example, one sometimes hears the industry saying that gambling is purely a matter of a person's individual choice in the use of his or her discretionary recreational income. This ignores the fact that what leads to problems is only partially the responsibility of the individual, and has as much if not more to do with the promotion of gambling, the nature of EGM machines, public education, government policy, and so on.

Some comments on the limitations of staying within a medical or addiction model of gambling come from a recent Australian National Association of Gambling Studies conference:

Gambling is primarily a risk taking activity that can cause harm and as such is a health issue. A significant portion of our community however view problem gambling as a 'disease'. This perception is the primary challenge facing community education officers working in this area. In order for education and preventative strategies to be effective, we need to firstly address this myth and ensure that the community views gambling as a health issue. (Michaleas, 2000. p. 14)

The term "addiction" has gained a degree of acceptance in Australia as a descriptor for the condition, which lies at the extreme end of the continuum of gambling problems. Despite that acceptance, there is concern expressed, or fears held, that the use of the term may be seen as medicalizing the problem and putting all the responsibility for problem gambling on the player. It is recognised that it is important to take into account factors associated with the wider range of factors influencing gambling behaviours, problematic and non-problematic. (Soares, 2000. p. 19)

It is the more inclusive, less medicalised view of public health we take here. With this in mind, we now proceed to consider what we argue to be the optimal approach to gambling in New Zealand from a public health perspective – that of health promotion.

PART 2: HEALTH PROMOTION – THE NEW PUBLIC HEALTH

In previous times, the term 'public health' tended to conjure up pictures of immunisation programmes for infectious diseases, or providing sanitary water supplies and sewerage. Today, public health has a whole new face, especially since in most developed countries, infectious diseases have taken second place on the health agenda to 'lifestyle diseases' such as coronary heart disease, cancer and depression. (Depression, which is often associated with gambling problems, is reliably predicted by 2020 to be the second largest disease category in the world (Murray and Lopez, 1990)).

The Ottawa Charter for Health Promotion and the Treaty of Waitangi – the core documents for health promotion

In 1986, a significant event took place for public health with the publication of the **Ottawa Charter for Health Promotion**, a WHO consensus document contributed to by over 40 industrialised countries, including New Zealand. This document was seen as epitomising what is called '**the New Public Health**'. Like the term public health, 'health promotion' had previously meant something else – mainly health education and lifestyle modification for individuals. The Ottawa Charter changed that, and we saw the emergence of what was called the 'social model' of health promotion (HP), which took the position that good health is determined by many factors, not just individual behaviour, lifestyle, genes or 'germs'. In particular, the whole social, political, environmental and cultural context is important, and governments have to take responsibility for that. As we will see, the argument we make for adopting a HP approach in gambling is based primarily on the systematic approach to the 'wider picture' that the domain of HP offers. To quote the Ottawa Charter:

Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector... The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity....Political, economic, social, structural, environmental, behavioural and biological factors can all favour health or be harmful to it. ... To enable people to reach their fullest health potential, [the requirements] include a secure foundation in a secure environment, access to information, life skills and opportunities for making health choices...[This] demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organizations, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities.

This representation of health and wellbeing within its wider social and political context is usually called 'the social model of health', and as such, can be compared with the more circumscribed 'medical models' and 'lifestyle models' relating to health and health promotion. The term 'ecological model' of health is also sometimes applied to capture the Ottawa Charter kind of perspective. This is currently the dominant model in public health and HP around the world today.

In New Zealand, the Ottawa Charter, plus the Treaty of Waitangi, are regarded as the key documents for HP. Both documents are concerned with wide issues relating to the wellbeing of whole peoples, and the responsibility of government with regard to

this. At the heart of the Ottawa Charter is the concept of 'enabling' – that is, it is government's responsibility to provide policy and resourcing frameworks to enable the people themselves to be the primary determinants of what they want regarding health promoting action, since health is such a personal and community matter. In short, the Ottawa Charter marries the two levels of healthy public policy and community action, two of the pivotal HP dimensions advocated in this document.

The enabling dimension of the Ottawa Charter is clearly seen in its definition of HP, now universally accepted as the core definition.

Health promotion is the process of enabling people to increase control over, and to improve, their health.

As can be seen, the concept of 'control', previously mentioned as key to health promotion, features here. In this context, 'health' means more than just 'physical health'. The WHO's traditional definition of health (produced in 1946) is a broad one. ('Health is a complete state of physical, mental and social wellbeing'), and the Ottawa Charter takes this as its springboard. This clearly positions gambling as potentially a part of the public health arena, in terms of its place as an economic and social activity which can have a direct impact on health – physical, mental and social - as we showed above.

This complex 'social' or 'ecological' approach to HP (and gambling) at first looks quite daunting in its scale. However, the Ottawa Charter outlines five quite straightforward action streams for planning and implementing this broad-based approach to health promotion. These are as follows:

- **Build healthy public policy**
- **Create supportive environments**
- **Strengthen community action**
- **Develop personal skills**
- **Reorient services**

Health promotion as represented by the Ottawa Charter also is concerned with issues of equity and social justice. We saw this in the reference to 'social justice and equity' above, and in addition, the Charter says:

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential.... People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

This theme of all people being able to have control over the issues which affect their health and wellbeing is core to health promotion, and is obviously an even greater issue where there is inequity. In New Zealand, this inequity refers precisely to those groups most vulnerable to the impacts of gambling, and its effects on their health and wellbeing. There is a moral duty of governments to act here. This is what in legal circles is called 'duty of care', and it is what the Treaty of Waitangi is largely about. The Charter expresses the view that:

People in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned [should] join forces in introducing strategies for health promotion.

We believe it is the duty of government to take the initiative here, and to show its moral responsibility for something which is clearly in its jurisdiction, that is to say, the health and wellbeing impacts of gambling in New Zealand society. At present, however, the New Zealand government, with its significant income from gambling, its role as both a provider and regulator of gambling, and its failure to acknowledge the public health dimension of gambling, is in a position of perceived moral ambiguity, to say the least.

An important theme underlying the Ottawa Charter type of approach to HP is that of empowerment and of community-based action. Empowerment means people making their own decisions relating to important areas of life, rather than just being 'regulated'. Community based action permits this to happen in a local context. For example, the community action stream of the Ottawa Charter says:

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities, their ownership and control of their own endeavours and destinies.

For this writer, this is the core statement to guide what we would want to do in a community based health promotion approach to gambling. The Charter sees this as happening through a process of 'community development', which it outlines as follows:

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

These statements form the basis of the health promotion strategies suggested in this document.

One area that the Ottawa Charter is relatively weak on is that of culture, although it does get a mention:

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems...

Health services need to embrace an expanded mandate which is sensitive to and respects cultural needs.

In New Zealand, we are strongly aware of the role of culture in all aspects of health and health promotion. In particular, the **Treaty of Waitangi** is regarded as a crucial HP document, with the primary role it gives to the responsibility of the Crown towards the indigenous people of New Zealand, and with its principles of partnership, protection and participation (TUHANZ, 1999), which can be seen as applicable to all New Zealand people of all cultures. These principles would seem to be very important for the government's relationship to the community with regard to the

gambling issue – that of partnership with the communities concerned, the protection of the vulnerable and disadvantaged, and the encouragement of community participation in the important decisions and processes surrounding gambling, both locally and nationally.

Mental Health Promotion

A relatively recent variant of HP is that of **mental health promotion** (MHP) (Joubert and Raeburn, 1998), which is seen as especially relevant to gambling (e.g. CGS, 2000). MHP extends further the concept of HP beyond physical health, and especially emphasises the concept of **resilience**, an intrinsic resourcefulness arising from each person's own knowledge, skills and decision-making capacities. Resilience can be trained and fostered at each age level, and this process consists of knowledge- and skills-building ('capacity-building') in a supportive environment. The Mental Health Foundation of New Zealand has MHP as its primary function, and uses a definition of MHP which (like the Ottawa Charter) originated from an international meeting in Canada. This definition is:

Mental health promotion is the process of enhancing the capacity of individuals and communities to take control over their lives and improve their mental health. Mental health promotion uses strategies that foster supportive environments and individual resilience, while showing respect for culture, equity, social justice, interconnections and personal dignity. (Joubert and Raeburn, 1998, p.16)

This definition reflects its debt to the Ottawa Charter. In short, it says that MHP is to do with positively experienced wellbeing and quality of life, arising through people's sense of their own resourcefulness and control over life, facilitated by an environment which supports these processes. It is this, we assert, that should be the aim of healthy gambling policy in New Zealand.

Health Promotion works!

On a broader scale, there is substantial evidence from around the world that health promotion is effective, and this is shown by examples from many countries, such as the steadily declining rates of deaths from cardiovascular diseases, falling traffic crash rates, improved nutrition, falling infant mortality rates, lower alcohol consumption, lower smoking rates, increased life expectancy, containment of the AIDS epidemic, and so on. In developing countries, community based health promotion efforts have been especially effective (Durning, 1989). In New Zealand, Maori health statistics are starting to improve and converge with those of nonMaori, and this can partly be attributed to health promotion efforts.

Recommended principles for health promotion applied to gambling

To summarise, then, it can be argued that the internationally accepted concept of health promotion, as defined by the Ottawa Charter (and in New Zealand also by the Treaty), is a very appropriate framework for looking at health and wellbeing issues related to gambling. The key features of this health promotion approach applied to gambling (HPG) would be:

- To **view gambling in a wide ecological and societal context**, and to recognise that the impact of gambling on New Zealanders is a product of a **variety of determinants**, including policy and regulation, the industry, culture, facilities, accessibility, treatment services, knowledge, education, community, income, disadvantage, individual psychology, lifestyles, and probably many other factors.
- To **plan action** for optimising the enjoyment of gambling, minimising the negative impacts, and contributing to the overall health and wellbeing of the community by using the **five action streams of the Ottawa Charter**.
- To give an important role to the **Treaty of Waitangi**, both in terms of its definition of the **relationship of the Crown to Maori**, and in terms of its wider principles of **partnership, protection and participation** with regard to government-community relationships around the issue of gambling, and perhaps also to industry-community relationships.
- To see the **desired outcomes** of public health action as **including but going beyond harm minimisation** to the broader view of **the overall health and wellbeing of society**, and of where gambling fits into and influences this.
- To use the health promotion concepts of **empowerment and equity**, and the mental health promotion concept of **resilience in a supportive environment** as guiding principles to focus these activities from an individual and community perspective.
- To spearhead these activities by use of a **community action strategy**.

Health promotion vs related concepts

For those not familiar with the territory, it is sometimes hard at first to make distinctions between some linked and overlapping concepts. This is not the place to go into this in detail, but probably the most important are the distinctions and commonalities between health promotion/public health and the concepts of harm minimisation and prevention.

Relevant to this is a recent Australian paper by Ryder which says:

...We need to be clear about what we mean when we use some of the more technical terms [in the gambling and health area]. While this might seem like a detached semantic argument the reality is that much heat but little light has arisen from debates around terms such as harm minimisation and public health.... Differentiating between the different forms is useful given the differences in public perception, political will and extent of problems that apply to each. (Ryder, 2000)

In this distinction, harm minimisation (HM) is seen as a somewhat narrower field than public health, and is tied strongly to an addiction model. HM can also be seen as a narrower approach than health promotion, as that has been defined here. In general, HM focuses primarily on the problems, and usually the most severe ones (like pathological and clearly identifiable problem gambling deserving of treatment). It seldom takes a broad social view on this, and processes are often primarily

regulatory and treatment oriented, rather than educational or community-oriented. It is 'reactive', whereas HP tends to be proactive, future oriented and developmental. However, it needs to be emphasised that **health promotion and harm minimisation are not 'either-or' concepts – rather, they are complementary strategies in an overall public health approach to gambling.**

As for HP and prevention, many of the same issues apply. In general, prevention tends to be a narrower enterprise than HP. In the health and social issues area, prevention tends to be conceptualised in terms of specific illnesses or social problems. HP obviously has prevention goals – it aims at the reduction of problems and ill-health - but on the whole, it has a wider 'social' view than prevention, and is concerned with more general quality of life issues than prevention's more individualised and specific problem focus. Again, these are not opposing approaches, but complementary within a broad public health framework.

The aims of health promotion applied to gambling (HPG)

If it is agreed that a public health/HP approach is relevant to gambling, we now move to see how that might actually be made to work in the New Zealand context. The first step is to be clear about our aims.

First, what is the **overall purpose** of taking a health promotion approach to gambling? In general terms, and using broadly the kinds of concepts found in the Ottawa Charter, we could state the following:

To enable people and communities to have more control over and enhance their health, wellbeing and quality of life related to gambling.

The aim of this is to enhance the enjoyment and resilience of those who wish to gamble, to reduce the distress related to gambling, and to have communities and society generally satisfied with what is happening with regard to gambling in their midst. This requires particular attention to community wishes, equity and cultural issues, and to the situation of vulnerable groups, especially youth.

This could be summarised as:

To enhance the wellbeing and to decrease the distress related to gambling in society.

The community+knowledge+policy approach

For gambling to be dealt with as a HP issue, it is suggested that there are three dimensions of the Ottawa Charter approach which need most emphasis, namely **community action, knowledge/skills, and healthy public policy**. These together would constitute a **community+knowledge+policy** approach to enhancing wellbeing, resilience and quality of life in relation to gambling from a national perspective. These dimensions are now elaborated briefly:

- 1. Facilitating community participation and action.** We have seen that some of the strongest negative impacts of gambling are at the level of local community. It is also clear that communities vary greatly in their attitudes to gambling and its benefits/ disadvantages. We suggest that the pivot of a public health approach to gambling should be people-in-context, which is best considered at the level of

local community. Such an approach needs to balance the interests and responsibilities of individuals with the wider national context. However, community allows people to look in 'both directions' - 'down' to the needs and situation of individuals and families, and 'up' to the more general regional and national context.

Much research shows that the strongest health and wellbeing effects at the community level come when that activity is 'empowering', and that is best attained when there is **active participation** by the community (e.g. Poland, Green and Rootman, 2000; Raeburn and Rootman, 1998; Durning, 1989). In particular, communities need to feel that they have control over, and ownership of, the issues of concern (Raeburn, 1992). Of course, many of the crucial issues surrounding community impacts are the result of wider national policy. What is required here is that communities feel they have an active input into policy, and that policies are flexible enough to serve their local purposes. This goes beyond just 'community consultation' to active engagement in decision-making, the control of action taken, and input into policy. It requires a partnership relationship with government and perhaps the industry, and an active role in policy formation and 'testing'.

2. **Increasing public, community and individual knowledge regarding gambling in society and its health/wellbeing impact on people.** It is a cliché that 'knowledge is power'. If we are to adopt an empowering approach to gambling issues in New Zealand, then full, factual, unbiased and culturally appropriate knowledge available to all people is essential, so that people individually and collectively can make their own decisions in a responsible and informed way. It is clear that public knowledge of, say, the kind of information in this report, is currently minimal. Obvious locations for knowledge dissemination are the media (e.g. TV campaigns), point of sale (e.g. EGMs with health warning signs on their screens), schools, community and cultural organisations, churches, and so on. We need to have a culture of knowledge regarding gambling, as we have developed a culture of knowledge around smoking, dangerous driving, alcohol consumption, AIDS, and so on – this is the strongest tool health promotion has. However, it is clearly a long term endeavour, and we need to plan for the future here.
3. **Making healthy public policy.** Policy refers to formally adopted plans, approaches and regulations, usually in written down form, and often embodied in legislation, by government and institutions of society which wield significant influence over the lives of the population. It is clear that much if not most policy is intended to impact positively on the overall quality of life of a population. With regard to national policy on gambling as it relates to public health issues, it would appear that the government's social policy committee is the most relevant policy-making body, since its mandate is both social and health policy. With regard to a HP approach to policy for gambling, it is felt that what we need is proactive and positive social policy which acknowledges that gambling is a powerful reality in our society, and which aims to shape community, individual and commercial frameworks in such a way as to enable and support the 'healthiest' outcomes with regard to gambling. This particularly needs to support community initiatives and decision making with regard to gambling.

To sum up, then, there are three main streams of health promotion action being proposed here: community action, knowledge dissemination and healthy public policy. We are proposing that **community be the primary action location for a**

health promotion approach to gambling. At the same time, we need to recognise the equal necessity for government and industry responsibility with regard to gambling policy and self-policing, and the recognition of gambling as a quality of life issue for the whole of society. In short, all three parties (community, government and industry) have responsibility with regard to dealing with gambling, and all three need to work together in partnership for a healthy community.

Health promotion applied to gambling – international examples

As could be anticipated from the difficulty of getting gambling accepted as a public health enterprise, there is relatively little literature available on the topic of health promotion and gambling. However, there are some examples, especially from the health education and community areas. Here, we give brief examples to show what is possible.

Health education – UK

The British organisation GamCare is a good example of a national body with a broad health promotion/education set of aims, whose main role is the provision of information to gamblers and professionals. Their aims are:

- *Improve the understanding of the social impact of gambling*
- *Promote a responsible approach to gambling*
- *Address the needs of those adversely affected by a gambling dependency (GamCare, 1999a)*

An example of their information provision is a brochure called 'Dealing with debt: a guide for problem gamblers', which says such things as:

If gambling is resulting in debt issues for you, and you have loan sharks, bailiffs or other creditors chasing you....try not to panic....

First Steps

- *Stop all gambling while you are addressing your problems....*
- *Take responsibility for your gambling – and for your debt*
- *Share your problems with a friend or professional....*
- *Ask someone you trust to look after your bank book/savings....*
- *Cut up your cash-point card and credit cards if necessary (GamCare, 1998)*

GamCare also puts out resources for professionals to work in preventive ways, especially with youth. For example, in their list of publications, they show resources such as:

A Dead Cert? Gambling Trigger Pack

By Jane Farman. Published 1998 and available by Gamcare, price £10 per copy for non-members, £8 per copy for members inc. p&p

This gambling pack is intended for use by youth workers or a youth work setting. The pack is designed to trigger discussion among young people so they are able to develop an awareness of gambling issues, express their learning needs and identify problem gambling behaviours. If young people

know the risks they can be empowered to make their own choices about gambling.
(GamCare, 1999b)

Probably most western countries will have similar resources available.

School curriculum modules - Queensland

In Queensland, there are a number of sophisticated HP strategies taking place. The 2000 fifth form school curriculum has a 'Promoting the Health of Individuals and Communities' stream in the Health and Physical Education component. In this is a 'Gambling and Health: Communication Skills' module. Its purpose is stated as follows:

Students predict the long-term and short-term health consequences of problem gambling. They propose actions that deal with gambling-related issues and that therefore promote health now and in the future. They develop interpersonal and communication skills that will enable them to deal effectively with gambling-related challenges and conflict....

Activities in this module are based on a learner-centred approach with an emphasis on decision making and problem solving. They are sequenced as tuning in, exploring, looking and sorting, acting and reflecting phases....(Queensland School Curriculum Council, 2000)

There follows a 42 page resource book taking students through the activities in this area.

Healthy public policy – Queensland

Healthy public policy with regard to gambling is also evident in a number of constituencies. Such policy goes beyond regulation to the active and explicit agenda of promoting the wellbeing of gamblers and society. Here, Queensland appears to be an exemplar again. On 7 December, 2000, the Queensland Government circulated a draft document for consultation called the Queensland Responsible Code of Practice. In describing this, they say:

This draft strategy is currently being developed for public consultation to stimulate discussion and ideas towards an environment of responsible gambling in Queensland....

"The strategy is directed at maximising the social and economic benefits of gambling in Queensland, while minimising the potential harm to individuals and the community."

....The strategy will be developed to reflect cultural diversity and regional diversity and community needs throughout Queensland.

...For the purposes of the strategy, a broad and inclusive definition [of problem gambling] will be developed which recognises the health, safety and wellbeing needs of individuals and communities. It will assume that problem gambling is a complex individual and community problem influenced by a range of societal and cultural factors....The responsibility for achieving responsible gambling outcomes thus becomes a broad community concern rather than being "owned" by one sector or group of professionals.
(Queensland Responsible Gambling Advisory Committee, 2000)

The focus here is mostly on 'problem gambling'. However, the wider community context and complex assumption of determinants, plus an explicit health focus, make this statement entirely consonant with the HP approach we have been advocating.

Community approaches – Alberta and South Australia

Perhaps the kind of health promotion most relevant to that in the present discussion is that with a community focus. Some of this comes under the label of 'prevention', but in reality it has considerable overlap with what is meant by HP here.

For example, the previously mentioned Alberta Alcohol and Drug Abuse Commission (AADAC), an 'agency of the Alberta Government', has services which include 'community education and prevention' in the area of gambling. Their stated values are as follows:

- *We value individuals, families and communities as partners in addressing addiction problems.*
- *We value people, treat them with respect and believe in their ability to succeed.*
- *We value staff, their skills, creativity, initiative and expertise.*
- *We value being grounded in good research and experience.* (Alberta Alcohol and Drug Abuse Commission (AADAC), 1999)

Of their prevention and education programmes, they say:

We develop our prevention programs in consultation with communities. We design them to fit each community. Our prevention programs aim to:

- *Educate people about problems related to abuse of alcohol, other drugs and gambling.*
- *Participate in building healthy, supportive communities.*
- *Help people learn the skills they need to live without depending on addictive substances and activities.* (AADAC, 1999)

With regard to gambling prevention specifically, they say:

Each community and demographic group has different requirements for protection and support, and the most creative, dynamic and effective ideas result when we allow the community to take the lead....(AADAC, 2001)

We know that effective prevention of gambling-related problems must include a range of responses suited to the needs of specific communities. It is necessary and important that government agencies and community groups combine their efforts and resources. AADAC is encouraged by the growing community willingness to address problem gambling issues. One way in which we support relevant community-based prevention strategies is through the Problem Gambling Community Projects in Educational and Prevention Program.

This program provides up to \$10,000 per qualifying community project that prevents and minimises the harm associated with problem gambling....We look for projects to reflect a balanced approach to the education and

prevention of problem gambling. We suggest that the project involve the participation of the target group (e.g. youth, seniors, adults). We ask community groups to collaborate to plan, implement and evaluate the project. (AADAC, 2001)

A few of the many community projects funded under this scheme are:

- *The production of a 20-minute video targeted at key influencers of youth to promote the concepts of resiliency in their prevention of problems with gambling, or with alcohol and other drugs.*
- *A problem gambling awareness strategy targeting youth and adults based on a community needs assessment of the impact of problem gambling.*
- *A series of workshops to educate parents on the issues of problem gambling and enhance their capacity to build self-esteem in themselves and their children.*
- *The hiring of a coordinator to create newsletter and to deliver information sessions, displays and school presentations. (AADAC, 2001)*

A recent issue of the South Australia Department of Human Services periodical Health Matters: A Publication of Health Promotion SA (September, 2000) was devoted to the topic 'Gambling – A Community Response'. Editorial comment in this publication says:

The Ottawa Charter for Health Promotion (1986) action step, Strengthening Community Action, signals that health promotion works best through effective community action. Communities need to identify health and related problems or issues and direct attention to ownership of solutions, thereby gaining control over their initiatives and activities.... (Health Matters, 2000, p.9)

As in Alberta, funds in South Australia are available to communities to design their own HP projects. According to a report on this:

Priority was given to projects that addressed issues that are of priority to a local area or target group such as youth, the Asian community and the Aboriginal community; addressed inequalities such as those related to gender, age, Aboriginality, ethnicity, disability, geographic isolation, or socioeconomic status; incorporated prevention or harm minimisation as a focus; demonstrated partnership between community-based organizations using a collaborative approach to address a local issue; and involved the affected target group/community in the project development and implementation. (Health Matters, 2000, p. 9)

Examples of projects are:

- *SHine SA: Peer education program with 15 young Aboriginal women*
- *Noarlunga Health Services: Develop a cross-curriculum education kit to help students develop the knowledge base and skills necessary to think critically about gambling.*

- *Northern Metropolitan Community Health Service: Raise awareness amongst care-givers and parents of gambling and its effects. Foster community participation and a collaborative approach to the reduction of problem gambling through the involvement of parents, school, health workers and community agencies.* (Health Matters, 2000, p.9)

In the same publication, McCabe (2000) explicitly advocates for a community based health promotion approach to gambling, which he calls a 'win, win strategy'. He says:

....Efforts to consult and involve the community are critical in the planning of effective strategies which will be acceptable and utilised. Applying health promotion approaches to gambling offers many opportunities in a wide range of settings and disciplines....This is a multi-sectoral responsibility.... Health promotion can certainly make a significant difference in this area as it has in so many other areas of preventative health. (p.14)

Health promotion applied to gambling – New Zealand

In New Zealand, the Compulsive Gambling Society (CGS) (about to be reconstituted as the Problem Gambling Foundation) has probably single-handedly taken upon themselves the health promotion mantle with relation to gambling in this country.

HP has only been an explicit CGS activity from February 1998, with the one half time person becoming full time on the 1st of July 2000. Over that time, we have seen a stream of excellent educational materials to rival anything in the world. Examples of these materials are posters, booklets and information packs for problem gamblers and those working with them, and information specific to the different age, gender and cultural groups affected by problem gambling. These include:

- **Posters in Tongan, Cook Island, Samoan, Fijian, Korean and Chinese**
- **Booklets and leaflets targeted at women, youth, older people, families, Maori, problem gamblers, and the general public**
- **GP Information Pack and Manual**
- **The Eight-Screen Information leaflet, in English and Chinese**
- **Information on the Problem Gambling Helpline and Gamblers Anonymous Information**
- **An alcohol and drug resource kit**

In addition, in the past year, CGS has to set up community-based HP project teams targeting a number of special interest areas. Recently, a full-time manager was appointed to coordinate these programmes. Most of these activities have a strong community and/or cultural emphasis. The current project groups are:

- **Youth**
- **Pacific Island**
- **Asian, Chinese and Korean**
- **Maori**
- **Women**
- **Families affected by problem gambling**
- **Professionals, especially GPs, using the 8-Screen Test for Problem Gambling**

CGS has generally been a strong advocate for healthy policy for gambling in New Zealand, and has championed the cause for a broad national HP strategy for gambling in New Zealand. That is the topic to which we now turn.

PART 3: A HEALTH PROMOTION STRATEGY FOR HEALTHY GAMBLING IN NEW ZEALAND

In this third part, we look at a possible approach to a long term strategy for HP applied to gambling (HPG) in New Zealand. To do this, we draw on the three 'cornerstones' suggested before as necessary for a balanced and comprehensive HPG strategy:

- **Facilitating community participation and action**
- **Increasing public, community and individual knowledge**
- **Making healthy public policy**

Previously, it was asserted that the primary or pivotal emphasis for a HPG strategy, at least in New Zealand (where the sense of community is strong), should be a community-based one. The strategy now outlined follows this. Obviously, many details would have to be worked out, but extensive knowledge of the way New Zealand communities work, a sense of what they already want and feel about the gambling issue, and the common themes that arise out of the community research overseas, would all lead one to believe that such a strategy would be optimal.

Note that what is suggested here is only one of a variety of possible approaches to implementing a health promotion strategy for gambling in New Zealand. This author believes that something like this would be optimal. But it is not the only way.

The proposed strategy will now be considered under a number of headings, which broadly follow a chronological sequence of steps. After the steps are outlined, there will be a discussion of the rationale behind this approach, and of who might be responsible for undertaking this project.

There are three broad sequential steps, and then 12 more detailed ones. The three broad ones are:

- **Develop community awareness**
- **Support community organisation and action**
- **Provide a framework for community input into policy**

The more detailed steps are as follows:

1. State overall aim of the enterprise.

For example, this aim could be:

This strategy is to enable communities to feel more in control of the local issues surrounding gambling, so that their health, wellbeing and quality of life is enhanced, and the potential damage done by gambling is minimised.

In addition, it is to facilitate the input of local communities into the processes of national policy development related to gambling, and to address the wider gambling-related issues of health, wellbeing and quality of life of the country as a whole.

2. Plan and execute a TV media campaign.

The aim of this is to inform the nation about the basic 'facts' about gambling in the past 10 years in New Zealand, with an emphasis on the community and personal impacts of gambling. This is seen as a general awareness-raising and informational exercise.

3. Prepare community resource kits.

As a follow-on from this campaign, resource kits would be made available for trial communities wanting to work on their own gambling issues (see next step). These kits would have both an informational aspect, and an aspect of how to organise locally around gambling issues. Both the discussion of information and the taking of action steps would be done with the assistance of trained facilitator/researchers, for whom a training programme would need to be set up.

4. Find (say) three trial communities wanting to volunteer for participation in a trial project.

The ideal here would be to find three diverse communities, perhaps one urban, one rural, and one of predominantly Maori or Pacific culture, all of whom have some known issues surrounding gambling. Stakeholders would be approached, the project outlined, and participation decided upon by the community itself.

5. Assist those communities to set up an initial organisational structure to be the local project steering group. (Note: this and the next four steps refer to activities within a given community).

It is possible that a volunteering community will already have an established group of people who are interested in community gambling issues, otherwise a new one will need to be set up. The aim would be to get a group specifically oriented to community wellbeing issues, with no industry or other axe to grind. Residents representing youth, the elderly, Maori and other important community sectors should be sought. The aim would be to have a wise and balanced group of people, which avoids any extreme or prejudiced views – the interests of the overall community should come first. The approach needs to be a consensual one, rather than a radical one. For want of a better name, we will call this the Community Gambling Interest Group (CGIG).

6. Enter a process of 'brainstorming' the local issues.

The CGIG meets regularly with the facilitator to raise their level of knowledge, and then to start to work on a local approach to gambling in their community. This would include addressing matters such as the overall aim of what they want to do; clarifying the overall parameters of gambling in their community; identifying issues, stakeholders and vulnerable groups; determining local values and attitudes related to gambling; and starting to look at the community's wishes relating to gambling, with the intention of working towards a more systematic needs assessment (next step).

7. Do a systematic needs assessment.

Needs/wishes assessment is the key to effective working at the community level, and the key to an empowering approach. That is, once the community is well

informed about the issues, and has a good grasp of the options, a systematic process is undertaken to finding out representatively from that community what it would like for itself around the domain of concern, in this case, a healthy approach to gambling. This could also include what is deemed the best way to deal with counselling and treatment for problem gambling. A broad and inclusive approach would be taken, which could include economic, recreational, educational, lifestyle, family, political and other such issues. The advantage of working in a local community manner is that one can take all these 'ecological' or 'holistic' factors into account at the same time, because the population is relatively small. This is seen as superior to dividing gambling issues into autonomous problem areas over, say, the whole country, since so many aspects of community life are interconnected.

Needs assessments can take a variety of forms, but can include door-to-door surveys, focus groups, community forums, hui on marae, in-depth interviews with key people, and looking at local statistics and social indicators. Some combination of these methods is best, the overall aim being to get a representative and true picture of the priorities of the community, and what action they would like to take.

8. Establish priorities and goals on a consensual basis, and set up task groups to deal with these, ideally using a planning model approach.

The usual and most effective way of working from this point on is to set up a system which encourages community participation in all aspects of what happens, including control over the project, establishing priorities and goals, getting resources, taking action, and evaluating what has happened. This uses what is called 'the planning model', which is a step by step 'management by objectives' approach to what needs to be done, based on written down goals and evaluative processes. A number of successful community projects in New Zealand use this approach (Raeburn and Rootman, 1998), and it is widely regarded as a useful organisational approach in other countries for community-based HP. (Note: cultural factors come into play here, and it could be that some communities would choose to work in another way, but with the same general objectives).

9. Evaluate both process and outcome of these endeavours.

A goal-based approach, as one finds in the planning model, makes evaluation relatively straightforward. Goals enable one to see how progress is being made on identifiable targets, and whether community needs are being met. This is useful both from a management perspective (when used in an ongoing review manner), and for accountability and assessments of overall impact of activities (on, say, an annual basis). Other evaluative measures can include surveys looking at the impact on the community of different activities, interviews, satisfaction measures, health measures, wellbeing measures, social indicators, psychometric measures, and so on. (See also Step 12).

10. Refine methods and approaches on the basis of this trial, and set up a national resource centre.

If this trial approach is successful, and positive health and wellbeing indicators related to gambling begin to emerge in these communities, and the negative dimensions of gambling are deemed to be being held in check, reduced, or at

least being managed in a satisfactory way, then it is time to move on to a more coordinated national effort.

Starting this project on a relatively small scale (perhaps for a period of two years or so) means that the 'bugs' can be ironed out of systems at the local level, and lessons learned for general applicability in other settings. This would then lead to the refinement of procedures so that manuals of good practice can be set up, and the resource kits for communities expanded and refined. This in turn would lead to these resources being made available to communities throughout New Zealand. There would need to be ongoing development of new resources and information. It is suggested that a national resource centre be set up in due course to enable communities to set up their own structures, and pursue their own priorities vis a vis gambling, within a structure of good information, good resources, and supportive government and other policy.

11. Develop ways in which informed, empowered communities can interact with government and others in the policy domain.

The assumption here is that communities are the best arbiters of what is good for them with relation to the impact of gambling on the wellbeing and quality of life of their residents. However it is clear that there is a wider responsibility of government and the industry with regard to this. There will always be a need for national regulation, and a national overview. In addition, since communities are relatively fragile power entities in the wider political spectrum, there should be in place policy and legislative measures which enable and support the kinds of activities outlined here. There will also need to be some ongoing resources required for these activities, and the source and nature of these would have to be worked out at a national level. So that communities can use their wisdom and perspectives to inform this policy framework, effective ways will have to be set up so that this can happen in an optimal way. At present, there do not seem to be established ways for communities to interact with government in the policy domain in any area, other than making presentations to commissions or select committees. It is felt that some less formal and more ongoing process should be established, one in which communities truly feel heard and supported, but also one where government feels confident about the value and integrity of what is happening. If industry could be involved in these processes in a way that represents their interest in the public good, then that would be desirable too. This author is not sure what these structures and processes would be, but in theory they would seem possible to set up with the right motivation and expertise.

12. Do periodic evaluations of the whole set up and process.

This community HP strategy assumes that there is no 'quick fix'. Rather, what is being sought is a long term developmental process which is enduring, and which is demonstrably effective in a global sense. With this in mind, it is suggested that, say, every five years, there be an overall evaluation and stocktaking of where things are, and of the impacts of these measures on communities and individuals. Here, the evaluative questions addressed would be such matters as:

- **Are communities happier than five years ago with regard to all local aspects of gambling? Do they feel they have a meaningful role in the wider policy arena?**

- Are there measurable impacts of what has happened in communities participating in the strategy which indicate improved health, wellbeing and social impacts related to gambling?
- Are the usually recognised problems associated with gambling lessening, or at least not increasing, and is their management satisfactory in terms of community expectations and standards?
- Are communities satisfied with this community-controlled approach? What changes need to be made?
- Are mechanisms in place for effective partnerships between communities, government and industry for the development and monitoring of healthy policy with regard to gambling?
- Do these processes seem to be associated with a more general improvement of wellbeing and quality of life in the community? For example, does the community generally feel more empowered, listened to, and more in control of things?
- What needs to be done over the following five years?

PART 4: CONCLUSIONS

It is clear that gambling is a growing and powerful force in today's society, and that it appears to have caught our culture by surprise. Gambling is one of a number of attractive recreational activities which entail a degree of risk. Judiciously used, it is a pleasant and exciting activity. But because of the prevalence and power of gambling today, there are increasing numbers of people who experience its direct or indirect ill-effects. In particular, it seems that it is the most vulnerable in society who are being most damaged, and our youth are of particular concern. (It seems likely that as poverty, disenfranchisement and boredom grow in our society, together with increasing pressures to consume, many see gambling as the way to get a 'big win' to fix their situation). The most detrimental impacts of gambling are probably on people's health and wellbeing, and to a lesser extent, on the social cohesion of communities. It is with these domains that this paper is concerned.

It was suggested here that a public health framework is an appropriate one for looking at the health and wellbeing sector with regard to gambling, both from a positive (wellbeing-enhancing) and negative (damage control and treatment) perspective. It is suggested that the optimal conceptual model for long term positive change is that of health promotion, which now has wide acceptance around the world, as well as in New Zealand. In particular, the kind of health promotion most recommended is that based on the Ottawa Charter for Health Promotion and the Treaty of Waitangi. This approach to health promotion is an ecological one, and it takes into account all the principal domains of life which impact on health and wellbeing, in particular policy, the environment, community, knowledge and skills, and services. It is felt that the most coherent health promotion approach to gambling in society would be one that emphasises three of these domains, namely community action, knowledge and skills, and healthy policy. The aim of this is to build community and individual resilience in terms of people feeling they have a sense of control over gambling issues with regard to everyday life. The overall aim is wellbeing and quality of life in local communities, where gambling has a role which is judged by most residents to be beneficial rather than harmful. Here, the values of empowerment and equity are uppermost. It is felt that a community perspective should drive the enterprise. This requires a systematic approach based on community development and planning model principles. It also requires appropriate partnerships with government and the industry to provide the wider healthy policy and environmental framework to support and enable this kind of community action. This policy should have the health, wellbeing and quality of life of our nation as its primary aim.

The 12-step health promotion strategy for gambling in New Zealand suggested in this document takes a community action perspective as its core driving force. The steps have to do with a media campaign to raise community awareness and knowledge, the voluntary participation of three or so communities in a trial project, the working out of processes for community action based on each community's perceived needs and wishes with regard to its wellbeing and gambling issues, the development of manuals and procedures which can be used on a wider basis throughout New Zealand, the evaluation of what is done, the setting up of a national resource centre to coordinate these activities in communities throughout New Zealand once the trial period is over (and shown to be a success), and a five year stocktaking and planning cycle thereafter to appraise what is going on, and to set directions for the future. It also involves ways of facilitating an interchange between local communities and government for an optimal policy formation process.

In following such a comprehensive, community-based health promotion strategy, New Zealand would be a world leader. To date, whether internationally or in New Zealand, there have been only relatively few examples of health promotion efforts in the gambling area, although they are growing. To take the comprehensive community-driven health promotion approach suggested here would, we submit, enhance the health and wellbeing of communities with regard to gambling, and help to contain the mounting problems associated with the rapid growth of gambling in society. It would also add to the overall wellbeing of the country through having communities who feel in control of their own destinies, and who feel they have an important overall stake in their own health, wellbeing and quality of life.

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