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Kanohi ki te Kanohi

A Maori Face to Gambling

Lorna Christine Te Aroha Dyall

A thesis submitted for the degree of
Doctor of Philosophy, The University of Auckland, 2003
Abstract

Background

Prior to the commencement of this study, gambling was not considered a significant health issue for Maori, even though the first national gambling prevalence study in New Zealand in 1991, identified that Maori had at least three times the risk of problem gambling of non-Maori. In the early 1990s, through the provision of a gambling telephone helpline and gambling counselling services, it was identified that Maori and in particular Maori women, were increasingly seeking help with problems with gambling. Gambling is an integral part of the culture of New Zealand. To understand gambling and problem gambling requires an understanding of the social, economic and cultural context it plays in being Maori.

Aim of Study

This study investigated whether gambling and problem gambling is an emerging health issue for Maori and if so, the extent of the problem, its effects on Maori and health approaches, and interventions which are likely to be effective for Maori. A public health approach to address problem gambling has been investigated and a plan developed.

Methodology

This study has been undertaken from a Maori-centered and an action-oriented research approach. It has involved integrating existing and new information from the following sources: Maori patterns of gambling and expenditure, gambling prevalence data, Maori utilisation of gambling treatment services and gambling by indigenous people. Fifteen Maori problem gamblers have been interviewed to understand from the “inside looking out” their experience of problem gambling.
Thirty key informants have also been interviewed to understand from the “outside looking in” their perspective as to whether gambling is an emerging health issue for Maori. This research has involved quantitative analysis and qualitative research.

Findings

This study has found that problem gambling is an emerging public health issue for Maori. The effects of problem gambling for Maori are invisible and masked by other health problems such as alcohol abuse or mental health problems. Maori prevalence of problem gambling is similar to other indigenous populations which have shared similar historical and socio-economic experiences. Problem gambling often leads to crime, imprisonment, development of other health problems and the break down of families.

Focusing alone on problem gambling ignores the real issues for Maori, a wider perspective is needed which focuses on Maori and tribal development. A public health strategy is proposed to reduce Maori gambling related harm.
Acknowledgments

This thesis has been undertaken with the support of the Problem Gambling Committee, and the Departments of Maori and Pacific Health and Community Health of the Faculty of Medical and Health Sciences, Auckland University. It is appreciated, the encouragement and support my colleagues from both departments have given me, to complete this dissertation.

I thank my supervisors Dr Jennifer Hand Senior Lecturer, Department of Community Health, Auckland University and Professor Colin Mantell, Tumuaki, Faculty of Medical and Health Sciences, Auckland University who all have provided guidance and support throughout this research. The help of Associate Professor Carolyn Coggan, Director of the Injury Prevention Research Research Centre in the beginning of this study is also appreciated.

I thank all of the participants of this study who have shared openly and frankly about their views on gambling, their experience of gambling, the impact gambling has had on their life, and others who are important to them, and solutions they propose to reduce gambling related harm for Maori. Without your input, this study could not be completed to provide a Maori face to gambling. Nga mihi nui, nga mihi aroha ki aku kaitautoko katoa.

Without wonderful friends and family this research project could not have been completed. I thank all the people in my life who have contributed to my personal and professional development, and whose wisdom and support is now incorporated in this dissertation. I thank Janfrie Wakim, Glennis Mark, and Lady Keith for reading this dissertation and providing helpful editorial comments, Iritana Hankins for cultural advice, and my husband Alexander Simpson for his encouragement, and lastly my son Peter Simpson, who this dissertation is dedicated to. May he be inspired to set his own goals and achieve them in life.

"Whaia e koe ki te iti kahurangi; ki te tuohu koe, me maunga"

Let nothing but the unsurmountable turn you from your purpose
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Chapter One:
Maori and Gambling: Introduction and Overview of Thesis

1.1 Introduction

Gambling has meaning only within a socio cultural context. It may be a game, a social activity, or a platform for economic development at either a micro or a macro level, and so gambling as an activity needs to be culturally defined, and understood within its operating context. (Mcmillen 1996) The concept of culture is defined as the total collection of behaviour patterns, values and beliefs that characterise a particular group of people. Maori are a unique indigenous population, introduced to gambling through contact with tauiwi (new settlers) or non Maori who had come to Aotearoa/ New Zealand.1 The term “Maori” was used originally by the first inhabitants to define themselves as “normal, usual or ordinary”, but over time the meaning has changed to define individually and collectively the indigenous population of Aotearoa/New Zealand. (Reid and Pouwhare 1992)

Prior to contact with new settlers over 170 years ago Maori had no traditional words to describe gambling. Advisers to the Maori Language Commission have suggested that the appropriate words to describe gambling are “ringa totoa” loosely translated; this means the “hands that uses money carelessly”.2 This description of gambling suggests an activity that is unproductive for Maori. This view is in direct contrast with the beliefs of agencies such as the Department of Internal Affairs (or gambling providers) which claim gambling is beneficial and contributes positively to the social, economic and cultural fabric of New Zealand society. (Grant 1994)

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1 The terms nonMaori, Pakeha or New Zealanders will be used interchangeably to define those who do not define themselves as Maori.

2 Advice provided by Huata Consultants who work as expert advisers to the Te Taura Whiri i te Reo Maori (Maori Language Commission) 1997.
Over the 170 years since that first contact with non Maori gambling has become a normalised social and recreational activity in many Maori communities. It has become an integral part of many Maori social occasions and helps finance numerous Maori cultural structures, such as marae, (meeting place/house) kohanga reo (language nest) and so forth. Some individual Maori have also experienced problems associated with the introduction of gambling.

Abbott and Volberg (1991) carried out the first major study of the prevalence of problem gambling in New Zealand prior to the introduction of casinos. From that study, Maori were identified as two to three times at risk of problem gambling than non Maori. (Abbott and Volberg 1991) Following the results from the Abbot and Volberg (1991) study, staff working at gambling treatment services, in Auckland, and at the national gambling hotline noticed that, in relation to the national New Zealand adult population, a growing number of Maori were seeking help for problem gambling. (Compulsive Gambling Society of NZ 1998) Other studies by the Department of Internal Affairs had also highlighted that Maori in general were at risk of problem gambling. Maori spent more on gambling than non Maori, were heavy track betters and Housie was a popular form of gambling for Maori, especially amongst Maori women. (Department of Internal Affairs 1995; Department of Internal Affairs 1996) Information leading from these studies suggested that there was a need for discussion with Maori regarding emerging trends on Maori and gambling.

1.2 Background: Investigator’s Involvement in Maori and Gambling

Ms Lorna Dyall, the investigator of this study, has been involved in Maori health policy and Maori health service development for approximately twenty years. Gambling and problem gambling was chosen as an area of study by the investigator, as little was known about its impact on the development of Maori and overall Maori health status. An opportunity to be a board member of the Compulsive Gambling Society of NZ Inc. in 1996-2000 has led to this study.

This study has arisen from three hui organised by the investigator with the support of the Compulsive Gambling Society of NZ, (CGS) now called the Problem Gambling
Foundation and the Committee on the Management of Problem Gambling now called the Problem Gambling Committee.

1.2.1 Papakura Hui: Maori and Gambling

The first national hui (meeting) on Maori and gambling was organised by the investigator and was held at Papakura Marae, Auckland, in 1997. (Compulsive Gambling Society of NZ Inc. 1997) At that hui, the following information on Maori and gambling was presented:

- Maori as a population group were disproportionately seeking help with problems relating to gambling. Over 20% of CGS clients were Maori, and they sought help both through the national gambling telephone help line and by using counselling services.
- In proportion to the total New Zealand adult population, Maori should have been only 10% of all clients of specialist gambling treatment services.
- Over a third of Maori seeking help were women. Their preferred mode of gambling was gambling machines. Maori women, seeking help, were aged between 20 to 67 years of age.
- Maori men seeking help were aged between 17 to 50 years. On average, Maori presented ten years earlier than non Maori for help.\(^3\)
- Overall, gambling machines, track betting and casino were the main forms of gambling, which created real problems for Maori, but Housie, Lotto, and card games were also important.
- Maori often presented with associated problems with alcohol and drug use. Co-addictions were identified then as an issue for Maori requiring specialist gambling treatment services, to be able to work with Maori clients, and whanau (family) who had multiple needs.
- It was found that gambling problems often developed quickly for Maori, with small wins providing an incentive for some Maori to see gambling as

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3 Earlier presentation of a health problem for Maori is quite typical of many health issues Maori experience, such as, the early onset of heart disease, respiratory problems and diabetes.
a means to solve pressing financial and personal problems e.g. to pay debts, to meet children’s needs, to achieve personal dreams and to escape from a personal predicament. (Compulsive Gambling Society of NZ Inc. 1997)

A discussion paper for the hui was prepared by the investigator titled “Kua noho koiata mai te totoa i nga take hauora Maori: Gambling as an emerging health issue for Maori”. (Compulsive Gambling Society of NZ Inc. 1997) This paper provided information to participants on gambling developments in New Zealand, a framework to consider the Treaty of Waitangi and gambling developments and questions that could be asked to stimulate discussion with invited speakers.

At this hui, the Ministry of Health reported that it did not regard problem gambling as a significant health issue for Maori. (Earp 1997) The Ministry of Health was also reluctant to become involved in gambling due to a Cabinet decision of then National Government, that this matter was the responsibility of the Department of Internal Affairs and Treasury. (Compulsive Gambling Society of NZ Inc. 1997) The Department of Internal Affairs also acknowledged that gambling was an introduced activity to Maori occurring around 1840. (Compulsive Gambling Society of NZ Inc. 1997)

Six major recommendations emerged from the Papakura hui. They were that:

- Maori should be consulted and involved in all aspect of policy and research relating to gambling;
- independent information should be produced to inform Maori of the positive benefits and negative impacts associated with gambling;
- the Treaty of Waitangi should be the basis for the development of policy;
- relationships should be established with Maori and tribal groups so Maori could benefit directly and indirectly from gambling;
- the Committee on the Management of Problem Gambling should purchase a wide range of health services to reduce gambling-related harm for Maori;
- advertising standards should be developed to warn people of the risks associated with gambling to redress the view that gambling is a normalised recreational activity.
These recommendations were broad and supported a public health approach to address problem gambling for Maori. (Compulsive Gambling Society of NZ Inc. 1997)

1.2.2 National Workshop on Treatment For Problem Gambling

Following on from the Papakura hui, a second hui was held the following year (1988) as part of a National Workshop on Treatment for Problem Gambling in Auckland. At that meeting Maori participants stated that there was a need for information which focused on “Maori and gambling”, so that positive solutions could emerge from a Maori perspective. (Compulsive Gambling Society of NZ 1998) By taking this approach it was envisaged that:

- Maori would not be victimized;
- information would be available which uplifted Maori;
- information would enable Maori to reconsider the role gambling plays in the “life of being Maori” and the impact gambling has on Maori wellbeing;
- information would complement the growing statistical profile of problem gambling, which indicated clearly that Maori, as a population group, were at risk to problem gambling.

At this hui participants questioned the lack of significant Maori involvement on key decision-making bodies, which influenced gambling policy and decisions. It was requested that there should be Maori representation on the Committee on the Management of Problem Gambling, and that a Maori purchasing strategy should be developed to address and reduce problem gambling for Maori. Monica Stockdale, experienced in working with Maori with addictions, was subsequently appointed to this body to represent Maori interests.

Research planned by the Department of Internal Affairs for a further study on the prevalence of problem gambling in the New Zealand community was also questioned. It was recommended that future research related to the prevalence of problem and pathological gambling should provide information, which was relevant and useful to Maori. (Compulsive Gambling Society of NZ 1998)

A Maori action group was formed at this hui to raise Maori awareness about the risks associated with gambling and to encourage Maori leaders, at a national and local
level, to become involved in gambling matters. Members of the action group submitted a submission on the Gaming Review Bill 1998. (Select Committee on Internal Affairs and Local Government Committee 1998) The group recommended that any future gaming legislation should recognise the Treaty of Waitangi and in the process of licensing of casinos or gambling machines in the community Maori should be consulted so that tangata whenua (people of the land) were not adversely affected and benefited from gambling developments. (Dyall 1998)

1.2.3 Rehua Marae Hui: Christchurch

Following on from the two hui a further hui was held in Christchurch (1999). This hui was organised with the support of Te Puni Kokiri (Ministry of Maori Development). (Dyall 1999) The purpose of this hui was to raise Maori awareness of the possible implications for Maori of two to three additional casinos in the South Island. This hui was well attended with Maori participants travelling from Dunedin and Invercargill to seek information about how to treat and support people who had problems with gambling.

Many insights were shared about the differences between people who had an alcohol or drug abuse problem and problem gamblers. Maori working in the addictions field considered then that problem gambling was the most difficult to treat and often it was the underlying cause of other problems such as whanau dysfunction, crime, violence and abuse in the home or in the community.

Although participants shared knowledge it was recognised that there was little information available to inform Maori generally and health workers about the risks of problem gambling, and no research was available to inform Maori as to which treatment options were effective for treating people who were addicted to different forms of gambling. This endorsed the need for a national resource kit for Maori regarding gambling. (Compulsive Gambling Society of NZ 1998)

Participants at this hui were also concerned about Maori or local iwi (tribe) involvement in the establishment of additional casinos in Queenstown and Dunedin. They considered that the presence of a casino in Christchurch had impacted on the Maori community and was taking on a similar role as a marae in providing a meeting place for whanau (family) to meet and socialise ((Dyall 1999). Information from all three hui has provided the basis of this thesis.
1.3 Purpose of Thesis

The purpose of this thesis is to investigate whether gambling and problem gambling is an emerging health issue for Maori. From the beginning of this study “Maori and Gambling”, Maori have stated they to do not want Maori to be seen as the problem. Instead they want this research to provide “a Maori face” on gambling so that Maori can be part of the solution in determining the place, size and role gambling plays in New Zealand society. Maori-centred, action-oriented research, and qualitative interviews have provided the approach which form the methodology for this research and information to propose future policy directions. (Te Roopu Rangahau a Eru Pomare 1995; Cunningham 2000)

The aims of this thesis are:

- to consider the place of the Treaty of Waitangi in the development of gambling policy in New Zealand;
- to identify Maori attitudes, pattern and expenditure on gambling in Aotearoa/New Zealand;
- to identify the prevalence of problem and pathological gambling for Maori and to consider implications of that for the wellbeing of whanau, (family) hapu (sub tribe) and iwi (tribe);
- to review critically, international and national research to assess the current and probable future impact of gambling on the health of Maori;
- to identify current Maori use of gambling treatment services and implications for future planning and health service development;
- to review critically the situation of Maori and other selected indigenous populations that are exposed to gambling in order to determine the similarities and differences which exist and to suggest the implications of these for Maori health and Maori development;
- to investigate Maori problem gambler views on gambling and the impact gambling has had on their health and that of others affected by their behaviour;
- to explore the views of key informants representing different stakeholder interest groups to determine whether they consider gambling an emerging
health issue for Maori and the interventions they would support which could reduce Maori gambling-related harm;

- to identify the strengths of a public health approach to address Maori gambling-related harm;
- to propose a public health strategy to address Maori gambling-related harm and which support Maori development.

### 1.4 Thesis Overview

This thesis is organized as follows:

- Chapter two sets the scene for the research project “Maori and gambling”.
- Chapter three describes and discusses the pattern of Maori and non Maori gambling and the extent, size and effect of problem gambling in New Zealand with a particular focus on Maori.
- Chapter four discusses Maori utilization of gambling treatment services and the effectiveness of gambling treatment options offered, and considers Maori problem gambling in relation to that found in other indigenous populations.
- Chapter five describes a public health approach to addressing problem gambling as a recognised health issue for Maori.
- Chapter six outlines the methodology of the study from a Maori research perspective.
- Chapter seven presents the results of interviews with a sample of Maori problem gamblers, some currently receiving treatment.
- Chapter eight presents results of interviews with three different groups of key informants Maori health workers, crown policy advisers and individuals associated directly or indirectly with the business of gambling to identify their views on Maori and gambling.
- Chapter nine presents the overall findings of the study, its strengths and limitations and proposes a public health strategy to address Maori gambling-related harm.
1.5 Summary

This chapter has outlined the importance of reviewing gambling and problem gambling within a socio cultural context. The investigator’s role prior to the commencement of the study Maori and Gambling has been outlined. Views expressed by Maori at three gambling hui have been reported and used to shape this study. This research has been undertaken from a Maori-centred and an action-oriented approach to provide a Maori face to gambling.

This study aims to investigate whether gambling is an emerging health problem for Maori and if so, the extent of the problem, its effects on Maori and health approaches which are likely to be appropriate and effective for Maori. This study investigates these issues by reviewing New Zealand and overseas research related to gambling, by interviewing Maori problem gamblers and by interviewing key informants involved in delivering health services to Maori, providing gambling or health policy advice, or who are involved directly or indirectly with gambling.

Chapter two sets the scene, it defines key concepts, models of health and discusses background information which is important to understand the role, place gambling occupies in Maori and New Zealand societies.
Chapter Two:
Setting the Scene

2.1 Introduction

Chapter two is presented in five sections. Section one introduces the chapter. The next section describes the role of being Maori in Aotearoa/New Zealand. Section three outlines and discusses key definitions and concepts. The fourth section outlines Maori activities relating to gambling and the last section provides a summary. Overall this chapter sets the scene and provides the foundation for the study. Its defines key concepts and models of health, discusses the place of the Treaty of Waitangi in Aotearoa/New Zealand, reviews the role and place of gambling in New Zealand society, outlines briefly gambling policy in place and indicates where issues are discussed further in this thesis.

2.2 Maori in Aotearoa/New Zealand

2.2.1 Definition of “Maori”

Concepts of ethnicity and identity are sensitive issues especially in Aotearoa/New Zealand and are often visible in the debate amongst non Maori as to how this population wishes to define its self such as being either “Pakeha” or New Zealander. Ethnic identity is a socially constructed concept in New Zealand. Until 1974, Maori were required to define whether they were full Maori or “half-caste” and this was defined in relation to a notion of blood purity. Since that date the concept of Maori has been defined in relation to declared identity. Individuals are given the opportunity in many different situations to define their own ethnic identity. Nevertheless, who is asking the question, the situation and how the information may be used can influence an individual’s choice of ethnic identification in New Zealand. (Murchie 1984; Durie 2001)

Individuals who define themselves as “Maori” can now state that they are solely Maori, that Maori is one of the ethnic groups they identify with or that they have Maori ancestry. Additional information may also be provided concerning tribal affiliations. Definition of “Maori” is an important health issue in New Zealand because the way it is defined at either a numerator or denominator level affects the statistically recognized size
of a population. It can also influence the reporting and interpretation of health data such as whether a particular health issue has or has not improved over time. Ultimately, it can influence policy and resource decisions in New Zealand. (Pomare, Keefe-Ormsby et al. 1995)

Whakapapa (genealogy) provides the basis of establishing identity and enables people to determine whanau, hapu and iwi connections. Kinship linkages enable participation in different tribal developments and access to current and future resources. Some hapu and tribes have already received settlements for past Treaty of Waitangi grievances. (Durie 1998)

Any person can claim to be Maori if they can trace their identity to another Maori by using their whakapapa or genealogy connections. (Pomare, Keefe-Ormsby et al. 1995) The use of whakapapa also enables individuals to define whether they have mana whenua status (local tribal authority linked to current or previous land ownership). This gives different tribal groups throughout New Zealand the right in their area to determine the kawa (protocol) for different social and cultural situations, and to act as kaitiaki (guardian) over local environmental matters. Mana whenua status is becoming increasingly important where local resident iwi have influence over local health purchasing and health service delivery systems such as Maori Health Purchasing Organisations (MAPO). (Ministry of Health 2002)

Identification as Maori is also being increasingly recognised as a political statement, with individuals defining themselves as sole Maori or stating Maori as one of the ethnic groups they identify with irrespective of their level of cultural knowledge, participation in Maori activities or the possible stigma of choosing to be Maori. (Durie 1995) Some choose to go onto the Maori Electoral Roll simply to increase the number of Maori seats in Parliament.

In the 2001 Census, 526,281 individuals, or one in seven New Zealanders identified themselves as Maori. Ninety per cent of Maori live in the North Island, one in four Maori live in Auckland and the median age of Maori now is 22 years of age, an increase of two years from the previous census. (Statistics New Zealand 2002) Maori see themselves in Aotearoa/New Zealand as belonging to specific tribal groups and also as tangata whenua.
They also see themselves as the indigenous population of Aotearoa/New Zealand. For the purposes of this study, the term “indigenous” applies to the first settlers in a country who have a special relationship with the land, and see their wellbeing directly related to their physical environment, spiritual and ancestral relationships, social structures, values, beliefs and language. (Lawson-Te Aho; Te Puni Kokiri 1994) It is discussed further in chapters three and four the demographic profile of the Maori population and implications for Maori and gambling.

2.2.2 Te Tiriti o Waitangi/Treaty of Waitangi

In 1840, some tribes of Aotearoa/New Zealand signed Te Tiriti o Waitangi (the Treaty of Waitangi) with representatives of the British monarch, Queen Victoria. The Treaty of Waitangi is now regarded as the founding document of New Zealand as a nation. (Ministry of Health 2002) The preamble and Article One of the Treaty of Waitangi place responsibility on the Crown and the elected Government of the day to protect and to promote the interests of Maori through appropriate legislation and governance.

Article Two gives Maori the right to ownership and management of their own resources, such as land, fisheries, forests and any other properties or “taonga”, considered a treasure. It also accords Maori the right to “tino rangatiratanga” or self-determination. The principle of self-determination is important in health and an integral part of the philosophy of the Alma Ata Declaration “Health For All”, the “Ottawa Charter”, and the developing United Nations “Draft Declaration on the Rights of Indigenous Peoples”. (www.hpforum.org.nz/wishprom.htm, 2001)

Article Three of the Treaty of Waitangi accords Maori the same rights as British subjects. It places responsibility on government agencies to ensure legislation and policies create equal outcomes for Maori and non Maori. This article has also been used to dismiss article two and to suggest that Maori have no special rights or status over and

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4 There are two versions of the Treaty of Waitangi a Maori text and an English text. The Maori version of the treaty takes precedent in law. Over 500 Maori chiefs signed this version in comparison with the English version in which only 39 chiefs signed. The Treaty of Waitangi Act 1975 recognizes both versions and allows for treaty grievances from 1840 to be considered by the Waitangi Tribunal. This body has appointed ministerial representatives who hear grievances and make recommendations to the Government when it considers the Treaty of Waitangi has been breached.
above other population groups who have special health needs. (Department of Health 1992)

Recognition of the Treaty of Waitangi in the health sector has been used to enable both Maori and the Crown to try to work in partnership to improve the health and wellbeing of Maori in particular and all New Zealanders generally. (Dyall, Hankins et al. 2000) The health sector has accepted that fulfilling the Treaty of Waitangi requires recognition of three overarching principles protection, partnership, and participation when setting health priorities, funding and delivering of health services. (Durie 1994; Ministry of Health 2000)

Recognition of the Treaty of Waitangi in health legislation was attempted when the New Zealand Public Health and Disability Bill (2000) was first introduced into Parliament. This Bill provided for specific Maori representation in health decision-making bodies and required public health agencies to improve Maori health outcomes. (Dyall, Hankins et al. 2000) While these provisions were supported by some interest groups, the then Race Relations Conciliator considered that inclusion of a specific Treaty of Waitangi clause would create human rights issues as it would be unfair for Maori to receive greater access to health care than other populations with similar health needs. (Race Relations Conciliator 2001)

The Select Committee on Health weakened the Treaty of Waitangi clause and the Labour-Alliance Government (1999-2001) developed another approach to recognise the Treaty of Waitangi. It supported the statutory requirement for Maori participation in health decision-making and for improvement in Maori health outcomes and developed a new Maori policy statement as part of the New Zealand Health Strategy. This statement recognised Maori as tangata whenua in New Zealand, with the right to self-determination and the right to live in Aotearoa/New Zealand as Maori. (Ministry of Health 2000)

These obligations now require the Crown and its agents, such as District Health Boards, to work with Maori in good faith, with mutual respect, to co-operate and to have trust in the development and implementation of health strategies. (Waitangi Tribunal Reports 2002) At the same time the Government also stated that it has a responsibility to balance its duties and govern on behalf of the total population signalling clearly to Maori
that they must fit within the parameters set by Government policies and priorities. (Ministry of Health 2001)

Despite the removal of recognition of the Treaty of Waitangi from this health legislation, public sector agencies are becoming increasingly aware of Maori expectations and their responsibilities to recognise the Treaty of Waitangi in the processes of policy development, allocation of funding and service development, and the need to address inequities between Maori and non Maori.

Table One is a framework developed by the investigator to consider and recognise the principles inherent in the Treaty of Waitangi and the ongoing rights and responsibilities between Maori and the Crown. It can be applied to any public policy issue and incorporates legal decisions which have been made by the Waitangi Tribunal and the Court of Appeal. (Crengle 1993)
Table 2.1  
Treaty of Waitangi Framework

<table>
<thead>
<tr>
<th>Article</th>
<th>Maori</th>
<th>Crown</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Protection</strong></td>
<td>Right of Protection</td>
<td>Responsibility to good governance</td>
</tr>
<tr>
<td>Preamble and</td>
<td>Right of Protection of taonga (treasures)</td>
<td>Responsibility to protect the interests of Maori</td>
</tr>
<tr>
<td>Article I</td>
<td>Right to good faith and reasonableness</td>
<td>Right to good faith and reasonableness</td>
</tr>
<tr>
<td></td>
<td>Right to tino rangatiratanga (self determination)</td>
<td>Responsibility to ensure Maori participation in governance</td>
</tr>
<tr>
<td><strong>Active Partnership</strong></td>
<td>Right to be consulted</td>
<td>Responsibility to consult Maori</td>
</tr>
<tr>
<td>Article II</td>
<td>Right to ownership of taonga</td>
<td>Right to negotiate with Maori share of ownership of resources for common good</td>
</tr>
<tr>
<td></td>
<td>Right to tino rangatiratanga</td>
<td>Responsibility to support tino rangatiratanga</td>
</tr>
<tr>
<td></td>
<td>Responsibility to establish and maintain partnership with the Crown</td>
<td>Responsibility to establish and maintain partnership with Maori</td>
</tr>
<tr>
<td><strong>Active Participation</strong></td>
<td>Right to equality and equity</td>
<td>Responsibility to ensure equality and equity for Maori</td>
</tr>
<tr>
<td>Article III</td>
<td>Right to participate in decision making and to be included in an ongoing way</td>
<td>Responsibility to establish processes and structures for Maori participation</td>
</tr>
</tbody>
</table>
2.2.3 Gambling and Sovereignty

The position and treaty status of Maori and that of Native Americans is often compared. There are distinct similarities and differences between Native Americans interested and involved in gambling as a means of expression of their sovereignty rights (e.g. establishing casinos) at a Federal and at a State level and tribes in New Zealand which have sought legal redress for past breaches of treaty rights. (Duffie 1988) Both groups have tried different means to achieve economic independence where Governments are generally paternalistic and controlling. (Duffie 1988; Durie 1998)

Sovereignty is defined from an indigenous perspective as:

*The legitimate exercise of power and authority by the people themselves, sometimes in partnership with other national entities, sometimes not, in order to direct their own authentic courses of political action, separate and apart from any other kind of dependency status.* (Duffie, 1998, pg. 186)

This definition appeals to Maori and increasingly, tribal groups are seeing themselves as first nation peoples which can unite with other tribes in a spirit of kotahitanga (unity) through such bodies as the Iwi National Congress and the Fisheries Commission, to achieve their aspirations. (Durie 1998)

Some Native American tribes in America have used gambling to assert their sovereignty rights and have negotiated for the Indian Gaming and Regulatory Act 1988 (Abt and Mcgurrin 1992; Anders 1996). Native American tribes have a unique legal status known as “dependent sovereignty”, in which they must comply with legislation in each state in criminal matters, such as murder, but in non-criminal matters tribes can make their own decisions on Indian land, such as zoning, or other activities. (Rose 1992) The Indian Gaming and Regulatory Act 1988 has been established to promote Indian economic development, self-sufficiency and to establish the National Indian Gaming Commission. (Indian Gaming Association 2002)

Over 300 Native American tribes or groups are now involved in gambling in America and together they take approximately 10% of the forty billion dollar gambling business. Income from Native American gaming is generally used to support tribal development initiatives. This is in contrast to other gambling stakeholders such as Donald Trump Enterprises, which are involved for corporate or private profit. (Duffie 1988)
Indian Gaming and Regulatory Act 1998 has become extremely politically contentious in recent years. Other groups involved in gambling consider that Native American tribes have an unfair advantage in that they can develop their gambling operations within the provisions of their state and can also assert their own sovereignty by developing their own rules of gambling on their land, such as the size of jackpots for bingo or gaming tables.

Despite the adverse effects that gambling can create in different communities and population groups, involvement in gambling has created new opportunities for first nations tribes in the United States. (Cozzetto and Larocque 1996) Some Maori groups have noted these developments and to assist Maori consider options, a specific paper has been written which Maori groups can use as a checklist to assess the costs and benefits of tribes becoming involved in major gambling developments such as casinos. (Lommis 1998)

However, there are major differences between Maori and Native American tribes in America. First, Maori do not have "dependent sovereignty" and can only develop initiatives within the laws set for the whole country. Secondly, as the Treaty of Waitangi has never been ratified its legal status is always open to question with the result that Maori are always in a vulnerable position when advocating for their perceived rights.

Each Government since the 1980s has developed its unique position on the Treaty of Waitangi. Durie (1994) has traced the development of the Treaty of Waitangi policies of different Governments and has recognized that, although various Governments have recognised the Treaty of Waitangi in policy, they have been reluctant to include specific clauses in social legislation. On the other hand, Governments have been willing to include recognition of the Treaty of Waitangi in legislation relating to environmental resource management, Crown research, hazardous substances and State Owned Enterprises. (Durie 1994)

The place and recognition of the Treaty of Waitangi in relation to gambling requires further consideration but from the outset of the establishment of casinos in New Zealand in the 1990s, Maori have expressed interest and have been seen either as a key stakeholder group which should be involved or used as the reason another interest group should be considered as the preferred licence applicant, such as in the bid between two
different interest groups for the Auckland casino licence. (Schmidt 1993; Te Maori News 1995)

In organizing the first national hui on gambling, Dyall (1997) noted links between the settlement of Treaty of Waitangi grievances and the expansion of gambling in New Zealand. As part of the publicity for the first national hui on gambling, Maori leaders were urged to attend as it was seen that valuable Maori and iwi resources could be taken by the Crown and private gambling organizations, if Maori expenditure on gambling individually and collectively increased. (Compulsive Gambling Society of NZ Inc. 1997)

The Crown, for example, could gain Maori money from gambling losses, such as Lotto tickets (weekly government national lottery) which were not winners, and from tax collected directly or indirectly from gambling operators as casinos and gambling machine licence holders. (Compulsive Gambling Society of NZ Inc. 1997) The place of the Treaty of Waitangi in relation to gambling is discussed throughout this thesis.

2.2.4 A Maori perspective of health

Culture and views of health are intimately related. (Ngata, Dyall et al. 1984) It is undesirable, therefore, to look at a specific population’s view of health in isolation from their unique values, beliefs, historical experiences and position in society. Maori health is not about sickness but about the development of a group of people. (Durie 1998) The health status of Maori over time reflects Maori experience of colonisation and loss of control over many matters which affect their daily life. (Durie 1994; Durie 1998)

Social and economic injustices of the past must be addressed if Maori health is to improve. This requires health professionals to look at the health of Maori from a wide perspective not only focusing on symptoms of a problem, but also working with Maori and the Crown to solve current and present injustices, thus supporting the positive development of group of people in today’s context.

Maori view health broadly, and propose that health is more than the World Health Organisation’s (WHO) view. Since the late 1940’s the WHO has defined health as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity”. Over time the WHO definition has widened to recognise the importance of the environment and social connections as family and spirituality. (Durie 1993; Dyall 1998)
For Maori, good health embodies at least four dimensions of wellbeing. They are: Te Taha Wairua (spiritual wellbeing), Te Taha Hinengaro (mental wellbeing), Te Taha Tinana (physical wellbeing), and Te Taha Whanau (family wellbeing). (Department of Health 1984; Durie 1998) Often this model is called the Te Whare Tapa Wha view of health or the four cornerstones of wellbeing. It is depicted as the four walls of a wharenui (meeting house) which need to be of equal strength to provide harmony, protection, warmth and an appropriate nurturing environment for those who live within or who use it on many different occasions, including tangihanga (farewell for the dead). The marae (courtyard) and wharenui (meeting house) are the heart of many Maori communities and often have been established through the efforts of people working together, often using gambling as a means of fund raising.

Te Whare Tapa Wha model of health emphasises the importance Maori place on their view of health, it is holistic and can be used for the management of specific health issues such as Diabetes Type 2 and mental health issues. (Rochford 2000) This model is now being developed as a tool for assessing health issues for Maori such as in mental health and as a platform to support Maori health and Maori development. Its use in gambling treatment services until recently has not been documented in any literature relating to gambling developments in New Zealand. (Herd 2002)

Alongside the Te Whare Tapa Wha is the Te Wheke model which uses the octopus. This model recognises each individual, as being is unique with his or her own life force. Using the eight tentacles of the octopus, the model suggests that each person has their own wairua, (spirituality) whanau, (family) Mauri, (life force) ha, (breath of life which is inherited from ancestors) whanaungatanga, (extended family) whatumanawa, (emotions) hinengaro, (mental wellbeing) and waiora (total wellbeing). (Pere 1994)

These dimensions are important to recognise when working with Maori in a therapeutic situation, as Maori see their health in relation to others and there is a close relationship between an individual’s health and the health of their family. (Turia 2003) An individual’s health is also a reflection of the health of their ancestors, recognising that patterns of behaviour such as gambling and alcohol use are often learnt and transferred from one generation to the next. Genetic factors also can increase an individual’s susceptibility to particular health problems. Positive health behaviours such as manaaki
(care) and aroha (love) are also transferred from one generation to the next and are shared within whanau, hapu (sub tribe) and iwi (tribe).

For individuals to be healthy and part of a healthy community, another model of health has emerged. Defined as Nga Pou Mana, this model is focused on the development of public policy and recognises that Maori require an environment which supports whanungatanga, (extended family) taonga tuku iho, (the maintenance and development of cultural heritage) te ao turoa, (respect and protection of physical environment) and turangawaewae (land and a place to stand). This model is similar to Te Whare Tapu Wha and uses the same imagery of the marae. It acknowledges that, for Maori individually and collectively to enjoy good health, Maori require appropriate policies and legislation in place, which recognise the value of each of pou (pillar).

Another model of health involves the Treaty of Waitangi and the principles which it embodies. Maori see themselves as kaitiaki (guardians) of the physical, social and spiritual environments in which they live. As an equal partner with the Crown, Maori see that they have a role and a responsibility to shape and direct their own future as well as the future of others in New Zealand. This has been most recently expressed by Maori in the debate in New Zealand of the place and ethics of genetic modification and in particular, the transfer of human genes to other animals to create new products which could be beneficial to specific groups in the community or could create economic benefits for New Zealand. In considering any new technology, Maori are concerned about the protection of whakapapa (genealogy or ancestral connections) and the health and wellbeing of people. (Harry 2001; Revington 2001; Royal Commission on Genetic Modification 2001)

Increasingly Maori are advocating their perceived rights and responsibilities in New Zealand at a local, national and international level. “Globalisation” is a new term being used to support and legitimate social changes in New Zealand. As a concept it is defined as the “international integration of markets for goods and services and capital”. Maori see this as a continuation of the process of colonisation, where Maori may be further excluded from decisions, which directly or indirectly impact on their wellbeing.

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5 NZ Herald “Globalisation: for and against” NZ Herald, May 3, 2001 A13
Maori increasingly consider that they have a right to be involved in decisions, including at an international level and this has implications for gambling policy. (Korn 2000)

For instance in the gambling sphere the Department of Internal Affairs has sought advice as to whether New Zealand should be promoted as a “safe respectable haven” for Internet gambling linked to New Zealand’s “clean”, “green” and economically and politically safe image. (Department of Internal Affairs 2001) The implications of this proposed development has not been considered in relation to Maori. (Department of Internal Affairs 2001)

Currently, only the Totalisator Agency Board (TAB) is permitted to operate an Internet track and sport betting gambling site in New Zealand. (Department of Internal Affairs 2001) Consequently Skycity has established a site in Australia. Skycity is no longer a private company, focused on the ownership of casinos in New Zealand, but owns the Adelaide Casino, an internet site in Australia, and is looking to Pacific sites to establish new operations. A few Maori individuals and organisations have become involved in the ownership of shares in this company without any real consideration they may be exploiting other indigenous populations and disadvantaged groups. (Dyall 1998)

Another model of health to emerge is the concept that Maori have the right to be healthy. This view is consistent with United Nations documents and the Draft Declaration of Indigenous Peoples’ Rights (Te Puni Kokiri, 1994). At Te Ara Ahu Whakamua (1994), participants stated that Maori needed to have the following for good health; a sense of identity, knowledge of whakapapa, a positive sense of self esteem and pride, control over their own destiny, a voice which is listened to, wairua, tinana, hinengaro and an ability to be able to take both personal responsibility and co-operative action. Also it was advocated that Maori needed to have respect for others, promotion and protection of te reo (language) and tikanga (customs), economic security and whanau support. (Te Puni Kokiri 1994)

These models of health reflect Maori views of being tangata whenua and Maori relationships with the wider New Zealand society. Such models have encouraged other models to emerge, developed by different Maori health providers, which support their kaupapa (purpose), aspirations for their clients and overall Maori wellness. There are now independent Maori health and social service providers across the country providing a
wide range of health promotion, prevention, treatment and rehabilitation services covering public, personal, disability, mental health, gambling, accident related services and social services.

As mentioned Maori consider that their health is a reflection of the past and current influences which also shapes their future. Further, the present health of Maori, individually and collectively, is a result of previous interactions and reactions within New Zealand society, that is, the agencies, policies and legislation that have governed and influenced people’s lives. (Durie 2001) At least three different levels of intervention are required to improve the health of Maori: individual, whanau and total Maori population. Interventions at all these levels recognise that each Maori person and whanau are unique and have their own history or story to tell. Recognition of the past also prevents Maori from being victimized as individuals or as a population group. The application of Maori concepts of health and the dynamics of Maori health has not been considered in relation to problem gambling for Maori nor have they been considered in the development of health interventions but they certainly have relevance. (Dyall 2001) The impact of gambling on the health of Maori gamblers is reported in chapters seven and nine.

2.2.5 Maori Health Policy: Government Responses

In 1999, the Labour-Alliance Government was elected, and it gave a commitment that it would address the social and economic inequities which existed between Maori and non Maori. Policy was introduced under the title of “Closing the Gaps”, and was based upon many reports, in particular those released by Te Puni Kokiri, the Crown’s Maori policy agency. This agency reported growing inequities between Maori and non Maori in such areas as employment, education, health and income. The gaps identified were considered to be the results of previous governments’ policies especially those which were driven by free market ideologies and the concept of mainstreaming Maori. These policies increased the gap between rich and poor and widened the gaps between Maori and non Maori. (Te Puni Kokiri 1998 (c); Keenan 2000; Te Puni Kokiri 2000)

To close the gaps the Government made a commitment that it would make a difference by coordinating leadership across government agencies and by providing specific funding for capacity building in Maori communities. (Ministry of Health 2001) With Maori as the focus of government policy, there was swift criticism from non Maori
Labour supporters that Maori were receiving a disproportionate share of resources and support compared with other groups in the community who had similar needs.

Within a year, the use of the term “Closing the Gaps” was considered no longer appropriate in government policies and new policies were developed which focused on addressing inequities in Maori, Pacific and low income communities through a “whole of government approach”. The renaming and refocusing of Maori public policy demonstrates the dynamics of the social structures which exist within New Zealand society. There is considerable opposition from low income New Zealanders for Maori to socially and economically advance, for if the position of Maori advanced, the question arises, who would occupy the underclass position in New Zealand society. (Young 2003)

Maori lifestyle choices and overall quality of life are related to the structural arrangements and distribution of power in New Zealand society. (Ministry of Health 2001; National Health Committee 2002) The change in focus and policy direction shows the difficulties of the development and maintenance of a coherent Government Maori policy in an environment which is generally hostile to Maori interests. These dynamics are discussed further in this thesis, especially in chapter five, in relation to Maori health and gambling policy.

2.2.6 He Korowai Oranga: Government Maori Health Policy

Recognising that the active protection and promotion of health and wellbeing of Maori is a Crown responsibility, the Ministry of Health has developed a number of overarching and linking health strategies to lead the health sector and to support the development of District Health Boards. (Ministry of Health 2000; Ministry of Health 2001; Ministry of Health 2001) One of the linking strategies is “He Korowai Oranga” which focuses on supporting government health priorities and rebuilding and strengthening Maori whanau. Four strands underpin this policy: developing whanau, hapu, iwi and Maori communities, improving Maori participation at all levels in the health and disability sector, improving the effectiveness of health and disability sectors and taking a leadership role in working with and across different sectors. (Ministry of Health 2002)

This policy was released as a discussion document in 2000 and formally released as a policy with an action plan in 2002. (Ministry of Health 2002; Ministry of Health
2002) It is discussed further in Chapter five and the strands are used in Chapter nine to recommend a Maori health strategy to reduce gambling-related harm. Although He Korowai Oranga, is the Government’s key policy for Maori health development, the Ministry of Health has not used it as a framework for reducing gambling-related harm for Maori (Ministry of Health 2002).

Considerable publicity was given to the release of He Korowai Oranga however, no additional funding was provided by the Government to support it. (Ministry of Health 2002; Turia 2003) Instead the Government stated that it expected District Health Boards to develop health initiatives with Maori and iwi groups within current health resources. This policy has similarities with the Closing the Gaps initiative, in that the Government is reluctant to give funding specifically for Maori development at the expense of other groups in the community. It also supports the view that although Maori health may be stated as a priority, political action and actual social change are often dependent upon advocacy by Maori or by Pakeha individuals who are supportive of Maori aspirations. (Dow 1999; Lange 1999; Durie 2001; Dyall 2001; National Health Committee 2002)

2.2.7 Maori Development

Maori development is a key aspiration for many Maori individually and collectively and is often used by, elected governments to promote and implement their policies. As a concept the term will be used broadly to characterize the positive development of Maori, as defined by Maori. It embraces many issues such as those which focus on Maori whanau, hapu and iwi advancement, Maori right to tino rangatiratanga (self-determination), Maori identity, recognition of the Treaty of Waitangi, the protection of the social, economic and cultural environment for current and future generations and Maori economic self reliance. (Durie 1998)

Increasingly it is being recognized that New Zealand’s future will depend on policies which allow Maori to achieve their full potential as then resources spent on negative areas of development such as ill health services, imprisonment, and income support can be reinvested into areas of positive development, such as education, regional business development, sport and cultural development. (Laws 2000) These are issues, which must be considered in developing policies and strategies related to Maori and gambling and are discussed further in chapters three, five and nine. (Dyall 2002)
2.2.8 Maori Public Health Approaches

Models of Maori health discussed previously support the need for recognition of a New Zealand approach to addressing health issues. For the purposes of this study the term “public health”, is defined broadly to mean “the science and art of preventing disease, prolonging life; and promoting health through the organized efforts of society”. (Committee of Inquiry into the Future Development of the Public Health Function 1988; Public Health Commission 1995) This definition means that a public health perspective requires “taking specific measures to improve the health of the community, protecting people against ill health and minimizing the risk of disease, and promoting good health”. (Public Health Commission 1995, pg. 6)

Maori support this public health view and traditionally have developed their own public health strategies based upon Maori tikanga, especially tapu (sacred) and noa (clean) as means of social control and protection so that all members of a whanau, hapu, iwi, are able to participate in everyday activities, free from spiritual, physical, or emotional harm. (Dyall 1997; Durie 1998)

Maori have also developed their own styles of health leadership inspired by such leaders as Sir Maui Pomare, Te Rangi Hiroa Buck and Te Puea. (Lange 1999; Durie 2000; Durie 2000) Their style of leadership has included showing respect for and involvement of community leaders in health decisions, recognising local tribal tikanga, recognising the need to develop interventions which uplift Maori, the need to focus on social and economic determinants of health, and the importance of sharing information so that there is co-operation and not resistance to proposed health changes. (Durie 2000)

These strategies are still appropriate today and demonstrate the health leadership necessary to gain support for public health initiatives. (Te Puni Kokiri 1992) A wide range of public health strategies have been developed or adapted by Maori as they have become aware of the factors that have influenced the spread of different infectious diseases or lifestyles which have created health problems. Maori are supportive of interventions which focus on groups or populations even though they may sometimes compromise individual freedom or choice. (Durie 1994; Haami 1995; Public Health Commission 1995; Lange 1999) Maori concepts of public health are discussed further in chapter five.
Maori see the Treaty of Waitangi as the foundation for public health in New Zealand as it is inclusive of all New Zealanders and its overall purpose is to protect the health and safety of Maori. Recognition of the Treaty of Waitangi has provided impetus for the Ottawa Charter to be adapted to meet New Zealand circumstances with a key strategy to support Maori achieve tino rangatiratanga (self-determination) through healthy public policy, appropriately supportive environments, building local and national leadership, developing personal skills and resources and restructuring health services. (Health Promotion Forum of New Zealand 2000)

Therefore a public health strategy to address problem gambling cannot simply be taken from overseas and applied. It must be adapted or developed within New Zealand so that it affirms Maori models of health, Maori views of public health, incorporates Maori styles of health leadership and supports Maori and tribal aspirations for positive development.

2.2.9 Maori Health Advocacy and Problem Gambling

Maori gambling and problem gambling has been difficult to place and thus receive recognition on the health and general political agenda. (Dyall 2002) Without constant Maori advocacy, Maori problem gambling is unlikely to receive significant attention because there are many key stakeholders, including the Government, which have a vested interest in maintaining the status quo environment. (Department of Internal Affairs 2001) Gambling policy issues are discussed throughout this thesis, especially in chapters three and five when considering the role and responsibilities of different organisations or groups involved or associated with gambling.

Maori problem gambling cannot be addressed in isolation from Maori and general politics. The views of different stakeholders are considered as part of this thesis and reported in chapters eight and nine.

2.2.10 Maori Utilization of Health Services, Cultural Identity and Mental Health

Maori individuals, whanau and communities are now significant users of health services, have high health needs, and many health needs of Maori continue to go undetected, such as alcohol abuse or those problems arising from gambling. Due to the way in which ethnic information is collected in the health sector, the use of health services by Maori is often under-reported. In some situations it is estimated that this
under-reporting is by at least a third. This has profound implications regarding the allocation of health resources and registering the difference in health status between Maori and non Maori. (Kilgor and Keefe 1992)

Identification as Maori can be seen as a positive statement of a person’s sense of wellbeing and self-esteem. It can also be used as an indicator of a person’s state of health and recovery as individuals during the course of health care often change their ethnic identification to Maori. (Dyall 1997) Increasingly, the importance of cultural identification as an indicator of good health is being recognised in the development of mental health promotion and has strong links with public health promotion. (Ministry of Health 2002)

Mental health promotion is a new domain of mental health that recognises the importance of individuals and groups having “resilience” as a basis for the protection and promotion of good health. It is suggested that the ability of an individual or a group to cope with different positive and adverse situations is influenced by their sense of “being”, “belonging”, and “becoming”. The concept of “being” is defined as how we feel about ourselves, and “belonging”, relates to our social, cultural and environment. In contrast, “becoming”, relates to the aspirations of an individual or a group and how they develop and achieve them. These three concepts are considered an integral part of a quality of life perspective and are important when considering the impact that colonisation and globalisation has had and will have on the quality of life experienced by Maori. (Joubert and Raeburn 1988)

Durie supports the emerging ideas of mental health promotion and he advocates that a strong and secure cultural identity is one of the prerequisites for good health for Maori in New Zealand. He suggests that it is time to recognise and measure Maori cultural indicators alongside socio economic indicators, for they are benchmarks, which can be used to assess the state of health of Maori individuals and groups. (Ministry of Social Development 2001) They can also be used as measures to assess the process of health recovery and healing for Maori. (Durie 2001)

Cultural indicators for good health for Maori are broad and include access and knowledge of te reo, control over Maori environmental resources, and participation in whanau and tribal activities. (Durie 2001) These indicators are being incorporated in
Government health and social policies. (Ministry of Health 2000; Ministry of Social Development 2002) Chapter four discusses further Maori utilization of gambling treatment services in Aotearoa/New Zealand. The views of Maori problem gamblers in relation to being Maori and use of gambling treatment services are reported in chapter seven.

2.3 Key Definitions and Concepts

2.3.1 Definition of Gambling

The concept of gambling is often not defined as it is assumed it is widely understood. For the purposes of this study, gambling is defined as “to risk anything of value on a game of chance or on the outcome of any event involving chance, in the hope of profit”. (Arnold 1978, pg 8) The Productivity Commission defines gambling in a similar way as “staking money on uncertain events driven by chance”. (Productivity Commission Report 1999, pg 6) Gambling is seen as different from financial investment because generally the games played by gamblers are designed so the gambling operator will also win money. (Department of Internal Affairs 2001) As an activity, gambling can includes games of chance, informal or regulated through legislation, such as playing cards, track betting, casino games, gambling machines, raffles, lotteries and sport betting. Investment on the stock exchange is usually excluded from the definition of gambling, as it is not considered to be a game but a calculated risk or investment. However with the development of Futures’ investments through the use of the telephone and the Internet there is a strong argument that the stock exchange should be included in the definition of gambling. (Arnold 1978; Shaffer and Korn 2002)

As part of the gaming reform in New Zealand the Department of Internal Affairs in 2001 has defined “gambling” or “gaming” as having the same meaning and generally involves playing a game with the following elements: a stake or bet, an entry fee of money or something of value, an event where the outcome is partly or wholly dependence on chance and a prize of something of value. (Department of Internal Affairs 2001)

2.3.2 Continuous and non-continuous gambling

Gambling can be defined by whether a game is continuous or non-continuous. Games of chance, which are continuous, are defined as those in which the prize can be
immediately reinvested such as wins from a gambling or gaming machine, or a win from a casino game. For this group of gamblers, gambling provides more than fun, entertainment, excitement, and a chance to socialize or is a hobby. It can become a habit which can lead to problem gambling. (Abbott and Volberg 2000 (a); Department of Internal Affairs 2001)

In contrast, non-continuous gambling involves those games in which there is a break before reinvestment, such as Lotto, TeleBingo, Housie games and raffle tickets. For individuals who participate in this type of gambling, it is suggested that gambling provides a different function; it is “social” and merely a chance to win money or a specific item. (Abbott and Volberg 2000 (a)) From these two definitions gamblers can be defined as continuous or non-continuous gamblers.

Maori problem gamblers are both continuous and non-continuous gamblers and have high rates of conversions to new gambling games as they are introduced and will participate in one or more forms of gambling on a regular basis such as playing gambling machines, Lotto and then buying Powerball tickets. In their most recent study Abbott and Volberg (2000), have shown that on average Maori are still track betters, participate in playing TeleBingo and gambling machines, spend about $50 per month on gambling and their most favourite gambling activity is gambling machines outside of casinos. (Abbott and Volberg 2000 (a))

2.3.3 Benign Gambling

Recognising the difference between games of chance, Howland (1994) has noted that the New Zealand Lotteries Commission has carefully redefined gambling as “relatively high cost entry with low to medium odds, with a perception that a person’s skill can alter the outcome, and the ability to reinvest on a double or nothing basis almost immediately” (Howland, 1994, pg. 47). The New Zealand Lotteries Commission has then redefined gaming as being different from gambling and has promoted gaming as “mass market activity having low entry cost, with high odds, little skill and limited reinvestment

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6 Lotto and Powerball are both operated by the New Zealand Lotteries Commission. The later was introduced early in 2001 to increase the funds of this organisation to allocate to the Lottery Grants Board for distribution. This new game has been credited for allowing the Lottery Grants Board to increase funding to specific Crown agencies which are dependent upon it for the majority of their funding.
potential" (Howland, 1994, pg. 46). Adopting this definition, the New Zealand Lotteries Commission has been able to redefine Lotto as not a real form of gambling but a form of "benign-gaming", which creates minimal harm in New Zealand. This is the form of gambling most New Zealanders report playing at least once a year. In 1999 over 85% of New Zealanders reported that they had purchased a ticket at least once, two thirds had bought one over the past six months, and over a third (35%) purchased a ticket at least once or more a week. (Abbott and Volberg 2000 (a))

Terminology and definitions are important as they reflect the values and perceptions of a society, the interests of key stakeholder groups, such as the Department of Internal Affairs and the New Zealand Lotteries Commission and influences how activities and products are marketed, interact with each other and the impact they have on different population groups. The selling of Lotto in shopping malls and supermarkets, and mass media advertisements have enabled this game to become a powerful medium, which has been instrumental in redefining the role and place gambling plays in New Zealand society. (Howland 1994)

No longer is gambling considered morally “wrong”. Indeed the regular purchase of a weekly Lotto ticket is part of the cultural values and behaviour of being “a good Kiwi”. Lotto jackpot winners are often front-page news in major daily newspapers in New Zealand and support the concept of fairness claiming that every player has a chance of being a “Lotto winner”. Participation is open to anyone or any group even though the minimum legal age at which tickets may be purchased is 16 years. (Department of Internal Affairs 2001) Tickets are often bought for individuals under this age as birthday presents or to mark special occasions. (Howland 1994; Department of Internal Affairs 2001) Many Maori individuals and whanau regularly purchase Lotto tickets and participate in a wide range of gambling activities, both continuous and non-continuous games of chance. Chapter three discusses further Maori and New Zealanders’ patterns of gambling and expenditure.

2.3.4 Continuum of Gambling: Abstinence, Social, Problem and Pathological

A continuum of gambling exists in that within in any population which allows legalised gambling there will be a proportion of the population who choose not to gamble. There will also be a population group who choose to gamble as a fun activity.
The latter group of individuals are often defined as “recreational or social gamblers”, and although there are opportunity costs associated with their gambling, generally it is considered that they experience “no harmful effects from gambling”. (National Research Council 1999 pg 20) The majority of individuals who gamble do so for social or recreational purposes.

For some individuals who gamble for fun, their wagering can progress further to become “problematic” creating problems within their life and others associated with them. Within this population some individuals will also progress further where their gambling becomes out of control and they may be assessed and defined as “pathological gamblers”. Although social gambling, problem and pathological is conceptualised as operating along a continuum, individuals can move from either end of spectrum and can change their pattern of gambling depending upon individual or social circumstances. New Zealanders and Maori patterns of gambling and triggers which influence gamblers to move across either side of the continuum of gambling is discussed further in chapter three.

“Problem gambling” however, is a term not well understood and can convey different meanings to individuals, groups or communities. Generally, problem gambling is seen to be at the moderate to the extreme end of the continuum. (Abbott 2001) Problem gambling is often defined as “all of the patterns of gambling behaviour that compromise, disrupt or damage personal, family or vocational pursuits”. (Abbott and Volberg 2000 (a), pg. 28) Similarly the Department of Internal Affairs defines problem gambling as “occasional or regular gambling to excess, to the extent that it leads to problems in other areas of life, particularly with finances, work and inter-personal relationships”. (Department of Internal Affairs 2001, pg 33) The major difference between the two definitions is that the latter shows that problem gambling not only affects an individual’s relationships and work pursuits, but can also affect their finances which can then lead onto other problems such as debt or criminal activity.

As a working definition the Ontario Addiction Research Foundation in Canada defines “pathological gambling” as:

A progressive disorder characterized by a continuous or periodic loss of control over gambling and with obtaining money with which to gamble; irrational
thinking, and a continuation of the behaviour despite adverse consequences. (Kezwer 1996, pg 85)

It is also suggested that the difference between the problem gambler and the compulsive or pathological gambler is that:

The latter "chases" his bets trapped in the impossible strategy of increasing his bets in hope of covering his losses. (Kezwer 1996 pg85)

Chasing to recoup losses is recognised as one of the major patterns of behaviour of both problem and pathological gambling. A pathological gambler is unable to stop gambling until all available funds have been lost. Winning or losing therefore no longer provides pleasure or meaning, the only behaviour that is important is being able to continue to gamble.

For the purposes of this study social or recreational gambling will be defined as that form of gambling where no harmful effects occur. In relation to problem gambling the definition used by the Department of Internal Affairs (2000) will be used in which occasional, regular or excess gambling leads to problems in a person’s life, particularly with finances, work and inter-personal relationship. For pathological gambling the definition developed by the Ontario Addiction Research Foundation will be adopted in that it is a progressive disorder characterized by a continuous or periodic loss of control over gambling, a preoccupation with obtaining money to gamble, irrational thinking, and a continuation of the behaviour despite adverse consequences.

Individuals' perceptions of their behaviour or that of others is influenced by their own views as to what is normal and their own values and beliefs. New Zealanders' attitudes and perception of what is considered problem or pathological gambling are influenced by their past history and views as to what they consider normal and support Mcmillen’s statement that the context, role and place gambling plays within in a country, community or population group, needs to be understood within a cultural context. (Howland 1994; Mcmillen 1996)

The Minister of Internal Affairs announcing a new review of gaming defined problem gambling as a social problem:
Problem gambling is a significant social issue that needs to be addressed, but legislation to enable education about gambling and to assist problem gamblers is almost non-existent. (Burton 2000)

The transformation of the process that takes place when a social problem is redefined and considered as a legitimate “medical health problem” and then redefined again as a “public health issue” is discussed further in chapter five. Prior to the completion of the Gaming Review at the International Conference Gambling: Understanding & Minimizing Harm 25-28 July 2001, Auckland, New Zealand it was announced that problem gambling would become part of the responsibilities of the Ministry of Health. (Department of Internal Affairs 2001)

Maori perceptions and definitions of gambling, problem and pathological gambling are discussed further and reported in chapters seven, eight and nine.

2.3.5 Gambling-related harm

Gambling-related harm is hard to define or measure, as it is often politically or socially defined within a cultural context. (Productivity Commission Report 1999) For the purposes of this study the term harm will include:

(a) Harm or distress of any kind arising from caused or exacerbated by a person’s gambling; and includes personal, social, or economic harm suffered.

(b) by, the person, the person’s spouse, partner, family, whanau, or wider community, in the workplace or by society at large.

(Select Committee on Government Administration 2002, (clause 4))

This definition has been included in the Responsible Gambling Bill and the concept of harm is discussed throughout this thesis in relation to different issues. As the concept of harm has been legally defined it is possible that in the future that compensation could be sought by different individuals and groups from gambling operators for the harm their products have created similar to cases taken by complainants in relation to tobacco companies. (Jacobson and Warner 1999) The issue of litigation as a public health intervention to address gambling-related harm is discussed further in chapter five.
2.3.6 Gaming or Gambling Legislation

Key legislation, which governs gambling in New Zealand, includes the Racing Act 1971, the Gaming Duties Act 1971, the Gaming and Lotteries Act 1997, and the Casino Control Act 1990. Currently no gambling legislation includes any recognition of the Treaty of Waitangi, although there was a requirement under the Maori Councils Act 1900, for councils to regulate and licence gambling in Maori communities. (Lange 1999)

There is no such current gambling legislative requirement which requires recognition of Maori or tribal aspirations, Maori involvement in licensing or Maori representation on key policy setting or distribution bodies, such as the New Zealand Lottery Grants Board, the Lotteries Commission, and the Problem Gambling Committee. (Dyall and Morrison 2002)

In 1996, the Department of Internal Affairs released a discussion document “Gaming-A New Direction For New Zealand” inviting public submissions which resulted in the Gaming Law Reform Bill (1998) under the National Government. (Department of Internal Affairs 1996; Select Committee on Internal Affairs and Local Government Committee 1998) The new Government then initiated another review on gaming and the Department of Internal Affairs released a discussion document supporting this new review. (Department of Internal Affairs 2001)

Both Governments used the term “gaming” instead of “gambling” although the latter term is more likely to be understood by the public. The terms “gaming” and “gambling” are often used interchangeably and are assumed to be the same. (Department of Internal Affairs 2001) However, as discussed, there is a subtle difference in the way these terms are used to support gambling as a positive recreational activity in New Zealand society. (Howland 1994)

Maori gamblers and key informants understanding of the terms gambling and gaming is reported in chapters seven, eight and nine.

2.3.7 Recognition of the Treaty of Waitangi in Relation to Gambling

Until the 1990s, most government documents relating to gambling policy did not consider the rights of Maori in relation to the Treaty of Waitangi, the wide social, economic and cultural needs of Maori, or the impact gambling developments may have
had on the health and wellbeing of Maori. As part of the Department of Internal Affairs Review of Gaming in 1996, it was suggested that one of the guiding principles, which should govern future gaming policy developments, was that they should comply with the principles of the Treaty of Waitangi. (Department of Internal Affairs 1996)

The principles were not defined but were proposed as part of the then Department of Internal Affairs’ recognition of the Treaty of Waitangi. (Department of Internal Affairs 1996) The Lottery Grants and Trust Board 1997 then recognised the Treaty of Waitangi and commissioned a report. (Gardiner and Parata 1997) This report served to provide guidance to this organisation to give effect to the Treaty of Waitangi in its role and allocation of funds from Lotto. Clear recommendations were proposed in this report in relation to the Treaty of Waitangi including that Maori should receive a fair share of funding. This was supported by the organisation’s own “Te Waka Tahua”, a responsiveness plan to support Maori. Gardiner and Parata (1997) also recommended that a clear conceptual framework should exist to implement the Treaty of Waitangi, funding for Maori initiatives should be topped up because of past and current under funding and the allocation of grants should reflect the size of the Maori population in New Zealand.

It was also recommended that a specific committee should be established for the allocation of funding for marae developments removing the responsibility for such funding from Te Puni Kokiri (Ministry of Maori Development). Many marae developments have been supported directly or indirectly from gambling activities instead of by legitimate tax funding. In 2000/1, the Lottery Grants Board allocated $5.79 million to the Lottery Marae Heritage and Facilities to fund the development and conservation of marae and a lower amount for 2002/3 ($4.99 million). (Lottery Grants Board 2000; Lottery Grants Board 2001)

The 2000 mission statement of the Lottery Grants Board was “To ensure empowered communities, community wellbeing and a sense of nationhood and that Treaty of Waitangi obligations are fulfilled”. (Lottery Grants Board 2000, pg3) Neither the resources allocated for Maori development, nor the extent to which this body met its Treaty of Waitangi obligations, were defined in its 2000 Annual Report. (Lottery Grants Board 2000) Recognition of the Treaty of Waitangi in the review of gambling has been
supported by such organisations as the Compulsive Gambling Society Inc (1996) and the Committee on Management of Problem Gambling (1998).

However, despite advice provided by Maori, recognition of the Treaty of Waitangi has not been captured in gambling policy developments e.g. contracted Crown research relating to gambling, allocation of funding from the proceeds of gambling, and proposed future gaming legislation such as the Gaming Review Bill 1998 and the Responsible Gambling Bill 2002. (Australian Institute for Gambling Research 1998; Abbott 2001; Select Committee on Government Administration 2002)

As gambling was introduced into New Zealand around the same time of the Treaty of Waitangi, it is proposed that gambling should not be treated any differently to any other assets or developments, such as the allocation of fishing quotas or airwaves that have been established by the Crown to generate income. (Dyall and Morrison 2002) Maori gambler and key informants views on recognition of the Treaty of Waitangi in relation to gambling are explored as part of this study and reported in chapters seven, eight and nine.

2.3.8 Normalisation of Gambling for Maori

Maori are one of the few peoples of the world that, prior to European or settler contact, appear to have had no history of the consumption of alcohol or tobacco or the practice of gambling. (Reid and Pouwhare 1992; Hutt 1999) Traditionally as mentioned previously, Maori had no words to define or describe gambling. Other activities, such as smoking and drinking alcohol were introduced to Maori as part of the process of colonisation. Today all three introduced activities are now regarded as creating or contributing to significant addictions, co-addictions and broader health problems for Maori. (Durie 2001)

It is estimated, for example, that over 100 Maori die each year prematurely from alcohol abuse and over 450 Maori die each year from smoking related diseases. (Laugesen and Clements 1988; Te Puni Kokiri 1997) The number of Maori who die each year from gambling problems is largely unknown, but increasingly it is being recognised that problem gambling is a contributing factor to Maori: imprisonment, mental health admissions, co-addiction problems, violence, accident related admissions and deaths related to suicide. (Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c))
Like smoking in the past, gambling has been used in different institutional settings, such as in prisons and in mental health institutions, to provide entertainment for those who require custodial care, or as a therapeutic option to support their process of rehabilitation. New Zealand soldiers and associated personnel have long used gambling, as a form of entertainment. To cope with stress in World Wars One and Two, many Maori who joined the armed forces, such as the Maori Battalion, were known for their engagement in gambling. (Grant 1994)

Such gambling supported the development of addictions for Maori and the continuation of normalization of behaviours such as smoking and misuse of alcohol. The prevalence studies of problem gambling in both male and female prisons, for example, have shown that at least a quarter of survey participants continued to gamble whilst in prison even though problem gambling and other co-addictions had contributed to the events which led to their imprisonment. (Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c)) This suggests the need for ongoing research which quantifies the social, economic and cultural effects of gambling on the health and wellbeing of Maori and all New Zealanders. (Chetwynd 1997; Abbott and Volberg 2000 (a)) New areas of research that would support Maori involvement in gambling policy or improvement in Maori health are discussed throughout this thesis.

2.3.9 Gambling: Cultural Baggage

New Zealand has a unique history in relation to gambling. When the first non Maori settlers arrived in New Zealand, problem gambling was endemic in Britain and in Europe, and many individuals and families left or along the way by ship won or lost their fortunes. (Grant 1994) New immigrants, including early Chinese settlers also brought with them their own games of chance and replicated such behaviour again in New Zealand. Grant (1994) defines gambling in New Zealand as “cultural baggage”, introduced by the new and immigrant settlers to create personal wealth, to raise funds to establish many sporting, social and cultural services and to provide revenue to successive governments.

Gambling has been used over the years to create and maintain New Zealand’s social, cultural and sporting infrastructure and has become an integral part of the culture and values of New Zealanders. (Abbott and Volberg 1996) Although the effects of
problem gambling on individuals and families are often discussed in New Zealand's historical literature and is part of the stereotype of being a "Kiwi", it has taken some time for problem gambling, including pathological gambling, to be defined and recognised as a legitimate health problem. (Abbott and Volberg 1984; Phillips 2000)

The introduction of gambling has coincided with the process of colonisation to such an extent that it is now an integral part of the culture of Maori whanau, hapu, iwi and local communities. The effects of gambling as cultural baggage for Maori are discussed throughout this thesis. Maori problem gamblers' and key informants' views of the impact of gambling on Maori culture are discussed in chapters seven, eight and nine.

2.3.10 Socialisation into Gambling in New Zealand.

Gambling is seen and defined in New Zealand as a normal recreational activity, which provides enjoyment to many people, young and old, and across different ethnic groups. In 1995, the Department of Internal Affairs interviewed 1200 randomly selected people from different households and found that 90% had taken part in at least one gambling activity in the previous year. (Department of Internal Affairs 1995) This study has been repeated again in 2000, and is discussed further in chapter three regarding Maori and New Zealanders' participation, expenditure and patterns of gambling.

In New Zealand, introduction to gambling often occurs within families, across generations and within communities. Children, for example, are often regularly encouraged by elders such as parents, teachers and grandparents to become involved in gambling, for example, by selling school raffle tickets to neighbours and friends. (NZ Press Association 2002) They are encouraged to choose which racehorses will win and which numbers may provide the winning Lotto. Normalisation of gambling supports the development of problem gambling which not only impacts on gamblers but also on significant others. It is estimated that for each pathological gambler at least five other people are adversely affected, often with long lasting effects. (Productivity Commission Report 1999; Sullivan 2000 (b)) The passive effects of gambling on Maori are discussed in chapter three and nine.

Since the introduction of gambling around 1835 some Maori tribal groups and individuals have become involved in the different forms of gambling including horse racing, card playing, lotteries, Housie and games of chance played at the casino. Maori
have used gambling as a strategy for economic and social development in a similar way as non Maori. It has provided funding to build marae, a means to support cultural events, a way of assisting the costs of tangihanga (bereavement) and a way to help accumulate individual, family and communal wealth.

Many Maori organisations are also now actively involved in gambling. The Department of Internal Affairs reported that early in 2001, 117 Maori groups held licences to operate Housie events. (Department of Internal Affairs 2001) Most Maori organisations have not considered in any depth the ethics of being involved in gambling or using the proceeds from gambling to support Maori development. (Dyall 2001) Instead, the benefits of gambling have been highlighted with almost no research allocated to assess the negative impact on Maori. Gambling has contributed to the under development of Maori to such an extent that valuable resources, both time and money, are regularly redirected away from the enhancement of whanau and children.

The effects of gambling on Maori whanau are investigated as part of this study and reported in chapters three, seven, eight and nine. Opportunity costs associated directly and indirectly with gambling are also explored. The social, cultural and economic costs of gambling for Maori are discussed throughout this thesis and incorporated in the overall findings.

2.3.11 Maori and Indigenous Links

In their analysis of the pattern of problem gambling Volberg and Abbott (1997) suggest that Maori, along with other indigenous populations, use gambling to cover the costs of daily living like food and rent. (Volberg and Abbott 1997; Abbott and Volberg 1999 (b)) At another level, gambling provides a chance to achieve a personal or collective dream, such as the purchase of significant household items such as a car, or a washing machine or the establishment of a marae or whare kai (dining room). Gambling may also provide a means by which individuals obtain and retain mana (social standing) in one’s whanau, hapu, iwi or community. Maori links with other indigenous populations, which share similar socio-economic and historical circumstances and opportunities to gamble, are considered as part of this study and is reported in chapters four and nine.
2.4 Maori Activities Relating to Gambling

2.4.1 Maori Gambling and Maori Cultural Development

There is growing concern by some Maori that their cultural icons are being used to promote gambling and the normalization of gambling. This is visible with Maori involvement in the opening of New Zealand casinos, advertising of Lotto and TeleBingo and the recent cover of the discussion document “Gaming Reform in New Zealand”, (2000). (Hendery 2000; Department of Internal Affairs 2001) Maori community health workers interviewed by Bayly (1999) regarding the social and economic impact of the Auckland casino on the use of social services expressed concern about the use of Maori tikanga in the opening or expansion of casinos. (Bayly 1999) From their perspective this involvement suggests that there exists a tangible relationship between Maori culture and gambling.

Similarly the Compulsive Gambling Society Inc (1997) and Te Whanau Waipareira Trust (1997-8) have together taken a proactive stance against Skycity by developing posters. The first one suggested that the Skycity “Tower” was like a vacuum cleaner in which household money was sucked up and taken away from other whanau priorities. The second poster suggested that the Skycity “Tower” was similar to a syringe and when injected into the arm of a person it suggested an addiction, similar to a drug addiction. The management of Skycity seriously questioned this negative publicity and this organisation considered no one could use their icon without their permission.\(^7\)

The use of Maori culture in the promotion of gambling has not been considered in any real depth but it is recognised that gambling can support Maori cultural values and transfer of tribal knowledge. (Morrison 1999) The impact of gambling on Maori culture is discussed throughout this thesis.

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\(^7\) Dyall (1997) developed the poster for the Compulsive Gambling Society (Inc) with Mr John Tamihere the Chief Executive of Te Whanau Waipareira Trust. He reported that Skycity objected to his organisation challenging its publicity strategy of using bus stops and local buses in West Auckland to encourage people to visit the casino. His organisation had noted that individuals, especially Polynesian people who had won money, were being used to induce other similar people to believe that they may have the same luck as winning a jackpot or a car at the casino. Skycity then took a proactive approach to advertising the casino by using advertisements on buses, bus shelters, television and newspaper advertisements. Te Whanau Waipareira Trust became concerned about the effects of gambling when it noted the number of whanau who were seeking help through their organisation social services unit, for help with food and money as they could not cover their normal household expenses due to gambling at the casino.
2.4.2 Gambling Expansion: Implications for Maori

Since the 1990s, opportunities to gamble in Aotearoa/New Zealand have increased with the establishment of several casinos, an increased number of gambling machines in pubs and clubs, new games of chance such as sports betting, and products operated through the New Zealand Lotteries Commission. The turnover on gambling during the past decade has increased each year with gambling industries still aiming to increase expenditure and therefore profits for distribution. Latest figures released by the Department of Internal Affairs on gambling expenditure shows that in 2001/2002 New Zealanders spent $11.6 billion on gambling and lost over $1.6 billion. Of the amount turned over $777m was on non-casino gambling machines, $410m on casinos, $251m on the Lotteries Commission and $228m on race and sports betting. The amount lost on non-casino gambling machines increased by almost a third from the previous year. (Department of Internal Affairs 2003) There are now more than 22,100 non-casino gambling machines on about 2150 sites, 610 retail outlets selling New Zealand Lotteries Commission products and just over 800 TAB sites outlets which support track and sports betting. Expenditure on gambling machines continues to rise and this is an area where Maori and New Zealanders lose a significant amount of money. (Department of Internal Affairs 2001; Department of Internal Affairs 2002; NZ Press Association 2002)

There are now opportunities for Maori to gamble anywhere in New Zealand. Maori have high rates of conversion to new forms of gambling while at the same time continuing to play or wager on other forms of gambling. (Volberg and Abbott 1997) Studies on prevalence of problem gambling in different populations and Maori attendance at specialist gambling treatment services, suggest that there is a relationship between access and opportunity to play different forms of gambling and Maori problem gambling. (Volberg and Abbott 1997) If this relationship is substantiated, licensing and regulation of gambling are important issues for Maori. This study explores Maori gamblers and key informants views on whether Maori should be involved in gambling policy developments in Aotearoa/New Zealand and this is reported in chapters seven and eight.
2.4.3 Maori Leadership and Gambling

Since the beginning of this study there has been growing concern about gambling amongst some Maori leaders and interest groups, such as Te Whanau Waipareira Trust, John Tamihere M.P and Maureen Waaka from Rotorua. They have taken leadership positions and questioned Maori involvement in gambling and commercialised profit oriented gambling. (Compulsive Gambling Society of NZ 1998) At times these leaders have expressed concern about the number of gambling machines in different communities, especially where Maori live or socialise, and the number of Maori, in particular Maori women, seeking help regarding their gambling habits.

Alongside this development, there is interest from tribal groups such as Ngati Whakaue through Pukeroa Oruawhata Holdings and Waikato (Tainui) to become involved in operating and owning a casino. This involvement is not new and since the establishment of casinos in New Zealand as a result of the Casino Control Authority Act 1990, Maori have expressed interest in being included with other business partners.

Maori have seen the adverse costs of gambling as the responsibility of the Government, for it is the State which administers current legislation and governs different types of gambling in New Zealand. By being involved in privatised commercialised gambling, Maori have downplayed the social, economic and cultural costs and have focused on their perception of the benefits of being associated with casinos, viz., increased Maori employment, tourism and development. The operation of casinos has been seen by some Maori groups as an opportunity to generate private economic wealth.

The interest by Maori in casinos mirrors First Nation developments in America and in Canada. First Nation Indians in America and in Canada have used gambling as an opportunity to achieve wealth separate from funding received from Federal or State governments. (Cozzetto and Larocque 1996)

In addition to casinos, some tribes and Maori groups are likely to see similar benefits from the ownership of gambling machine licences. Currently, only non-government voluntary organisations can own gambling machine licences outside of casinos. They have the responsibility to distribute a minimum of a third of their income to one or more voluntary organisations of their choice. Many voluntary organisations are
now dependent upon income from gambling machines, such as the Cancer Society. (Stickley 2003)

A licence was granted for the establishment of a casino in Hamilton and this opened in September 2002. This licence has been awarded to Skycity and the involvement of Tainui in this application has been highlighted publicly. The awarding of the licence generated considerable concerns from both Maori and non Maori with the requirement that the licence holder must provide gambling treatment services for Maori and implement appropriate host responsibility programs and strategies. (Casino Control Authority 1999)

It is possible that in the future, gambling machines could be placed on marae in settings where Maori consume alcohol and socialise. These machines may be considered easier to operate than running Housie on a regular basis to support the development and ongoing maintenance of marae or Maori social services.

Maori gambler and key informants views were canvassed as part of this study asking whether it is a good idea to have gambling machines on marae and whether Maori should be involved in running casinos. The results from these questions are reported in chapters seven, eight and nine.

2.4.4 Gaming Review 2000: Implications for Maori

In 2000, the Labour-Alliance Government announced a new gaming review which had similarities to previous gaming legislative reviews. (Department of Internal Affairs 1996) When first announced the Minister of Internal Affairs, called this review a “first principles review”. Its focus was to review current gaming legislation, to address inconsistencies regarding matters related to tax and the allocation of gaming profits and to investigate the extent and nature of social and personal costs from gaming. (Burton 2000)

When first announced, the review made no mention of the role and status of the Treaty of Waitangi. There was no requirement for the review team to consult with Maori

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8 Tainui involvement has decreased since the first application for a casino licence in Hamilton as it has had to sell some of share to meet financial commitments in other areas. However, Tainui involvement has supported the establishment of casino with Skycity and is now in a position to benefit financially from its involvement.
as a key stakeholder even though one of the terms of reference specifically focused on Maori as a casualty of gambling.

The review team was required to:

Review the extent and nature of the social and private costs of gaming, including the potential for organised crime, fraud and costs of gambling in Maori communities and make recommendations on the means of containing them and how to fund such interventions”.  

From the announcement of the review, Maori expressed concern to the Ministers of Health, Internal Affairs and Maori Affairs about the invisibility of Maori in this gambling review.

This lead Department of Internal Affairs to release additional information entitled “Maori and Gambling” (2001) and a press statement entitled “Gaming Review Hui: A Chance For Maori To Influence Gaming Legislation”. This press statement encouraged Maori to comment on the role of gaming in New Zealand society and how it should be regulated. (Department of Internal Affairs 2001; Department of Internal Affairs 2001 (a))

The statement acknowledged that Maori are involved in gaming in many different ways, such as providing gambling activities and receive funding from gambling. Some are opposed to gambling, some are involved and invest in gambling and others have problems with gambling, directly or indirectly. (Department of Internal Affairs 2001)

A series of hui were held across the country and several specific Maori reference group teleconferences were organised to give views on specific topics, such as Maori involvement in casinos or research issues related to gambling. Although Maori were encouraged to have a say, those who participated were dissatisfied with the information provided and the process of consultation. (Dyall 2002) This led to Te Puni Kokiri becoming involved and the Ministers of Maori Affairs and Health being briefed on gambling issues from independent Maori advisers. (Te Puni Kokiri 2002)

Gambling policy and legislative developments are still ongoing in New Zealand. This research investigates and records changing views on Maori gambling and problem

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9 Department of Internal Affairs Press Release Gaming Review Terms of Reference Released www.dia.govt.nz
gambling from a Maori-centred approach over the last three to four years leading to a specific public health strategy to reduce Maori gambling-related harm.

2.5 Summary

This chapter has defined and discussed key concepts such as the definition of Maori, gambling and gaming, problem and pathological gambling, continuous and non-continuous gambling, public health and gambling-related harm. It has shown that the Maori are unique indigenous population which prior to contact with non Maori had no recorded history of the use of gambling, alcohol or tobacco. These three products have all been introduced to Maori, normalised and promoted by the State through legislation, licensing and regulations for recreational or social use irrespective of the social or health costs for Maori. (Reid and Pouwhare 1992; Grant 1994; Hutt 1999)

The effects of alcohol and tobacco use on the health of Maori have been recognised by the health sector and in particular as public health issues. (Ministry of Health 2000) However, until recently the Government had not recognised gambling as a public health issue. It has seen problem gambling only as a social issue, allowing the health sector to ignore the health costs for Maori. (Ministry of Health 1996; Earp 1997; Ministry of Health 1998)

From the outset it is has been considered that as a fundamental principle that the Treaty of Waitangi should be recognised and the foundation for the development of gambling policy in Aotearoa/New Zealand and the basis for any public health response to address gambling-related harm. Maori concepts and models of health have been discussed and they provide the basis for the development of a unique response to address gambling-related harm for Maori and the wider community. The impact of gambling on Maori and affected others will be explored through the Te Whare Tapa Wha model of health.

A brief historical account of Maori involvement of gambling has also been presented to provide a context to discuss and consider the rights and responsibilities of Maori and the Crown in relation to gambling and the Treaty of Waitangi. Although it has been suggested since 1996 that the Treaty of Waitangi should be the basis for developing gambling policy in Aotearoa/New Zealand, this has been ignored in subsequent reviews
of gambling legislation and allocating the proceeds from gambling. (Department of Internal Affairs 1996; Gardiner and Parata 1997)

Government policy responses to Maori issues have been discussed to show that although the State may be concerned about disparities between Maori and non Maori under pressure it is quickly able to change its stance to avoid political fallout. This suggests that without considerable Maori advocacy and evidence of the impact gambling has on the health of Maori that there will be minimal support for changes to occur which develop or benefit Maori. There are many stakeholders in the community that have vested interests in maintaining the status quo, as policy changes may affect their income. This includes Government which is involved in all aspects of gambling in New Zealand. It is a gambling provider through the New Zealand Lotteries Commission, it is a distributor of gambling funds to community groups and bodies through the New Zealand Lottery Grants Board; and it is a receiver of income by way of gambling levies, casino licences and income tax.

The Gaming Review 2000 has been discussed as it provides an opportunity for this study to inform and support Maori participation in the development of gambling policy in New Zealand/Aotearoa. Policy proposals that arise from this review will be critiqued as part of this study.

Chapter three identifies Maori attitudes and patterns of gambling, using available information and the prevalence of problem and pathological gambling for Maori and its' impact on Maori development is estimated.
Chapter Three: 
Maori and New Zealanders’ Patterns of Gambling and Problem Gambling
- What do we know?

3.1 Introduction

This chapter addresses the question whether gambling and problem gambling is an emerging health issue for Maori. Section one outlines this chapter. Section two discusses New Zealanders’ and Maori participation in gambling, expenditure on gambling and views towards gambling. Section three provides an overview of the prevalence of problem and pathological gambling of Maori in comparison with non Maori. Tools used to diagnose or screen for problem gambling are discussed as they underlie the definition of problem and pathological gambling and have been used in recent studies to estimate the prevalence of problem and pathological gambling in the New Zealand community, in male and female prison populations, and in overseas studies. Section four discusses special populations at risk to problem gambling and implications for Maori. Section five discusses a range of issues which are important to Maori in relation to access to health services and research. The last section provides an overall summary and determines whether gambling and problem gambling is a health issue for Maori.

3.2 New Zealanders and Maori participation in gambling

3.2.1 Current Gambling Arrangements

Since the late 1980s gambling in New Zealand has changed dramatically with the introduction of different gambling products which have provided more opportunities for New Zealanders and Maori to gamble. (Abbott and Volberg 2000 (a)) From the late 1980s, gaming machines licensed under the Gaming and Lotteries Act 1977, have been introduced and now they are widely available in pubs, clubs, and casino bars. Licence holders of gambling machines are approved voluntary or charitable organisations which may allocate profits for authorised purposes, broadly defined to mean any charitable, philanthropic, cultural, party political purpose or any other purpose that is beneficial to
the community or a section of it.\textsuperscript{10} (Ayers 1998) Often voluntary organisations subcontract their licence to such organisations as Pub Charities, which place machines in pubs and clubs and administer them on their behalf for a fee.

Licence holders of non-casino gambling machines are required to donate a third of their income for charitable purposes, pay a third to the Government for tax and a third can be used for administrative and related costs. Before the Department of Internal Affairs approves a licence, the licence holder must give an assurance that a desired level of income will be achieved. The maximum number of machines that can be approved on any non-casino site is eighteen.

Non-casino gambling machines generate considerable wealth for owners of licences, approved charitable organisations, the Government, and venues where they are sited. This has recently become visible with a Serious Fraud Office Investigation of the Auckland Rescue Helicopter Trust which is heavily dependent on charitable donations. The trust’s income is around $17 million and $3.8 million comes from the proceeds from gaming machines.

This body established a separate organisation to own and run gambling machines in Auckland pubs and received dispensation from the Department of Internal Affairs to allocate 98\% of earnings to the Helicopter Trust. (New Zealand Herald 2002) The amount of money obtained from this organisation from gambling machines recently became public. It has been reported that the pubs which provided a site for machines received a monthly income from the Helicopter Trust under the guise of compensation for advertising costs. Income received was directly related to the monthly income received from gaming machines at each site.\textsuperscript{11}

Licensing and monitoring is difficult because of the way in which income is received from gambling machines and distributed. In October 2002, the Government announced that in the future, all non-casino gambling machines will be electronically observed as are machines in casinos, the maximum amount that can be charged for

\textsuperscript{10} The Department of Internal Affairs cannot identify the number of Maori organizations or societies which own poker machine licences. Personal Communication Gavin Duffy Department of Internal Affairs, 21 June, 2001.

\textsuperscript{11} This information became public as part of the Serious Fraud Investigation and discussed on the television “Holmes Show”, 14 March 2002.
administration costs associated with each machine is $150 per week and new gaming sites will have only 9 machines only if they are supported by the community. These decisions are to reduce the growth of non-casino gambling machines. (Department of Internal Affairs 2001; Gaynor 2001)

Increasingly, organisations such as Pub Charities, Lion Foundation and Lion Breweries are becoming linked as gambling machines help attract patrons, sell alcohol and increase the financial value of “pubs”. Venues for non-casino gambling machines such as the Returned Services Association clubrooms (RSA) and Working Men’ Clubs are also places where people socialise, drink alcohol, consume tobacco and participate in more than one legalised gambling activity which are owned and managed by different gambling operators, e.g. community raffles, (community groups) betting on the horses and sporting events, (TAB) and playing the machines (charitable organisations). These venues are places where Maori adults often socialise and use different gambling products, drink and smoke and can lead to co-addiction problems.

The previous Labour-Alliance Government acknowledged the effects of passive smoking on workers and patrons in hotels and has prompted legislative interest to provide smokefree environments in these settings. Casinos are now required to have 25% of their gaming floor smoke-free and must ensure that there are adequate signs designating these areas. (Deamley 2002) Key stakeholders, such as the Returned Services Association (RSA) clubs and tobacco companies have established strategic alliances to safeguard their interests e.g. clubs enabled to permit smoking. Similar alliances are likely to be established between clubs, gambling machine operators and community groups in order to support the growth of machines through different arrangements, such as amalgamating clubs to maintain income.

The Totalisator Agency Board (TAB) under the Racing Act 1971 operates all forms of track sports and Internet betting in New Zealand. Frequently the TAB has sites next to non-casino gambling machines and approval has been given for this agency to operate in New Zealand casinos and to have gambling machines on their premises if
supported locally by local territorial authority. (Department of Internal Affairs 2001; Select Committee on Government Administration 2002) Profits from track and sports betting are required to be reinvested in supporting organisations, and individuals involved in horse racing. This is considered another form of community gambling as profits benefit local racing clubs. (Department of Internal Affairs 2001) The New Zealand racing industry also supports the development and sale of thoroughbred horses, an industry which is worth $120 million, 80% of which comes from overseas buyers. (Read 2002)

The New Zealand Lotteries Commission operates under the Gaming and Lotteries Act 1977 and currently runs Lotto, Scratch Kiwi, Strike, Powerball and Risk. With the promotion of New Zealand Lotteries Commission products on television and in local shopping centres, many New Zealanders participate in so called “benign” forms of gambling on a regular basis. Advertising is regularly targeted at Maori and Pacific communities. (Cabinet Policy Committee 2001)

This Commission which is owned by the Crown is constantly investigating and introducing new games of chance to maintain a desired level of profit, which in turn can be distributed, by the Lottery Grants Board and its committees to support different community activities. For example, recently it has announced that New Zealanders may be able to purchase Australian Lotto tickets, and community groups could receive commission for the sale of these Lotto tickets.

Access to new forms of gambling is likely to increase Maori expenditure on gambling. (Clarke 2002) The use of television games and mass media advertising is convincing the New Zealand public that gambling is a normal recreational activity. Other forms of legalised gambling, are administered under the Gaming and Lotteries Act 1977, such as Housie and raffles.

The Casino Control Authority, in accordance with the Casino Control Act 1990, permits the establishment of each new casino providing that it will not cause substantial

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12 New Zealanders can bet through the Internet on other gambling sites which are not based in New Zealand and they can also operate Internet gambling sites as long as they outside New Zealand. The Government has recognised that it can control internet gambling only within New Zealand.

13 The New Zealand Lotteries Commission has announced (January 2002) that it intends to restructure its whole organization, relocating its marketing division to Auckland to increase sales and develop new products. This organization is concerned that, in relation to other countries, its profits from weekly national lotteries and other products has declined substantially.
harm but will create new employment, support national and local tourism and economic development. Six casinos now operate under the Casino Control Authority Act 1990, four in the South Island established in the following years: Christchurch Casino (1994), Queenstown Wharf Casino (September 1999), Dunedin Casino (October 1999), and Sky Alpine Queenstown Casino (December 2000). In addition to these casinos, there is Skycity in Auckland (1995) and a casino in Hamilton, which is a Skycity venture with Tainui involvement. Although a moratorium on casinos is now in place, there is growing recognition by the Government of Maori interests in the establishment of a casino in Rotorua as part of tribal and local economic development. There is a strong possibility that in the future an exception will be made to support a casino in Rotorua or administrative arrangements constructed so Maori can benefit economically from gambling developments. (Cabinet Policy Committee 2001)

The Casino Control Authority has recently reviewed the impact of two casinos, one in Christchurch and the other in Auckland. (Australian Institute for Gambling Research 1998) Since no information-gathering requirement was required as part of each separate casino licence, no meaningful data was available to assess the full social, economic and cultural impacts of these casinos on different communities, such as those in South or West Auckland where many Maori, Pacific and Asian families live, or on Maori, new immigrant groups and rural communities which live in or close to Christchurch.

No recommendations were proposed for routine collection of information for research purposes. This omission has meant that there is no overall monitoring framework in place to review the impact of casinos in New Zealand nor is it proposed as a key function of the Gambling Commission, which is to replace the Casino Control Authority when new legislation is passed. (Select Committee on Government Administration 2002) The Gambling Commission however could undertake this function when reviewing or changing casino licences, in the provision of advice to Government

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14 The Christchurch and Auckland casinos were given special provisions with their licence. Both casinos had the right to expand operations after two years of establishment as long as they were 100km away from their current sites. No other casinos can be established in these two areas or within 100 km for five years Department of Internal Affairs (1995). The Social Impact of Gaming in New Zealand A Report Prepared for the 1995 Review of Gaming. Wellington, Department of Internal Affairs.
and its Committee of Inquiry status. (Select Committee on Government Administration 2002, (clauses 198 and 199))

Although the Australian Institute for Gambling Research (1998) had limited mana whenua or tangata whenua involvement, no information was found that showed Maori used the two casinos disproportionately, or were more adversely affected than other ethnic groups. The number of Maori households consulted in this study was not disclosed. This study identified problem gambling as an issue for Maori and recommended that gambling treatment services should be tailored to meet Maori needs. It also showed that the prevalence of problem gambling is higher in these two areas than other parts of the country. (Australian Institute for Gambling Research 1998) Similar findings have been found by subsequent research, which suggests that casinos increase the prevalence of local problem gambling, and this needs to be considered when allocating or reviewing a casino licence. (Abbott and Volberg 2000 (a))

A monopoly arrangement exists for all casinos in New Zealand. Further, Auckland and Christchurch casinos have a licence to operate for 25 years without any substantial review. More research in New Zealand is needed to assess the full costs and benefits casinos create in New Zealand and the Productivity Commission’s report on the impacts of problem gambling creates an ideal model which could be adapted for New Zealand circumstances. (Productivity Commission Report 1999)

Because all legalised forms of gambling currently operate in New Zealand under different legislation and licensing regimes a review of gaming as mentioned previously was instigated in 2000. (Department of Internal Affairs 2001) Of the 1103 submissions received as part of this review, two thirds considered that gambling had no place in New Zealand society. Although these submissions cannot be considered to represent the views of all New Zealanders, they represent a cross section of the community and the diverse views of different stakeholders who have an interest in gambling. Only seven of these submissions could be coded as originating from a Maori interest group or perspective, highlighting the limitations of written submissions as a means of expression of Maori views. Five hui were also held across the country and although they were not well attended, a number of key policy issues emerged, including the need for Maori
involvement in gambling policy development and for a comprehensive health strategy to reduce Maori gambling-related harm. (Cabinet Policy Committee 2001)

Some New Zealanders' attitudes towards gambling are moving towards those expressed in the late 19th century where many women and Christian groups considered gambling as a social evil similar to alcohol, which threatened the wellbeing of families. At that time they suggested that gambling should be banned but, if permitted, licensing and regulation arrangements should be in place to control its activity.

Maori leaders also expressed similar views at the time, particularly in relation to alcohol which was banned on some marae and in Maori communities. (Hutt 1999) Grant does not mention Maori opposition to, or involvement with gambling in any significant depth and this is one of the major limitations of his review of the history of gambling in New Zealand. There is a need for research on the history of Maori and gambling so that appropriate information is available to support Maori involvement in gambling policy making and the development of appropriate Maori and tribal strategies to reduce gambling-related harm. (Grant 1994; Grant 2002) Further research in New Zealand is also required to identify the views and patterns of gambling in different ethnic groups, as there are variations between groups and these differences should be considered in future policy making and gambling developments. Cultural diversity in gambling research has been recognised as being needed in Australia. (Productivity Commission Report 1999) In sum, New Zealand has had a liberal licensing environment related to gambling but this situation could change slightly if new gambling legislation is passed. (Select Committee on Government Administration 2002)

3.2.2 New Zealanders' general involvement in gambling

New Zealand is fortunate that the Department of Internal Affairs has supported four studies (1985, 1990, 1995 and 2000) which have surveyed people's participation and their attitudes to gambling so trends can be observed. (Wither 1987; Christoffel 1992; Reid and Searle 1996; Department of Internal Affairs 2001) These studies have involved selecting randomly 1200 to 1500 people aged 15 years and over who live in private households, interviewing them face-to-face about their gambling pattern and attitudes towards gambling. Each study has used a similar questionnaire so that comparisons can be made. The most recent study was conducted in 2000 and the researchers had a
response rate of 54%. Due to the sample size and methodology used, the results tend to under-report real expenditure on gambling and New Zealanders' attitudes to gambling because there is no data collected on the non-respondents who could be the heaviest gamblers and declined to participate in the survey, as they did not want to declare their real expenditure or involvement in gambling.

The studies provide insight into changes occurring in different New Zealand households. Ethnicity of participants in these studies has been categorised in relation to three major groups: Maori, Pacific peoples and others. (Department of Internal Affairs 2001) The actual number of Maori participants in this study is not provided but statistical information is available of the degree of Maori participation in different gaming activities, income spent and attitudes towards gambling.

In the 2000 study, 87% of participants reported that they had taken part in at least one gaming activity in the 12 months prior to being surveyed, compared with 90% in 1995 and 1990 and 85% in 1985. These figures, although high, show a decline in participation even though opportunities to gamble in New Zealand have continued to increase. In contrast to this finding, it has been found that there has been an increase in the number of participants who have participated in more than seven gambling activities over the past twelve months. This pattern suggests that fewer New Zealanders are involved in gambling on regular basis but those involved are participating in more gambling, which in turn is increasing their overall expenditure in gambling.

Abbott and Volberg (2000) had similar findings and they suggest that participation in gambling has reached a maximum in New Zealand and is now declining. (Abbott and Volberg 2000 (a)) Those who are gambling on a regular basis are spending more and problem gamblers have increased their expenditure. (Abbott and Volberg 2000 (a); Department of Internal Affairs 2001) A similar pattern has been found in Australia where problem gamblers account for at least of a third of the expenditure on gambling. (Productivity Commission Report 1999) In New Zealand, it is estimated that 44% of current problem gamblers are likely to be of Maori or Pacific identity. (Department of Internal Affairs 2001)

With the exception of casinos and sports betting, all gambling products saw a decline in participation from the previous survey in 1995. While the percentage of
women who did not gamble remained the same (11%), the percentage of men who reported no involvement in gambling increased from 11% to 15%. Participation in gambling can no longer be defined as a male activity. Increasingly it is an activity of interest to women. There is a need for research to investigate why women are gambling in increasing numbers and why they develop gambling related problems. (Abbott and Volberg 2000 (a))

3.2.3 Maori Involvement in Gambling

Maori involvement in gambling is high and only 9% of those surveyed reported that they had not been involved in any form of gambling over the past year. The purchase of Lotto, Instant Kiwi, Daily Keno and TeleBingo tickets and playing non-casino gambling machines is extremely popular amongst Maori alongside sports betting and Housie. Maori have the highest level of participation in gambling products operated by the New Zealand Lotteries Commission. This justifies the Government’s decisions that Maori should receive greater benefits from government operated gambling (Select Committee on Government Administration 2002, (clause 247)) The impact of acknowledgement is reduced though by the Government also emphasising that older people, Pacific people and other ethnic communities require attention when distributing funds. (Select Committee on Government Administration 2002, clause 247 (5))

Maori have a high level of involvement in non-continuous forms of gambling and, it is suggested these meet different needs, as they are primarily social, and are not merely opportunities to win money or a specific item. Community groups and the Government often promote these forms of gambling as being “beneficial”, because proceeds are often reinvested back into community activities and without gambling, other sources of funding would have to be obtained. Many community groups and the Government are dependent on gambling. (Department of Internal Affairs 2001)

Although Maori participate in wide range of non-continuous forms of gambling activities, the amount spent by Maori has declined and is almost half the amount reported in 1990 ($912 per person). Currently it is estimated that on average Maori spend just over five hundred dollars ($538) per year on gambling. If correct, this decrease is substantial and Pacific peoples report the highest level of expenditure on gambling ($684)
while the general population expenditure is approximately $446, a decline of 8% since 1990. (Department of Internal Affairs 2001)

The figures tend to under-report real expenditure, as participants are likely to be very conscious of the stigma attached to excessive expenditure on gambling if they are on low incomes or dependent upon government income support. The 2001 census showed the median income of males as just under $30,000 and of women, the median income was approximately half that of men. (Devereux 2002) The median income for Maori males was just under $15,000 and for Maori women just under $10,000. (Binning 2002; Statistics New Zealand 2002)

Taking the median income of Maori males and females and the average amount Maori spend on gambling, it is estimated that men spend 3.5% of their income and women 5.3% on gambling. This is approximately $10 per week on gambling similar to the amount Maori households spend on health, goods and services and tobacco ($9.00 and $11.40) but is more than that spent on education ($7.30) on a weekly basis. (Te Puni Kokiri 1998)

Participation in different forms of gambling varies, with people from high income households more likely to make bets with friends, purchase a raffle ticket, or attend a casino evening compared with those on low incomes or blue collar employment who are more likely to purchase Lotto, play gaming machines or place a sports bet. Respondents with lower educational qualifications were more likely to gamble and spend more than those with better qualifications. (Department of Internal Affairs 2001)

The pattern of gambling of New Zealanders is related to social class and occupational status. As Maori generally have a lower level of educational achievement than non-Maori and if employed are in low income jobs, social class and ethnicity has become intertwined and influences Maori gambling. (Abbott and Volberg 2000 (a)) Similar findings have also been found in Pacific and Asian communities in New Zealand. (Gregory 2002) Further research is required to identify the inter-relationships between social class, ethnicity and Maori under-development.

3.2.4 Track, Internet and Sport Betting

The 2000 study has provided further information about track and sports betting, non-casino gambling machines and casinos. (Reid and Searle 1996; Department of
The results confirm that track betting has declined. Participants in this form of gambling are more likely to be male, place bets through TAB outlets rather than at the track, and are generally older. People on high incomes are participating more in this form of gambling whilst participation by those on low incomes has declined.

Participation in gambling activities is not static, but is dynamic and changes with people’s income and lifestyle changes. New Zealanders are willing to play new games of chance when new gambling products are introduced. High-income earners, despite their level of education, are willing to participate in forms of gambling which have increased risk and provide more challenge. Betting on the stock market is not investigated as part of this research but should be considered in future gambling research especially with new Internet developments allowing investment on different forms of stock. (Easton 2002)

In the past, Maori enjoyed track betting, but on average Maori now spend less than the general population ($15.60 compared to $24.10 per race betting session). Maori also report more favourable results from this form of gambling compared with the rest of the population and often saying that they won money or broke even. New track internet betting has been approved in New Zealand (October 2001). It is likely to suit those on higher incomes who feel confident using the internet or have access to a computer on a regular basis. (Department of Internal Affairs 2001) Impact of Internet betting requires further research in New Zealand. Its potential impact on Maori requires early assessment, as Maori are interested in new information technology and new forms of interactive gambling could provide the next wave in the growth of problem gambling in New Zealand. (Statistics New Zealand 2002) Young people are particularly at risk as Internet cafes are available throughout the country, and provide a similar function to that which hotels and clubs provide for adults and when internet access will become available. (Sullivan 1997) Interactive gambling has been predicted as the next form of gambling which will increase problem gambling and will be difficult to regulate as access can be both national and international, credit cards can be used and gambling operators can offer more attractive financial rewards as they have lower overheads than casino operators. (Korn 2000; O’Hare 2002)

The Government has sought advice whether internet gambling is congruent with the image of New Zealand as a “safe green haven”. (Department of Internal Affairs 2001)
Developments are already occurring in the Pacific where some nations are using gambling as a key strategy for economic development and money laundering. (Ansley 16 June 2000)

Sport betting is slowly becoming more popular with gamblers, including Maori. (Petraska 1996) Only 10% of participants reported that they had placed a sports bet through TAB in the past year and participation in this form of gambling was not on a regular weekly or monthly basis. Expenditure per session was generally below $10 and more males played this form of gambling. Maori interest in this form of gambling is however increasing with 11% reporting participation. The range of sports and events New Zealanders can bet on in the future is likely to increase as those sports which agree to allow betting receive 5% from totalisator sports-betting turnover, and 5% of gross profits from fixed odds betting. (Petraska 1996) With increased opportunities to bet on different sporting events, Maori participation in this form of gambling is likely to increase and impact on Maori requires further research. Sport is being used as a medium to promote good health, to support tribal development and to promote positive Maori male and female role models. (Te Puni Kokiri 2001)

3.2.5 Non-Casino Gambling Machines

Since 1995, New Zealand has seen a rapid increase in non-casino gaming or gambling machines. There are now over 20,000 spread throughout the country. Although the number of machines has increased, participation in this form of gambling has declined from 28% in 1990 to 18% in 2000. Although participation may have declined, on average expenditure has increased to $15 per session. Players are now spending approximately 50% more than those who played in 1995 ($10 per session) even though they are a smaller population group. Participants with high household incomes report that they are spending more on the machines.

Non-casino gambling machines have contributed to increased expenditure on gambling overall. From 2001 to 2002, expenditure on gambling machines increased from $597 million to $777 million an increase of 30%. Overall, New Zealanders lost $1.6 billion in 2001/2 on gambling. (Department of Internal Affairs 2003) This is revenue available for gambling operators and other stakeholders such as community groups and shareholders, which receive profits and the Government which receives tax and levies
through the Consolidated Fund. (Department of Internal Affairs 2002) Expenditure on gambling by New Zealanders is influenced by the discretionary income people have available. This has important implications for New Zealand's economic development in that either available or restriction of income can influence individuals' expenditure on gambling and therefore their risk of problem gambling. (Abbott, Williams et al. 1999 (a); Shaffer and Korn 2002)

More longitudinal studies, which include or focus on gambling, are needed so that New Zealanders' changing patterns and attitudes towards gambling can be observed. Research on the costs and benefits of gambling on New Zealand society is an area which requires investigation and could be undertaken by the Ministry of Economic Development, which has specific interest in regional development in New Zealand. (Productivity Commission Report 1999)

There are gender and ethnic differences in gambling with more females than males reporting playing non-casino gambling machines. The level of female expenditure at a session is slightly less than male, $14.80 compared with $15.20. Participants in this form of gambling are more likely to be young adults 15 to 34 years but participants over 45 years of age are also likely to play more often. Maori reported the highest level of participation in non-casino gambling machines compared with the general population. 69% considered that they won money or broke even when playing the machines and overall Maori were the most confident of all groups about the chances of winning from the machines. (Department of Internal Affairs 2001)

Maori perception of winning or breaking even influences their choice of gambling activity. When asked whether educational warnings would be of value, under half of Maori participants (41%) considered they would play less if the machines alerted them to how much they had won or lost and they were receptive to being paid by cheque if winnings were over $50. More participants from households of less than $30,000, this is the median income of most New Zealanders (2001 census) reported that they would play less if there were warnings on machines. (Statistics New Zealand 2002)

Maori participants reported more frequently than other participants that they could recall gambling advertisements such as Lotto and TAB advertisements. This implies it is timely to develop appropriate health messages for Maori to address problem gambling.
perhaps modelling a recently introduced advertising campaign Me Mutu, campaign which has focused on quitting smoking for the whanau.

Gaming machines as a form of continuous gambling has contributed significantly to the growth of problem gambling in New Zealand. (Abbott and Volberg 2000 (a)) Machines are programmed for the “house to win”, although participants may win small amounts intermittently. It is often the challenge and excitement of winning the jackpot, which encourages people to keep playing, while small wins provide rewards to keep people playing. For some Maori, participation in this form of gambling can lead quickly to problems even though they may have had little interest in gambling previously. (Compulsive Gambling Society of NZ 1998)

3.2.6 Casino Gambling

Although the 1990s can be seen as the era in which casinos were introduced to New Zealand, in 2000, only 16% of those surveyed had gambled at a casino within the previous year and this was infrequently, only once every two to six months. This suggests that the majority of people who visit a casino do so as a special event and those who attend regularly are a small group who spend a significant amount of money.

The need to encourage people to attend a casino has led Skycity and the Christchurch casino to develop relationships with different communities and business groups to offer hotel accommodation, conference facilities, wider recreation and leisure services and to support community initiatives which enable them to be seen as responsible corporate organisations. These areas of expansion are likely to continue now that casinos cannot increase their gambling activities. (Budd 2000; Department of Internal Affairs 2002)

Each casino in New Zealand must pay a 4% compulsory levy to the Government, pay income tax, make a voluntary donation to the Problem Gambling Committee to fund gambling treatment services, and have their own host responsibility initiatives, such as, allowing problem gamblers to ban themselves from the casino so that the police can

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15 In 2001, Skycity was awarded the leading New Zealand tourist award despite public criticism that this development should not be used to be the flagship of New Zealand tourism and in 2002 one of the most of successful companies which increased stock value Eagles, J. (2002). Year of big spender. New Zealand Herald. Auckland: C1, 4 January.
remove a person under the Trespass Act 1980. (Pitcher 1999; Easton 2002) Host responsibilities are now being strengthened with casino operators having to meet defined statutory responsibilities if new gambling legislation is introduced. (Select Committee on Government Administration 2002) Host Responsibility activities may change the environment of gambling but may not necessarily challenge the acceptance of gambling within a society, community or population.

Participants reported they spent on average $48.20 per session with over half reporting that they spent less than $21 at the casino. This is significantly less than reported by Skycity, at the Auckland casino, where gamblers regularly spend around $64 per visit and each day approximately 12,650 people visit this establishment. (Hendery 2001) Women and men had the same level of participation at casinos, but women reported spending more, supporting the view that women are attracted to this environment to socialise as it is generally safe and free of harassment and operates 24 hours a day. (Kiata 2002) Casinos accommodate women's work and home responsibilities. Pacific and Asian people also frequent the casino probably for similar reasons as women in general. In visiting the casino, men are more often attracted to the tables, and women to the gambling machines. (Department of Internal Affairs 2001)

Maori participants in the 2000 study reported that they often visited the casino at least monthly and spent around $31.40 session, less than the amount reported by the general and Pacific populations.

3.2.7 Gambling Regulation and Licensing

Those interviewed who were least involved in gambling supported gaming regulation and restrictions, whereas those actively involved wanted minimum restrictions to encourage greater competition between gambling industries and provide more choice for gamblers. Participants were supportive of gambling being used for “fund raising for worthy causes”, and this was particularly so for Maori who recognised Maori reliance on gambling proceeds for community and sporting activities. No participants were in favour of gambling activities as a means of “raising Government revenue”.

Maori considered that the Government should be involved in the regulation of gambling and the creation of gambling industry jobs for Maori. When questioned about the role of different Crown agencies involved in the distribution of funds, Maori
knowledge varied. Maori were aware of the Hillary Commission and the Lottery Grants Board but many were unfamiliar with the role of Creative New Zealand.

The views of participants of the 2000 study, submissions submitted by interest groups including Maori and growing community interest in the licensing and placement of non-casino gambling machines have influenced the Government to provide protection to current gambling operators to confirm their areas and avoid competition.

These New Zealanders' views towards gambling now reflect the normalisation of gambling in New Zealand acceptance of changes which have occurred since the late 1980s, alongside growing concerns about the effects of problem gambling. This mirrors developments occurring in other countries as awareness grows of the effects of gambling. (Abbott, Williams et al. 1999 (a); Korn and Shaffer 2000; Korn 2000)

It is worthwhile to note that information presented in this survey excluded the views of international tourists. Their assumed interest in gambling has been used as part of the justification for the establishment of casinos. It is likely that interests of tourists will be used to advocate for more opportunities to gamble in New Zealand, such as in Rotorua.

3.3 Problem and pathological gambling: Implications for Maori

3.3.1 Recognition and assessment of problem or pathological gambling

There are two differing schools of thought associated with defining problem gambling. The predominant school of thought utilises a medico-psychological model and perceives gambling as an individual pathology. This allows gambling to be seen as a disease, an addiction and a health problem, which can be addressed through medical or related interventions. (Lloyd 2002)

In contrast, another school of thought, grounded in sociology, sees gambling as a metaphor for the way in which people live and construct their social world. Any society is governed by rules, moral values, and behaviour and gambling is seen within a societal context as well as from medical and psychological perspectives. Both approaches will be considered when reviewing the evidence of gambling and problem gambling being a health issue for Maori. (Kiata 2002; Lloyd 2002)

Currently the focus on problem gambling in New Zealand is at the severe end, or that which is defined elsewhere as pathological gambling. After thirty or more years, it is
now recognised that pathological gambling can be considered a legitimate mental health problem influenced by the early work of Custer who first proposed the medical syndrome associated with gambling which he called "compulsive gambling". (Custer 1978) Lesieur and Rosenthal's have also been influential with their submission to the American Association Task Force on DSM-IV Committee to consider pathological gambling as an impulse disorder. (Lesieur and Rosenthal 1991)

Pathological gambling as a specific medical problem was first included in the Ninth Edition of the International Classification of Diseases (ICD9) in 1977, and was incorporated into the Third Edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM-111) in 1980. Currently the psychiatric disorder focuses on impaired ability to control gambling-related behaviour, adverse social consequences that disrupt personal, family or vocational pursuits and tolerance, and the need to gamble increasing amounts of money to achieve desired levels of excitement. The diagnosis is not made if the behaviour can be accounted for better as a manic episode. (Korn 2000)

Abbott and Volberg (2000) note that over time, the criteria used to define pathological gambling have changed. However, the consistent features of pathological gambling are defined as follows:

- continuous or periodic loss of control over gambling,
- a progression in gambling frequency and amount wagered,
- constant preoccupation with gambling and obtaining money so as to be able to continue gambling despite adverse consequences. (Abbott and Volberg 2000 (a))

To be diagnosed as having a pathological gambling problem using the current DSM-IV criteria (American Psychiatric Association 1994) a person must have:

(A) persistent and recurrent maladaptive gambling behaviour as indicated by five (or more) of the following:

- preoccupied with gambling (e.g. preoccupied with reliving past experiences, handicapping or planning the next venture, or thinking of ways to get money with which to gamble),
needs to gamble with increasing amounts of money in order to achieve the desired excitement,

- has repeated unsuccessful efforts to control cut back or stop gambling,
- is restless or irritable when attempting to control, cut back or stop gambling,
- gambles as a way of escaping from problems or relieving a dysphoric mood (e.g. feelings of helplessness, guilt, anxiety, depression),
- after losing money gambling, often returns another day to get even (chasing one’s losses),
- lies to family members, therapists or others to conceal the extent of involvement with gambling,
- has committed illegal acts such as forgery, fraud, theft or embezzlement in order to finance gambling,
- has jeopardized or lost a significant relationship, job or educational or career opportunity because of gambling,
- relies on others to provide money to relieve a desperate financial situation caused by gambling.

(B) The gambling is not better accounted for as a manic episode.

For a person to be diagnosed as either a problem or pathological gambler there is no time frame for the above patterns to occur. Problem gambling is defined as having three or four of the above defined patterns of behaviour. For pathological gambling it is five or more.

The allocation of a mental health diagnosis to an individual has both advantages and disadvantages. A person and/or their family can be offered health care and support but on the other hand, a mental health diagnosis may create stigma, and not address the real issues which are creating the problem. When according a medical or mental health diagnosis to individuals, a broad view needs to be taken such as the Te Whare Tapa Wha model of health to understand what creates their un-wellness and what needs to be in
place to support achievement and/or maintenance of their wellness. (Bridgman, Dyall et al. 2000) The advantages and disadvantages of where a health issue fits are discussed more fully later in chapter five when a public health approach is considered to address gambling and problem gambling.

Maori often describe or emphasise different symptoms from people of other cultures when presenting with illness such as depression. (Durie 2001) This has led to the view that diagnostic frameworks need to take account of the culture of individuals and their worldviews so that appropriate diagnosis and help is provided. Cultural assessment is being recognised as important in relation to the diagnosis of mental illness New Zealand. The importance of cultural assessment, has not yet been considered in the assessment, diagnosis or treatment of problem gambling, but should be considered when assessing whether a person is manic or has a gambling problem. (Mental Health Commission 2001) This is important for Maori as individuals will often state that they have had dreams, have spoken with their ancestors, or have the ability to see into the future and use these messages as signs for gambling. (Dyall 1997)

Pathological gambling, medically defined relates to a person’s cumulative experience of gambling. In contrast, measurement of the prevalence of problem and pathological gambling in the community often requires people to assess their behaviour over the last twelve or six months. A combination of both approaches has been taken by Abbott and his research team to determine the prevalence of problem and pathological gambling in the New Zealand community. (Abbott and Volberg 2000 (a))

Measurement of the prevalence of problem and pathological gambling has been difficult to determine in gambling related research as it requires an in-depth understanding of the pathology of gambling and symptoms or behaviour to identify which individuals have had or have current problems. To determine the number of people within a population who have problems with gambling requires the ability to have available an assessment tool which is able to consistently identify over time those individuals within a population who have no problems, those who have some problems defined as problem gamblers and those who have a severe or a pathological gambling problem. The tool must also be able to measure the degree of problems with gambling
within a defined time frame, such as those who have had problems sometime in their life or in the past six months. (National Research Council 1999)

3.3.2 Southern Oaks Gambling Screen: Use in New Zealand

To identify pathological gambling from a mental health perspective, a screening tool called the Southern Oaks Gambling Screen (SOGS) has been developed in America to be used initially as an assessment tool followed by a clinical interview to confirm diagnosis. (Lesieur and Blume 1987; Lesieur and Rosenthal 1991) This tool has a 20-item scale based on the criteria for assessing pathological gambling and has become the main instrument to study the prevalence of problem and pathological gambling in communities. This tool has been translated into different languages, such as French, German, Dutch, Spanish, Italian, Cambodian, and Lao for use in different countries and has been adapted and used as a shorter screen in different research settings. The Southern Oaks Gambling Screen or an adaptation has been used widely to determine the prevalence of problem and pathological gambling in community prevalence studies (Abbott and Volberg 1992; Abbott and Volberg 1999 (b); Abbott and Volberg 2000 (a)) for assessing problem gambling with Maori has never been considered in any real depth but it has been used in New Zealand to estimate the prevalence of problem and pathological gambling in two major community studies, in prisons and in clinical settings. The effectiveness of this screening tool and its application with indigenous populations has not been addressed specifically but it has been recognised that the reliability of this instrument may vary due to cultural factors. (Shaffer and Korn 2002)

Duvarci (1997) for example, has suggested that there is a need to ask culturally appropriate questions which provide information on gambling expenditure and which recognise gender and power differences within relationships and families. The reliability of screening tools to provide appropriate assessment is important otherwise the value of the information obtained is open to question. (Elia and Jacobs 1993; Zitzow 1996; Duvarci, Varan et al. 1997)

In America, Canada and Australia, researchers are beginning to review the place and impact of gambling on their communities. (National Research Council 1999; Productivity Commission Report 1999; Korn 2000) There is growing awareness of the
need to develop new screening tools which have a wider family and community focus. For example, the Canadian Centre on Substance Abuse is developing a new survey instrument called the Canadian Problem Gambling Index for use in population studies. This tool will place greater emphasis than the Southern Oaks Gambling Screen on measuring the social impacts gambling has on families, co-workers and communities at large. (Korn 2000)

It is hoped that this tool will incorporate issues of importance for indigenous populations, such as, the intergenerational effects of indigenous gambling on families, so that it could be adapted for use in New Zealand. The Mental Health Commission has stated:

*Constructing valid outcome measures is no small task, particularly in mental health and especially for Maori. However the benefits of such tools may be significant, not only in terms of quality assurance but also as a means of further validating Maori approaches to treatment and care. Not only are Maori providers likely to benefit but also funders and Tangata Whaiora*. (Mental Health Commission 1998, pg 22)

### 3.3.3 Screening and Maori views

Maori consider that the following principles should be considered when developing screening programmes with tangata whenua. They are: recognition of the Treaty of Waitangi, the need for an appropriate integrated primary health care system in place, the need to recognise social injustices, the requirement of inter-sectoral collaboration relationships with agencies, the need to recognise the interdependence between and across different health workers scope of practice, the need to recognise barriers which impede access to healthcare and the need to actively involving those at risk or affected by the health issue in defining the health problem and solutions proposed to address the issue. (Te Manawa Hauora 1993) Generally health screening is only undertaken for a health problem if it is an important health problem, the natural history of the disease is well understood, there is an available test which is acceptable to the general

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16 This term refers to mental health consumers.
public, treatment of the disease at its pre clinical stage is available compared with treatment when it is symptomatic, prolongs or enhances quality of life, adequate facilities are in place for treatment, the cost involved justifies the benefits, and the benefits of screening outweigh the possible physical, social or psychological harm. (Gardis 1996)

For Maori, screening is part of a process which empowers them to be involved in a health issue, and encourages the Crown or its delegated agencies to take responsibility for a health issue so that appropriate services and funding are in place to meet those in need. To screen or not to screen is a political matter in New Zealand as it can either magnify or reduce a health issue. Recognition of this fact is important for Maori often have health concerns that are not a high priority for non Maori but are important health issues for tangata whenua such as, the need to screen for Hepatitis B carriage a condition which particularly affects young Maori, Pacific nations and Asian males and who later in life can develop liver problems. (House of Representatives 1995; Ministry of Health 1995)

Screening can play a significant role in changing the status of a social problem to a legitimate health issue which warrants financial investment, ongoing surveillance, and the development of a skilled health workforce able to treat and manage the health issue and support ongoing research. Screening for problem gambling in different population groups has played an important role in identifying the size of the problem and the need for a public health approach to reduce the size of problem gambling in New Zealand. (Department of Internal Affairs 2002)

3.3.4 Screening For Problem Gambling In New Zealand

Problem gambling treatment services in New Zealand are required by the Problem Gambling Committee (PGC) to use the Southern Oaks Gambling Screen as a tool to identify the severity of problem gambling at treatment clinics, to enable comparison of data with national studies and to assess the severity of problem gambling of clients across different gambling treatment providers and between various population groups.

Using the Southern Oaks Gambling Screen, generally Maori are shown to have a greater severity of problem gambling than non Maori when they present for help. This suggests that either Maori have a higher acceptance of problem gambling before seeking
help, and or have difficulties in accessing appropriate care. (Paton-Simpson, Gruys et al. 2001) This pattern of seeking help is present in other areas in the health system, such as mental health services where Maori present in a crisis situation. (Pomare, Keefe-Ormsby et al. 1995; Te Puni Kokiri 1996)

Assessment by specialist gambling treatment services has shown that Maori have a different profile from other problem gamblers with Maori men and women, presenting earlier for help then people from other cultures suggesting increased exposure and participation in gambling. (Compulsive Gambling Society of NZ 1998; Paton-Simpson, Gruys et al. 2001)

The Southern Oaks Gambling Screen has been adapted by Sullivan to become a “self screen” tool in New Zealand and has eight questions that can be used by individuals to review their behaviour. If individuals answer yes to three out of the eight questions they are encouraged to seek help with their gambling. (Sullivan, Arroll et al. 2000) This tool has been tested in different settings, such as at general practice clinics. Its appropriateness for assessing problem gambling with Maori has not been reported. (Sullivan 2000 (a))

It has been translated into te reo Maori and is included in “Ta Te Iwi Maori Hei Arai Atu I Nga Mate Petipeti: Maori Action Against Problem Gambling Resource Kit”, (1998). The extent of its use by Maori individuals or by Maori health providers is currently unknown. (Compulsive Gambling Society of NZ 1998) Its use with Maori is an area worthy of further research as it enables Maori individuals to self screen, for health professionals to initiate discussion about gambling problems and is a means of raising Maori awareness of the signs and symptoms of problem gambling.

As communities become aware of the effects of problem gambling there is growing interest in the definition of problem gambling and pathological gambling. (Gregory 2002) Increasingly, it is being recognised that the definition of problem or pathological gambling is intimately linked to a country’s culture and the acceptance or non-acceptance of gambling. For instance, in New Zealand, a lower threshold of four symptoms is taken in relation to the DSM-IV diagnosis to defining problem gambling, whereas in Australia, a person is required to have five or more symptoms. (Productivity
Commission Report 1999; Abbott and Volberg 2000 (a)) Maori are interested in the definition of problem gambling and the place of gambling in Maori communities. 17 The appropriateness of Southern Oaks Gambling Screen has been discussed for its use with Maori has been assumed, but it is an area which requires further research.

3.3.5 First National Gambling Study in New Zealand

The first prevalence study of problem gambling in New Zealand was carried out in 1991, prior to the establishment of two casinos. Researchers interviewed 4,053 people aged over 18 years by telephone from different households using a modified Southern Oaks Gambling Screen tool, called the SOGS-R. Only one person per household was selected in this study and it provided insight into just over 4,000 New Zealand households. (Abbott and Volberg 1991; Abbott and Volberg 1996)

The purpose of the research was to identify the prevalence of lifetime and current problem and pathological gambling. Phase one, involved collecting information on participants' involvement in fourteen different forms of gambling, their expenditure on gambling, assessment of problems with gambling using the SOGS-R tool and demographic details. This phase enabled a wide range of information to be collected and the selection of participants for phase two of the study. Phase two involved face to face interviews, with a sub-sample of Phase one gamblers to provide additional information, especially from participants identified as having problems with gambling and to check the overall validity of the data of Phase one. (Abbott and Volberg 1991; Abbott and Volberg 1992; Abbott and Volberg 1996)

Selected households were called up to eight times before they were excluded from the study and the response rate was 66%. This was considered acceptable in relation to other epidemiological studies conducted in New Zealand Canada and America. (Abbott and Volberg 1996; Ladouceur 1996)

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17 This awareness has led to the establishment of a Maori Reference Group on Gambling to ensure that a Maori presence and voice is heard in future gaming decisions. A meeting was held in Auckland on 27 November, 2001 with interested Maori organizations, individuals and invited government agencies, to consider the need for such a body and to ensure Maori involvement following the Government decisions for new legislation to govern gambling and new funding for gambling related services to address problem gambling as a health issue.
In the 1991 study, Maori were under-represented when first surveyed and additional 120 Maori participants were added to the sample to gain a representative sample of the proportion of Maori within the total population. The validity and use of telephone access as a method of selecting and recruiting participants is often questioned in New Zealand as distinct population groups such as Maori and youth do not have the same level of telephone ownership as other groups and therefore their opportunity to participate is reduced. Although not perfect, prevalence studies can provide a picture at a point or period of time of the percentage of a population at risk of a specific problem and depending upon the design may also provide the incidence or the number of new cases within a defined time frame. (Abbott and Volberg 2000 (a); Department of Internal Affairs 2001) Only one study in the gambling area worldwide has reported on the incidence of problem gambling, and this has been in relation to a small prospective study of drug users. (Cotter 1998) Both prevalence and incidence studies are important as they provide information which can be generalised to the wider population, help in defining whether an issue is significant, and can assist in planning health services, such as specialist gambling treatment services.

Two measures are often used in defining prevalence, first, “lifetime”, in which individuals identify that some time in their life they have experienced a particular set of problems or behaviours. Alternatively they report behaviour within the past six months, which provides information on the second measure “current prevalence rate”. This rate is considered the most valid for planning purposes, as people are more likely to recall behaviour which they have recently or are currently experiencing.

From the Abbott and Volberg, 1991 study it was found that Maori, youth aged between 18 to 29 years, and males were most at risk of problem and pathological gambling. A quarter of current and lifetime problem and pathological gamblers were also found to identify as Maori. (Abbott and Volberg 1991; Abbott and Volberg 1996)

From this study, it was estimated for the total New Zealand population, the lifetime prevalence of pathological gambling was between 2.1 and 2.7% and lifetime

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problem gambling between 3.6 and 4.2%. For current pathological gambling, the rate was between 0.9 and 1.2% and current problem gambling was 1.7 and 2.1%. (Abbott and Volberg 1996)

These figures were a surprise in New Zealand, and applying them to the then New Zealand adult population it was estimated that in 1991, there were between 50,000 and 73,000 people with a lifetime pathological gambling problem and an even larger group (82,000 to 110,000) had a lifetime problem with gambling. Applying the percentage figures for current pathological gambling it was estimated then that 20,000 to 35,000 people had had a recent experience of this condition and for current problem gambling the figure was between 38,000 to 58,000 people.

A review of the study by Manly and Gonzalez (1994) suggested that, at the 95% confidence interval, the study showed that the percentage of pathological gamblers in New Zealand ranged from 0.55% to 3.55%, and that New Zealand rates were similar to other countries, such as Canada, which had an estimate of between 1 to 3% of their population with severe problems with gambling. (Manley and Gonzales 1994; Ministry of Health 1996; Korn 2000) The Southern Oaks Gambling Screen has been criticised for inflating the size of problem gambling in communities as it may identify people as problem gamblers but who do not have a real problem with gambling and are defined as being “false positive” and fit within the continuum as social or recreational gamblers. (Gambino 1997; Shaffer and Korn 2002)

Although prevalence rates may seem small when presented as percentage figures, when applied to the population a significant number of New Zealanders would have experienced problems with gambling in 1991. The 1991 study also showed regional variation in the prevalence of problem gambling with Auckland having the highest rate, a finding considered as being related to the higher proportion of Maori and Pacific people who live in this region. (North Health 1996; Australian Institute for Gambling Research 1998; Abbott 2001)

When the results from this study were released they were challenged severely as it was considered that they over-reported the situation. The results, however, were conservative as participants included only those living in the community, and excluded
adults in mental health, prison and other institutions. In addition to which, the study had low Maori and Pacific participation. (Abbott and Volberg 1991)

It was estimated that there were 12,000 to 68,000 New Zealanders who would have experienced or had a problem with gambling. Initially, the figure of 12,000 adults was taken for planning and funding of pathological gambling treatment services in New Zealand. The position of Maori was not considered in any substantial way, although it was recognised that Maori had three times the risk of pathological gambling than had European or Pakeha New Zealanders and that services needed to be tailored to meet the needs of specific cultural groups. (Ministry of Health 1996) Since the 1991 study, the responsibility for the development of appropriate Maori gambling treatment services has been dependent largely upon Maori advocacy. (Compulsive Gambling Society of NZ 1998)

3.3.6 Second Prevalence Study of Problem Gambling in New Zealand

The second study of the prevalence of pathological and problem gambling, in New Zealand in 1999 was carried out by Abbott and Volberg and published in 2000¹⁹. This study was designed as a telephone landline study to be comparable with the 1991 survey and other research which had been conducted in countries such as America and Canada so the results could be compared within an international context. (Abbott 1999) Two questionnaires were used in Phase one of the study, a household form to identify and select eligible respondents for the study and a personal questionnaire which covered a broad range of questions, regarding participation in gambling, the SOGS-R screen, problems with gambling personally or with family members, self-rated happiness, and socio-demographic details. This study has taken a wider view of the impact of gambling than was used in the 1991 study.

Informed consent was sought for participants who were selected for the Phase two of the survey to be contacted again by another group of researchers from the National Research Bureau, for further information on their pattern of gambling. (Abbott 2001)

¹⁹ This study will be referred to as the 1999 study as the field work was carried out that year and the results were published in 2000.
Abbott and Volberg (2000) suggest that the results from Phase one of the 1999 national prevalence study should be used with caution, as the population did not represent adequately the current New Zealand adult population, defined as those aged over 18 years living in the community. (Abbott 2001)

Due to the recruitment and sampling method of the study, selecting one person per selected household, there was a lower representation of youth and Pacific Island peoples yet again. The sampling method disadvantaged Maori and Pacific participation as often two generations or more live together to provide emotional and financial support. (Abbott 2001) This information is known but was not recognised in the design of the study even though these were two populations identified as being at risk of problem gambling. (Te Puni Kokiri 2000)

Since 1991, cheap mobile telephones have become common amongst youth and low-income households reducing further the number of people who could have been contacted for participation in the study. (Smith, Barnfield et al. 2001) As in the 1991 study, people in mental health and other institutions, overseas diplomats and overseas visitors expected to be resident less than one year were excluded. The exclusion of people in mental institutions, in prisons and old people’s homes has real implications as Maori are over-represented in both mental health and prison facilities and as problem gambling is invisible, it is regularly unrecognised as an underlying contributor to their problems. Two reviews of Maori mental health trends have demonstrated that Maori have different patterns of admission and discharge from mental health inpatient services, receive a different level of care in terms of hospital stay and more Maori women in their forty plus years are being admitted to mental health services in comparison with non Maori women. (Te Puni Kokiri 1993; Te Puni Kokiri 1996)

In 1999, 6,452 adults were interviewed by landline telephone, over a three-month period (23 January to 21 March) regarding their pattern of gambling and were assessed using an amended Southern Oaks Gambling Screening tool, (SOGS-R) as to whether they were a problem, pathological or non-problem gambler. To take account of the under-representation of the Maori population, the “Maori sample” was weighted to represent the national adult Maori population instead of over-sampling which occurred in the first
study. Additional cost has been advanced by the Department of Statistics to explain why over-sampling for Maori did not occur. This has been verified by Abbott and Volberg who comment they did not over-sample Maori and other ethnic minority groups, as this would increase cost, decrease the accuracy of the national statistics, and would make analysis of the data complex. (Abbott and Volberg 2000 (a))

These reasons seem valid, but given the findings of the 1991 study it would have been appropriate to design a study which actively supported Maori participation so that suitable information was available for both Maori and the Crown to support ongoing research, policy development and health service delivery. The New Zealand Lotteries Commission funded this research with input from the Department of Internal Affairs. These are two Crown agencies, which have ignored defined Treaty of Waitangi obligations to Maori. (Abbott and Volberg 2000 (a))

Due to the limitations of the 1999 study, there is a need for further research for future policy development to identify clearly the prevalence of Maori problem gambling in the community, in health and community-based social services, and in prisons so that the impact gambling has had on the health and wellbeing of Maori can be identified clearly.\(^\text{20}\)

Overall the 1999 study has focused on gaining national prevalence data and the research has not been conducted in a way, which recognises the Treaty of Waitangi, Maori principles for screening, Maori principles for research and, despite the importance of the study, no Maori have been invited to comment on the methodology or findings through a peer review process, although international and local reviewers have been involved.\(^\text{21}\) As over-sampling has not occurred there is uncertainty on the significance of the Maori data. Reviewers of the 1999 study have questioned the methodology and consider that the under-representation of specific groups, such as youth, Maori, Pacific

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\(\text{21}\) The researcher was invited to comment on the proposed questionnaire to be used in the prison studies but the design of the 1999 community study had been planned already. No further opportunity was made available for input by the researcher. The researcher was also part of a research team from the University of Auckland which contested to undertake this research. The methodology proposed was a randomized sample, face to face interviews rather than telephone and over sampling of Maori to gain sufficient Maori participants.
and Asians has skewed the data. (Smith, Barnfield et al. 2001; Sullivan 2001 (a)) In contrast Pakeha middle-aged women have been over-represented in this study and have made the results conservative. The findings of the study therefore need to be carefully considered. (Bunkle 2000)

Overall, a 75% participation rate was obtained for the 1999 study, and this figure is considered acceptable in comparison with a similar study carried out in Sweden in 1999. Although New Zealand and Swedish populations are quite different in cultural values, the differences in social policy, history of gambling, and demographic structure and ethnic make affects the epidemiological analysis. (Ministry of Health 1998; Ronnberg S, Volberg et al. 1999; Pearce 2000)

Only 432 Maori people were interviewed as part of the Abbott and Volberg 1999 study and, as Maori accounted for fewer than 7% of the participants and information was weighted to reflect the national adult Maori population of just under 12%, the results of this study are likely to under-report significantly Maori problem gambling, patterns of gambling and expenditure on gambling. The population sampled can provide information only on lifetime prevalence of problem gambling for Maori. Overall, the results are conservative and do not adequately recognise the diversity of gambling patterns within the Maori population. (Abbott and Volberg 2000 (a); Durie 2001) In 1999, it was estimated that between 38,300 (1.4%) and 68,600 (2.5%) New Zealanders aged over 18 years and over, could be classified as lifetime problem gamblers and an additional 19,700 (0.7%) to 39,100 (1.4%) could be classified as lifetime probable pathological gamblers. The lifetime estimates included current problem and pathological gamblers as well as people who reported having problems in the past but not currently.

It was estimated that the number of current problem gamblers, defined as those who had problems over the past six months, ranged between 15,400 (0.6%) and 30,700 (1.1%) and an additional 7,300 (0.3%) to 20,700 (0.7%) could be classified as probable pathological gamblers.

Overall, the lifetime prevalence of problem and pathological gambling in New Zealand was estimated conservatively as between 1.4 and 3.9%. For current problem
gamblers it was estimated between 0.6 and 1.1%. Table 3.1 reports the different rates and the size of problem and pathological gambling in New Zealand in 1991 and in 1999.

Table 3.1

**Summary of Prevalence of Pathological and Problem Gambling in New Zealand**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Pathological Gambling</td>
<td>2.1 to 2.7%</td>
<td>50,000-73,000</td>
<td>0.7 to 1.4%</td>
<td>19,700-39,100</td>
</tr>
<tr>
<td>Lifetime Problem Gambling</td>
<td>3.6 to 4.2%</td>
<td>82,000-110,000</td>
<td>1.4 to 2.5%</td>
<td>38,300-68,600</td>
</tr>
<tr>
<td>Current Pathological Gambling</td>
<td>0.9 to 1.2%</td>
<td>20,000-35,000</td>
<td>0.3 to 0.7%</td>
<td>7,300-20,100</td>
</tr>
<tr>
<td>Current Problem Gambling</td>
<td>1.7 to 2.1</td>
<td>38,000-58,000</td>
<td>0.6 to 1.1 %</td>
<td>15,400-30,700</td>
</tr>
</tbody>
</table>

The low current and lifetime estimates from the 1999 study have required Abbott and Volberg to reconsider their original hypothesis proposed in 1991, that problem and pathological gambling would increase over time with new opportunities to access, e.g. casinos and use new gambling products. Even though there are differences in design

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between the two studies and participants involved, Abbott and Volberg conclude that the 1999 study provides:

*a more accurate account of gambling and problem gambling in the New Zealand adult population than was provided in the 1991 survey.* (Abbott and Volberg 2000 (a), pg 183)

This statement has been severely criticized by independent reviewers who consider that the 1991 results are more valid although conservative. (Smith, Barnfield et al. 2001) Abbott and Volberg (2000) conclude that, although New Zealand's rate of prevalence of problem and pathological gambling may have declined since 1991, there are between 1 and 3% of New Zealand adults living in the community who have experienced problems with gambling, and despite the low estimates of both current and lifetime rates for problem and pathological gambling, New Zealand’s figures are similar to those states in America like Louisiana, Texas and Montana or provinces in Canada, such as British Columbia, outlined in Table 3.2 (Abbott and Volberg 2000 (a)).

**Table 3.2**

**Comparison of New Zealand's Current Prevalence Of Problem And Pathological Gambling In Relation To Other Populations Groups**

<table>
<thead>
<tr>
<th>Country</th>
<th>Current %</th>
<th>Problem</th>
<th>Current prob./path. %</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand (2000)</td>
<td>1.7</td>
<td>1.0</td>
<td></td>
<td>2.7</td>
</tr>
<tr>
<td>British Columbia (1996)</td>
<td>2.8</td>
<td>1.1</td>
<td></td>
<td>3.9</td>
</tr>
<tr>
<td>Louisiana (1998)</td>
<td>2.3</td>
<td>1.6</td>
<td></td>
<td>3.9</td>
</tr>
<tr>
<td>Montana (1998)</td>
<td>1.9</td>
<td>1.3</td>
<td></td>
<td>3.2</td>
</tr>
</tbody>
</table>

Adapted from Abbott, M. and R. Volberg (2000 (a)). Taking the pulse on problem gambling and problem gambling in New Zealand : A report on phase one of the New Zealand gaming survey. Wellington, Department of Internal Affairs.
Despite the limitations of the two New Zealand national prevalence studies they are unique. Although research has been carried out in different states in America and provinces in Canada, few countries have data from specific one off national studies covering the total adult population. In Canada, for example, a national study has not been undertaken but there is prevalence data available by combining estimates from 146 prevalence studies and undertaking a meta-analytical review. (Shaffer and Hall 2001)

Shaffer and Hall conducted the review of available data in America and Canada and they found that the prevalence of adults experiencing problems with gambling continues to rise. Groups particularly affected are youth, those involved in treatment with addictions and individuals in prison. To understand more fully what is happening in relation to gambling they suggest that prospective studies on the incidence of problem and pathological gambling are needed in the United States and Canada in order to determine whether the prevalence of disordered gambling increases within the adult general population and whether adolescent gambling patterns change as they age. (Shaffer and Hall 2001)

The above findings and the views of other researchers suggest that increased exposure to gambling, the normalisation of gambling and new forms of gambling, such as those which are continuous, will increase prevalence rates for problem and pathological gambling in communities and countries, especially for populations at risk. (Kezwer 1996) The relationship between promotion of gambling, access, and consumption requires further research perhaps by prospective studies to investigate why New Zealand had lower prevalence rates for problem and pathological gambling despite increased opportunities to gamble. (Abbott and Volberg 2000 (a))

In Australia, it is estimated that 2.07% of the total population has a problem with gambling and almost 1% with a severe problem. On average, Australians now spend $818 per year per person on gambling. The pattern of problem gambling and its effects in New South Wales (2.6%) and Victoria (2.1%) are worthwhile observing as many New Zealanders live in these states. Over half of all poker machines in Australia are in New South Wales, and New Zealand’s gambling public policy often follows developments
occurring there and it has been suggested that New Zealand's rate of problem gambling is likely to be similar to that of these two states. (Productivity Commission Report 1999; Cabinet Policy Committee 2001)

The involvement of Canada, America and Australia in gambling research is also important as these countries have indigenous populations which have had experiences similar to those of Maori and are exposed to many of the recognised factors which increase the risk of problem gambling. (Volberg and Abbott 1997) Research on the impact of gambling on indigenous peoples needs to be undertaken so that a collaborative approach can be taken by and with indigenous populations, which promotes their development and creates minimal harm to them or others. One of the major successes of effective gambling policy in America and in Canada has been the involvement of First Nation Tribes. Some tribes have gained financial independence and gambling has allowed them to develop their own sense of autonomy. Revenue from gambling has been reinvested in employment, education, health and social services especially in areas where government funding has been limited. (Stephenson 1996) Therefore, a balanced approach needs to be considered when reviewing the rights of indigenous peoples and gambling. (Korn and Shaffer 2000)

3.3.7 Prevalence of Maori Problem Gambling and Population Implications

The prevalence of problem gambling for Maori, using information from the Abbott and Volberg studies and the Maori populations in 1996 and 2001 censuses are

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24 The Productivity Commission reports that Australia has over 185,000 poker machines of which over half are in New South Wales. Further on per capital basis Australia has five times more poker machines that America where access machines are more restrictive. Productivity Commission Report (1999). Australia's Gambling Industries, Report Series 10. Canberra, Australia, Productivity Commission.

25 Problem gambling is an area where the trilateral collaboration with the Canadian Institutes of Health Research (CIHR), the National Health and Medical Research Council of Australia (NHMRC) and the Health Research Council of New Zealand (HRC) could sponsor research as a mutual area of interest which impacts on the health of indigenous peoples' Health Research Council (2001). Trilateral Collaboration to improve indigenous health. Newsletter. Auckland: 8. This form of collaboration has also been identified by Dr. B. Scoggins, Chief Executive Health Research Council of New Zealand, in his address as chair "Public Health Response to Problem Gambling", at the National Workshop Preparing For A Responsible Gambling Strategy, Auckland 21-22 March 2002.

26 Comment made by David Korn, Department of Public Health, University of Toronto, Faculty of Medicine, Toronto, Canada in keynote address at the International Conference on Gambling: Understanding & Minimizing Harm, Auckland, New Zealand 25-28 July 2000.
described so that current and future trends in relation to gambling can be considered. In 1996, 523,374 individuals identified as Maori, a 20% increase on the previous census, held in 1991, while the non Maori population had increased by only 7%. In 1996, there were 294,749 individuals, aged over 18 years who defined themselves as Maori. Just over a third (37%) was under 15 years of age, the median age of Maori was 21.6 years and one in five Maori were aged between 15-19 years.

These findings have real implications for a population which requires education, employment, income, social and family support and information to encourage adoption of healthy lifestyles. Information from the 2001 census confirms a similar pattern as the 1996 census, with a slight increase in the size of the Maori population (526,281). (Statistics New Zealand 2002)

In 2001, there were 299,000 individuals who identified as Maori aged over 18 years. (Statistics New Zealand 2001) In the medium term it is expected that the Maori population will begin to age quite dramatically, and by 2051, it is expected that 13% of the Maori population will be aged over 65 years. (Ministry of Health 2001) Overall it is expected that, without dramatic changes in future immigration, Maori will become a significant proportion of the total New Zealand population, approximately a quarter (22%) by 2051. (Ministry of Health 2002)

Maori have a distinct demographic profile, it is growing, and it is young. The population base is moving through from people less than 15 years to young adults. Increasingly, a large proportion of the Maori population is moving into their middle years. It is this age group which reported the most expenditure on gambling in the 1999 study. (Abbott and Volberg 2000 (a)) The Maori population is also beginning to age, and with both a young and an aging population it can be expected that high rates of problem and pathological gambling for Maori will continue. (Te Puni Kokiri 1998 (a); Durie 2001) 9 years of age in 1996, and close to 18 years of age when legal access to alcohol and to all forms of gambling is possible with the exception of casinos, which require

27 Members of this population would have been eligible for random selection to be invited to participate in the Abbott and Volberg 1999 study. The 1996 and 2001 census Maori population is used later to define the number of Maori who would have experienced lifetime or current problem or pathological gambling problem.
patrons to be 20 years of age. (Te Puni Kokiri 2000) In the 2001 census just under 50% of the Maori population was under 18 years of age. Maori youth are different from non Maori youth, in that they are more likely to leave school without educational qualifications, to experience unemployment, to be employed in low income and status occupations, to develop problems with alcohol or drugs and to have a high rate of youth offending. (Te Puni Kokiri 2001; Statistics New Zealand 2002) These factors contribute to and support Maori interest in gambling.

Gambling is now called “Te Ao Hou”, (a new lifestyle risk) that demands Maori involvement in all decisions relating to gambling as it has such a wide impact on the quality of life for Maori and, like alcohol, should be seen as a health hazard. Such hazards alone or together weaken the psychological wellbeing and behaviour of whanau, hapu and iwi. (Durie 1998; Durie 2001)

Abbott and Volberg (2000), show that in 1999 almost 93% of the Maori population had no problems with gambling. However, it was estimated that between 1.8 and 6.4% of the Maori population had sometime in their lifetime a problem with gambling and overall, it was best estimated that 3.6% of the Maori population had a lifetime estimate of problem gambling.

For lifetime pathological gambling the estimates ranged from 1.6 and 6.6% and overall the best estimate figure was considered 3.5% of the adult Maori population. These estimates were three times higher than those calculated for the European population (1.3% problem and 0.6% pathological) and were significantly below that of the Pacific Island population, viz. 7.8% for lifetime problem gambling and 3.2% for pathological gambling.

Table 3.3 provides ethnic specific data on the prevalence of problem and pathological gambling drawing upon both the 1991 and 1999 studies conducted by Abbott et.al. (Abbott and Volberg 1991; Abbott and Volberg 2000 (a))
Table 3.3

1991 and 1999 Lifetime Ethnic Gambling Status in New Zealand

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>1991: % No problems with gambling</th>
<th>1991 % Problem</th>
<th>1991 % Pathological</th>
<th>1999 % No problem with gambling</th>
<th>1999 % Problem</th>
<th>1999 % Pathological</th>
</tr>
</thead>
<tbody>
<tr>
<td>NZ</td>
<td>93.1</td>
<td>4.3</td>
<td>2.7</td>
<td>97.0</td>
<td>1.9</td>
<td>1.0</td>
</tr>
<tr>
<td>European</td>
<td>95</td>
<td>3.0</td>
<td>2.0</td>
<td>98.1</td>
<td>1.3</td>
<td>0.6</td>
</tr>
<tr>
<td>NZ Maori</td>
<td>84</td>
<td>9.0</td>
<td>7.0</td>
<td>92.9</td>
<td>3.6</td>
<td>3.5</td>
</tr>
<tr>
<td>Pacific Island</td>
<td>69</td>
<td>16.0</td>
<td>15.0</td>
<td>89.0</td>
<td>7.8</td>
<td>3.2</td>
</tr>
<tr>
<td>Asian</td>
<td>89</td>
<td>10.0</td>
<td>1.0</td>
<td>97.1</td>
<td>2.9</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>93</td>
<td>5.0</td>
<td>2.0</td>
<td>97.9</td>
<td>0.8</td>
<td>1.2</td>
</tr>
</tbody>
</table>

Using the Maori lifetime problem and pathological prevalence best estimates, and applying them to the Maori adult population in 1996, (294,749) it was likely that in 1999 10,317 Maori individuals would have been classified as problem gamblers and 10,316 as pathological gamblers. Using the 2001 census figures (299,000) and applying the 1999 figures 10,764 Maori adults would have been classified as lifetime problem gamblers and 10,465 as pathological gamblers. Tables 3.4 and 3.5 summarise the effects of problem and pathological gambling for both 1996 and 2001 Maori census populations and the results from both national gambling prevalence studies undertaken in New Zealand.

One of the differences between Maori and other populations is the close similarity in estimates of problem (3.6%) and pathological gambling (3.5%) In other population groups, the lifetime estimate for pathological gambling is generally significantly lower than the problem gambling estimate rate. If problem gambling is part of a continuum where some of the population become pathological gamblers then there is a significant
proportion of Maori in comparison with other populations, who have experienced serious problems with gambling.

The lifetime estimates for Maori, although higher than most other population groups in 1999, are significantly below the estimates that were calculated for the 1991 study, where 9% of the Maori adult population had a problem with gambling and 7% had experienced pathological gambling, thus 16% of the total population (Abbott and Volberg, 2000). In relation to the European population, Maori risk was approximately three times greater. (See Table 3.4) This difference has been replicated again in the 1999 study, with Maori having a rate of 7.1% compared to the European population of 1.9% even though overall the estimates of problem and pathological gambling are significantly lower and the Maori population was under-sampled. (Abbott and Volberg 2000 (a))

At a minimum, problem and pathological gambling is an important problem for at least 7% of Maori adults based upon the 1999 best estimate figure for lifetime Maori problem and pathological gambling. Effects of gambling on the health of individuals, families and communities are discussed later in this chapter. Taking account of the limitations of this study, the 1991 figures are likely to be more accurate with 16% of the Maori population having had problems with gambling sometime in their life.

It is estimated that in terms of both the 1996 and 2001 Maori census', populations between 20,633 and 46,161 Maori adults would have had problems with gambling some time in their life. The best estimate of lifetime problem and pathological gambling for Maori is between 7 to 16%, with the upper end more appropriate.

No Maori estimates were provided for current problem gamblers. Taking the overall New Zealand estimates and applying them to the 2001 Maori adult census population, between 1,794 to 3,289 would have been classified as probable problem gamblers, and an additional 897 to 2093 would have been classified as probable pathological Maori gamblers. Using the best estimate figures of 0.8 for current problem and 0.5 for pathological gambling and applying these figures to the 1996 Maori census adult population, it is estimated that 2,358 Maori individuals would have had a gambling problem and 1,473 Maori individuals would have had a pathological gambling problem. For 2001, it is estimated that there would have been 2,392 Maori individuals who would
have had a problem and 1,368 Maori individuals with a more severe problem. (Abbott and Volberg 2000 (a))

For planning gambling treatment services it is considered that the 1991 current best estimates for problem and pathological gambling are more appropriate for Maori. At any time there would be at 2.1% with problems with gambling and a further 1.2% with more severe problems, a total of 3.3% of the Maori adult population with problems with gambling at any time. Applying these figures to the 1996 and 2001, Maori census populations between 8,867 and 9,727, would have problems.

At any time, there will be between approximately 8,000-10,000 Maori individuals in the community who currently have problems with gambling, the degree of severity dependent upon the criteria used to differentiate between problem and pathological gambling. (Abbott and Volberg 2000 (a))

For every problem or pathological gambler, as mentioned previously, the lives of at least five or more, usually family members, are affected often with long lasting consequences. (Productivity Commission Report 1999; Sullivan 2000 (a)) Maori whanau members are seeking help either through the national gambling telephone help line or through gambling counselling services to cope with one of their kin who currently has or had problems with gambling. (Gruys, Hannifin et al. 2000; Paton-Simpson, Gruys et al. 2002)

No research has been undertaken with Maori to consider the effects of problem gambling on whanau and the effects on Maori underdevelopment. Durie (2001) has recognized that alcohol abuse and other forms of addictions have compromised the development of Maori and if not addressed in appropriate way will affect the health of future generations of Maori. He states:

*Alcohol and drug misuse are major threats to Maori health and wellbeing and have brought risks comparable to the infectious diseases that ravaged Maori society over a hundred years ago. While the death rates from alcohol misuse are not high alongside the consequences of tuberculosis, influenza, measles and diphtheria, the costs are similarly excessive in terms of unrealized human potential and unnecessary whanau suffering.* (Durie 2001, pg 125)
Abbott (2001) also supports this view in which he states:

*In total, the negative impacts on the lives of people who are not problem gamblers and people close to them will probably outweigh those directly associated with gambling. This is because people who experience small numbers of negative consequences greatly outnumber those who have more serious problems. This may appear paradoxical but it also applies in other situations, for example with respect to alcohol use.* (Abbott 2001, pg. 32)

He goes on to say that as with the effects of alcohol on others, such as car crashes, work and recreational injuries, assaults, family dysfunction and break ups, there is a need to recognise the real size of the problem and not just focus on the problem drinker. The population of others affected by gambling problems is likely to be larger than the population who are assessed as having a problem.

There is a need for immediate research by Maori or with Maori, to document and describe the full effects of Maori problem and pathological gambling and the impact that it has on Maori whanau, hapu, iwi and Maori communities and the development of New Zealand as a nation. Increasingly, it is being recognised that the under-development of Maori increases Maori risk to addictions and it is also limits the development of New Zealand, as valuable public resources are required to be directed into areas of Maori under development, such as Maori imprisonment, welfare support, health and social services. (Durie 2001)

Taking the Maori gambling prevalence figures further and considering that each problem gambler affects the lives of at least five others, generally family or whanau members, the size of the problem increases significantly. (Sullivan 2000 (a)) This figure is very conservative and it has been estimated that a problem gambler can affect on average ten to fifteen people if the effects on spouse, children, employer, employees, clients, consumers and insurance agencies are taken into account. (Productivity Commission Report 1999)

The effects of the problem gambler on others should be seen in terms of the passive effects of gambling, similar to smoking, in which it is recognised that the Crown has a responsibility to develop and implement policies which help smokers quit and protect those who don’t smoke from the effects of smoke. This analogy has not yet been
considered in New Zealand in the development of a public health response to gambling, although it is recognised that problem gamblers affect the lives of others, especially whanau or families. (Select Committee on Government Administration 2002)

Table 3.4
Summary Of Passive Effects Of Problem And Pathological Gambling On Maori using the 1996 Maori Adult Census Population

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1991 Lifetime Estimate</td>
<td>9%</td>
<td>7%</td>
<td>132,640</td>
<td>103,165</td>
<td>235,805</td>
<td>282,966</td>
</tr>
<tr>
<td></td>
<td>26,528</td>
<td>20,633</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999 Lifetime Estimate</td>
<td>3.6%</td>
<td>3.5%</td>
<td>51,585</td>
<td>51,583</td>
<td>103,168</td>
<td>123,801</td>
</tr>
<tr>
<td></td>
<td>10,317</td>
<td>10,316</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1991 Current Problem &amp; Pathological Estimate</td>
<td>Best estimate (2.1%)</td>
<td>Best estimate (1.2%)</td>
<td>Best estimate 30,950</td>
<td>Best estimate 17,685</td>
<td>48,635</td>
<td>58,362</td>
</tr>
<tr>
<td></td>
<td>6,190</td>
<td>3,537</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999 Current Problem &amp; Pathological</td>
<td>Best estimate (0.8)</td>
<td>Best estimate (0.5)</td>
<td>11,790</td>
<td>7,365</td>
<td>19155</td>
<td>22,986</td>
</tr>
<tr>
<td></td>
<td>2,358</td>
<td>1,473</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 3.5

Summary Of Passive Effects Of Problem And Pathological Gambling On Maori using the 2001 Maori Adult Census Population

<table>
<thead>
<tr>
<th></th>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1991 Lifetime estimate</td>
<td>9%</td>
<td>7%</td>
<td>134,550</td>
<td>104,650</td>
<td>239,200</td>
</tr>
<tr>
<td></td>
<td>26,910</td>
<td>20,930</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999 Lifetime estimate</td>
<td>3.6%</td>
<td>3.5%</td>
<td>53,824</td>
<td>52,325</td>
<td>106,149</td>
</tr>
<tr>
<td></td>
<td>10,764</td>
<td>10,465</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1991 Current Problem &amp; Pathological</td>
<td>2.1%</td>
<td>1.2%</td>
<td>31,395</td>
<td>12,940</td>
<td>44,335</td>
</tr>
<tr>
<td></td>
<td>6,279</td>
<td>2,588</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1999 Current Problem &amp; Pathological</td>
<td>0.8%</td>
<td>0.5%</td>
<td>11,960</td>
<td>6,840</td>
<td>18,800</td>
</tr>
<tr>
<td></td>
<td>2,392</td>
<td>1,368</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Using the 1999, Maori lifetime best estimates for problem and pathological gambling, and applying them to the 1996 Maori census population approximately 103,168 individuals would have been affected sometime by either a pathological or problem gambler\(^{28}\) (See Table 3.4). Including problem and pathological gamblers the number increases to 123,801.

For the Maori census 2001 population applying the 1999 Maori lifetime a best estimate for problem and pathological gambling the figure is 106,149 (See Table 3.5). Including, Maori problem and pathological gamblers the figures increases to 127,378. Given that the 1999 figures are considered to under-report problem gambling in New Zealand, there is high degree of intermarriage and or establishment of whanau partnerships by Maori with non Maori.

\(^{28}\) Not all of these individuals would be Maori, but would include non Maori. In New Zealand, there is high degree of intermarriage and or establishment of whanau partnerships by Maori with non Maori.
Zealand severely and that the 1991 figures are likely to be more accurate, the size of the problem for Maori increases at least three fold.

Using the 1991 lifetime figures and applying them to the adult 1996 Maori census population it is estimated that 26,528 adults would have had problems with gambling sometime in their life. This would have affected the quality of life of approximately 132,640 people, including children. For pathological gambling, it is estimated that 20,633 Maori adults would have been affected and this would have impacted on 103,165 people. Taking both the impact of problem and pathological gambling the problem increases substantially and 235,805 people would have been affected. Including problem and pathological gamblers the number increases to 282,966 people affected in some way by gambling-related harm. The majority of people affected would likely be Maori but would also include non Maori. This figure is almost half (45%) the total 1996 Maori census population.

Applying the 1991 lifetime figures to the 2001 Maori census adult population, it is estimated that 26,910 adults would have had problems with gambling sometime in their life affecting the quality of life 134,550 people. For pathological gambling it is estimated that 20,930 people would have been affected and they would have impacted upon the life of 104,650 people. Combining both the impact of both problem and pathological gambling 239,200 people would have been affected. Including both problem and pathological gamblers the number increases to 287,040. This figure equates to over half (55%) of the 2001 Maori census population.

Because there is often more than one problem gambler in a family, and a single person may be affected by more than one problem gambler, the number of people affected by Maori lifetime problem and pathological gambling may be less than estimated, although the burden may be more severe, viz., coping with the gambling debts of more than one person.

Gambling prevalence studies in 1991, and 1999, suggest that ethnic identification is closely associated with problem gambling. (Abbott and Volberg, 1999) The Abbott and Volberg 1999 study found that 44% of current problem gamblers identified themselves as Maori or Pacific identity. (Department of Internal Affairs 2001) This finding supports
previous research in which ethnicity is being recognised as a key indicator of socio-economic and health status in New Zealand. (National Health Committee 1998; Health Funding Authority 1999)

Identification and strength of identity is an important health indicator for Maori, in that those with strongest identity are likely to enjoy better health and wellbeing than those Maori who have a weaker sense of identity or involvement in Maori cultural activities. (Durie 2001) This view supports previous research where it was found that Maori women who were involved in Maori cultural activities were likely to view their health more positively. (Murchie 1984)

3.4 Special population groups at risk to problem gambling

3.4.1 Problem and Pathological Gambling: Implications for Maori Youth

The face of problem gambling in New Zealand is changing. In 1991, although problem gamblers came from across the socio-demographic spectrum, new faces were appearing which had not been visible before and did not fit the typical profile of problem gamblers viz. males in their middle years, employed in occupations of low income or status and track betters. (Abbott and Volberg 1991; Abbott and Volberg 1992)

This study showed that although youth were under-represented and accounted for only 29% of the total weighted sample, they had high prevalence rates of pathological gambling. Of those surveyed, 54% of lifetime probable pathological gamblers and 67% of current probable pathological gamblers were aged 18 to 29 years. This finding suggests that problem and pathological gambling is well entrenched in the behaviour of young New Zealanders by the time they reach the age of 29. (Abbott and Volberg 1996)

In the Abbott and Volberg 1999 study, the profile of problem gambling changed again, with youth aged between 15 to 24 years of age showing a lower risk of problem gambling than those over 65 years of age. It has been suggested that the change in pattern from the 1991 to 1999 study was related to those surveyed. In general youth are difficult to survey, especially by way of landline telephone for they are often out, and if contacted and have problems with gambling, they are likely to be reluctant to discuss their problems. It is recognised that young people with gambling problems under-use
gambling treatment services. People under 25 years of age account for fewer than 16% of telephone callers and they also account for less than 10% of clients seeking counselling. (Paton-Simpson, Gruys et al. 2001; Paton-Simpson, Gruys et al. 2002)

Factors most strongly associated with lifetime problem and pathological gambling in the 1999 study, were gender, ethnicity, age, household size and location. Five per cent of people in the 18-29 year age bracket had a lifetime gambling problem and 1.7% for pathological gamblers compared with the national profile of 1.9% and 1.0% respectively. For current problem and pathological gambling, the rate for youth aged 18 to 24 was 0.6% and 0.4% which was slightly below the New Zealand national rate of 0.8% and 0.5%.

This suggests that there is a need to know more about the pattern and effect of problem gambling on young people in New Zealand. A recent study in New Zealand high schools has indicated that young people have a high interest in gambling and are involved in a wide range of gambling activities including visiting the casino. (Sullivan 2002; Taylor 2002) This study included 569 students of whom 58 were Maori, 205 NZ European, 152 Pacific Nations, 18 Indian, and 65 Chinese. The study found that 7 to 16.7% of students were at risk to problem gambling. Pacific students were most at risk to problem gambling. Over half of the students considered that older people were more at risk to problems with gambling than they were, three quarters of the students played video games at least weekly, and over half (62%) considered that they could beat a gambling machine because of their skills. They indicated they would seek help with a gambling problem from their friends or parents rather than from health professionals or school counsellors. This study, although small and not representative of all New Zealand high school students, provides insight into an emerging problem, where youth have little information and awareness of the risks associated with gambling.

The study suggests that problem gambling amongst youth is higher than reported by Abbott and Volberg and that there is a need to investigate the effects of gambling on youth. Specific studies are also needed which focus on youth from specific ethnic groups, as their parents' behaviour and cultural values may influence their attitudes that gambling
as a normal recreational activity and may see gambling as a means to achieve personal goals and status. (Abbott and Volberg 2000 (a))

New Zealand youth and in particular Maori youth, have one of the highest rates of youth suicide in the world. In 1988, the Maori youth suicide rate was 34.9 per 100,000 in comparison with 22.3 per 100,000 for non Maori with both Maori males and females having a higher rate than non Maori males and females. The majority of suicides by Maori are committed by those in their mid twenties. (Mental Health Foundation of New Zealand 2000)In New Zealand it is recognised that a wide range of factors influence young people’s risk of suicide, but gambling has not yet been considered as a factor or trigger alongside other issues which contribute to New Zealand’s high suicide rate. (Durie 2001)

Indigenous populations, especially Aboriginals and Maori, are vulnerable to attempted and committed suicide and it is suggested that this is related to the historical and cultural changes they have experienced which have resulted in oppression, alienation and loss of spirituality. Suicide can be seen an ultimate expression of tino rangatiratanga (self determination). (Lawson-Te Aho) Losing everything by way of gambling, similar to attempting suicide, may be a demonstration by some Maori to show they have control over their life despite the adverse consequences. A national strategy has been established with key government agencies to reduce youth suicide in New Zealand and further research is required to investigate the relationship between gambling and youth suicide, and gambling and suicide generally. (Ministry of Youth Affairs 1998) In Australia, it estimated that gambling-related attempted suicides account for around 1500 for men and 1400 for women each year and in cities, which have a high level of casino and related gambling activities, suicide rates are higher. In America Las Vegas has been found to have the highest visitor suicide rate of places studied. (Phillips, Ward et al. 1997; Productivity Commission Report 1999)

The rate of attempted and committed suicides by people with gambling problems in New Zealand is unknown, but is an area which requires research, especially where there are casinos or a significant number of gambling machines and other forms of gambling. This research could be undertaken with gambling treatment services, addiction
services, primary health care services, accident and emergency services, mental health services, Maori health services and prisons. These are all settings where problem gamblers may seek help and present in a suicidal manner. Ab

Abbott and Volberg 1999 provide no information on the lifetime prevalence of problem or pathological gambling for Maori youth. Since Maori have approximately three times the lifetime risk of problem (1.3%) and pathological gambling (0.6%) than Europeans, the risk for Maori youth must be conservatively at least double that of Maori adults, possibly 14%. The 1999 lifetime risk for Maori youth, aged 18 to 29 years, is conservatively estimated to be six times that of European rate therefore between 12 to 14%. (Abbott and Volberg 2000 (a))

Applying the 1991 lifetime risk figures the European rate was 5%. Using this figure, it is estimated that approximately 30% of Maori youth would have had problems with gambling sometime in their life and is similar to the findings of the lifetime prevalence of problem gambling of New Zealand prisoners. (Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c))

International research has found that adolescent problem gambling is often significantly higher, with rates ranging from one and half to more than three times as high as for the adult population. (Derevensky and Gupta 2000) The New Zealand figures from both the 1991 and 1999 studies are comparable with other studies, which have focused on adolescent gambling. (Fisher 1993; Shaffer, La Brie et al. 1996)

A survey sponsored by the Department of Internal Affairs in 1996 which randomly selected New Zealanders found that respondents aged between 15 to 24 years were more likely to play gaming machines than the general population, as no age restrictions exist. (Reid and Searle 1996) These machines currently create the most gambling problems in New Zealand and from an early age young New Zealanders engage in both continuous and non-continuous forms of gambling. (Paton-Simpson, Gruys et al. 2001)

There is a need for further research to explore the link between problem gambling and suicide. People may be at risk to suicide prior to gambling or problem gambling may be a trigger which may motivate people to feel suicidal or attempt to take their own life.
This pattern of gambling behaviour was also found in a small study of 68 first year psychology students aged between 15 to 24 years of age, predominately Europeans enrolled at the Albany Campus at Massey University. From this small sample it was found that the entire sample had gambled for money at least once, a small group gambled regularly once or more per week, even though there are legal age restrictions for TAB betting and entry into casinos. Some had participated in these forms of gambling and a small group had tried a number of types of gambling activities. Although the study group was small, the people sampled had similar gambling attitudes and behaviour as to those of other young people previously surveyed in New Zealand. Overall the prevalence rates of gambling and problem gambling for adolescents in New Zealand are likely to be similar to those in the United States, Canada and Great Britain. (Clarke and Rossen 2000)

Participation in gambling and problem gambling in New Zealand is likely to increase in the future, with casinos and reduction in the legal age for people allowed to enter pubs and clubs and drink alcohol. This legal right gives young people more opportunity to be able to play gambling machines outside of casinos. (Department of Internal Affairs 2001)

Gambling may be used by youth as a form of experimentation, which may decrease with age. Adolescent problem gambling is also influenced by other forms of risk taking such as use of alcohol, tobacco, use of drugs, criminal offending prostitution and estranged relationships with family and friends. (Browne and Brown 1994)

Adolescents who have one or more parents who gamble are likely to model this behaviour although it has also been found that adolescents whose parents have a pathological gambling problem may be less likely to have gambling problems suggesting they have seen the effects of this behaviour and wish to avoid the problems that gambling has created in their life. (Ladouceur, Dube et al. 1994) This finding has been questioned by the Productivity Commission, which considers the intergenerational effects of gambling are significant. (Productivity Commission Report 1999)

There is a need to develop interventions to reduce the effects of young people copying gambling behaviours of their parents or other family members'. (Clarke and Rossen 2000) This is important for Maori and interventions could include promoting
gambling free homes, schools, marae and other settings, similar to the concept of smoke free environments. Maori could also be discouraged from giving Lotteries Commission products as presents, but perhaps “Bonus Bonds”, from the ANZ Bank which can be investment and may increase in value if a bond is won. (Department of Internal Affairs 2001) This still has an element of gambling similar to investment on stocks but no money is lost.

At the International Conference on Gambling: “Understanding and Minimising Harm,” held in Auckland, July 2000, there was concern amongst local and international researchers about the high rate of problem and pathological gambling amongst youth, and the potential effects that new technology such as the internet, new forms of gambling, such as, interactive games, and the promotion of new games, such as, “Kachingo”, which is not considered gambling currently, could have on young people.  

At this conference the effects of the normalisation of gambling on young people and the mixed messages they receive were discussed. In America, Canada and New Zealand, young people are urged to excel academically, and to secure successful jobs, but the notion that an easy way to success is through winning a jackpot or a lottery is also promoted. (Korn and Shaffer 2000) This leads to what is described in America as the “Yuppie Syndrome”, a belief in gambling and greed.

It also encourages “magical thinking”, the idea that someone, such as an ancestor, relative or spiritual being, is looking after your interests whilst gambling which is a common view amongst Maori gamblers. (Bero 1989) Such a belief bolsters a sense of fate, that luck will determine your future, not your own efforts. This mindset has implications for Maori as it encourages a view that your future is dependent upon luck rather than your own ability to influence and direct your own destiny. It also contributes

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Kachingo has recently been introduced by a number of large businesses in New Zealand with the aim to encourage people to buy their goods from their stores. For each purchase over a certain amount shoppers receive a line of random numbers, which resembles Lotto, and each person for that week has a chance of winning a certain amount of cash and other prizes. This form of consumer marketing and loyalty buying is expected to grow. As the shopper has not paid out any money to receive the ticket this game is not seen as gambling by the Department of Internal Affairs. Personal Communication with Paul Curry, Chief Executive of the Lottery Grants Board.
to some Maori being locked into a cycle of dependency and welfare support. (Ministry of Health 1998)

Messages which promote the "Yuppie Syndrome", and "magical thinking", are received by young people in New Zealand, through advertising campaigns which promote Lotto as a means of achieving their dreams. Alongside this form of advertising, gambling for young people is likely to prosper due to the Internet and new forms of gambling, which are being designed to engage with young people to play. Skills, which young people learn from playing interactive computer games are often assumed to be transferable to gaming machines and increase their chance of winning. Youth are often unaware that gaming machines have been programmed to win or lose on an intermittent basis irrespective of any skill that is acquired from interactive video games. (Griffiths 1991)

3.4.2 Older People and Problem Gambling

Older people are being recognised as a growing group at risk to problem gambling. The New Zealand's national population is aging rapidly and the Maori population is also aging. (Ministry of Health 2001) Many people in retirement have limited income and social networks. Like young people, older people are vulnerable to developing problems with gambling, especially with gambling machines which are widely spread in pubs and social clubs such as, the Returned Services Association (RSA) and Working Men's Clubs. These are places which are friendly to older people who are induced to frequent the premises with the offer of cheap meals, drinks and assistance with transport.

As with young people, many older people are unaware that gambling machines have been programmed for commercial purposes. Older people often have different issues to address in their life and gambling machines can provide a means to escape loneliness, the loss of a partner, children, health or social status and it can also provide a means of hope of winning extra cash. The Government is supportive of RSA clubs being exempt from new smoke-free provisions but this arrangement may encourage co-
addictions. Raising awareness of problem gambling should include information on life events and changes which can increase risk.

There is need for research in New Zealand to investigate the role gambling plays in the lives of older people and the prevalence of problem and pathological gambling amongst older people. This is important as often gambling is promoted as a hobby for older people who have limited mobility or interests. Older Maori are also more likely than non Maori to gamble for socio economic reasons as recent research has shown that at least a third of kaumatua and kuia experience financial problems. (Ministry of Social Development 2002)

The impact of gambling on older Maori requires investigation as kaumatua and kuia (elders) are important health leaders and their attitudes to gambling can influence the effectiveness of interventions to reduce gambling-related harm, such as support for gambling-free marae or opposition to the placement of gambling machines on marae. (Te Pumanawa Hauora 1996; Hirini, Flett et al. 1999; Morrison 1999)

3.4.3 Gender Issues: Implications for Maori women

Since the 1991 study, there have been changes in the prevalence of problem gambling amongst men and women. The estimate for current male pathological gambling has reduced from 2% to 0.4%, while for females, pathological gambling has changed from 1.0% to 0.5%, and for current problem gambling it has declined from 2% to 0.4%. These figures mean that women now have a slightly higher risk than men for current pathological gambling while males are more likely to be problem gamblers in comparison to females. (Abbott and Volberg 2000 (a))

The number of Maori and Pacific women with current pathological gambling problems has influenced the overall rate for women in New Zealand and this is visible with the number of Maori women seeking help at specialist gambling treatment services and being assessed as having pathological gambling problems. (Black 2000; Gruys,

31 The Smoke free Environments (Enhanced Protection Amendment Act) was passed December 2003, and will become enforceable one year later. No special exclusion provisions have been allowed for RSA clubs.
Again this indicates that Maori women may be unaware of the signs and symptoms of problem gambling and by the time they present for help they are in crisis. The number of Maori women seeking help suggests that this is only the tip of the clinical iceberg, as problem gambling is generally portrayed as a male problem with women, like youth and older people, unaware of the risk of gambling to themselves.

Women may also use gambling for different purposes than men. For instance, to escape from overwhelming problems, women become hooked on the “action of gambling”, dissociating from real issues which are weighing them down, such as relationship or financial problems, with the consequence that to dissociate they need more time and money to continue gambling. (Lesieur and Blume 1991; Rosenthal and Lorenz 1992; Kiata 2002)

Due to the “action of gambling”, Blume suggests that pathological gambling can be defined:

as an addiction to action, an addiction to the high and thrill of the excitement of gambling action. (Bero 1989, pg. 2599)

To understand what drives a gambler to continue gambling irrespective of the effects it creates on others it has been suggested that therapists need to:

understand the gambler from the inside out and not the other way around... the gambler needs his/her action to cope with the stresses of living. (Bero 1989, pg. 2603)

All of a person’s emotions are often tied up in the urge to gamble and it is suggested that men gamble for the “action”, while women use gambling to “escape”, especially from depression, yet both men and women become hooked on the action of gambling and the effect on their families is similar. (Lejoyeux 2000)

Because of the impact on family members Blume suggests physicians should become involved in the identification and treatment of problem gamblers and that the degree of problem gambling amongst Maori women may be an indication of undiagnosed
depression. Recognising the increasing number of women and Maori women who have gambling problems there is a need also to consider whether current therapeutic models of gambling treatment are appropriate for them. Many Maori women with mental health problems have been sexually abused and receive help from both health and accident funded services. Problem gambling therefore needs to be considered not only in the health sector but also by the Accident Compensation Corporation (ACC). Use of gambling by either women or men to cover the effects of sexual abuse should be considered in the assessment, treatment and ongoing support of problem gamblers. The relationship between problem gambling and sexual abuse is an area for further research.

Issues, which increase the risk of women developing addictions, are likely to be similar to but also different from those for men. Women should develop therapeutic models of treatment and counselling for women.

People working with gamblers need to understand their own values and attitudes as they may not be asking the right questions, not listening to the information which is given, or using research findings which have focused on male gamblers as women gamblers have been ignored largely in gambling research.32 (Smith 1991; Mark and Leiseur 1992)

Taking account of the limited focus on women and gambling and also for indigenous women, there is a need to develop new models of treatment of addictions, which affirm values and beliefs of women and indigenous peoples’. (Zitzow 1996) These developments are beginning to occur in New Zealand with the development of Maori-specific addiction treatment services and health programmes but there have been minimal developments for Maori women. (Ministry of Health 2002)

No real difference has been found in treatment outcomes between Maori and mainstream addiction services to date but it is an area which requires further study as Maori are not a homogeneous group and various styles of service such as whanau counselling or mirimiri (massage) may meet the needs of different groups. New outcome

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32 The Problem Gambling Committee (2001) has no specific treatment service provider which meets the specifically the needs of women on this decision making body. In New Zealand generally gambling is still seen as essentially as a male problem Gruys, M., J. Hannifin, et al. (2000). Problem Gambling in New Zealand 1997-2000. Wellington.
measures are also needed to capture the uniqueness of Maori services. (Sellman, Huriwai et al. 1997)

There is a need to assess the full impact of problem gambling on Maori women from gambling machines. Since the 1980s, Maori women have had to cope with many new changes and have had to take on roles and responsibilities which may have been traditionally male or those of others in their whanau, such as the being the head of the whanau, sole parent, or the primary income earner, and some Maori women have not found these changes easy. Anxiety, or stress, which can lead to depression, was identified in 1980s as the major health issue for Maori women for all age groups. (Murchie 1984; Ministry of Health 1998; Ministry of Maori Development and Ministry of Women's Affairs 2000)

As Maori women have taken up these new responsibilities, Maori men have also had to adapt to new roles and these changes have influenced relationships between Maori men and women and may be a factor in Maori mental ill health and wellbeing. (Dyall, Bridgman et al. 1999)

There is a need to look at problem gambling through the eyes of both Maori women and men from the “inside out”, to consider the reasons individuals become involved in gambling, and hence experience problems. The factors, which influence Maori women to gamble, may be quite different than those for Maori men.

Specific health interventions which focus on meeting the needs of both sexes may be needed as in the recent campaign “Me Mutu” where both Maori women and men have been portrayed as role models who have quit smoking for their whanau. This advertising campaign is part of a wider quit support smoking cessation program. (Ministry of Health 2001; Johns 2002) This approach will require current gambling stakeholders, to establish collaborative relationships with Maori, to recognise Maori values and beliefs and support Maori aspirations for tino rangatiratanga. (Te Manawa Hauora 1993)

3.4.4 Lifetime Problem Gambler: Implications for Maori

Following up problem gamblers from the 1991 study in 2000, Abbott and Volberg have found that this may not necessarily be a life long condition as individuals can
change their behaviour. (Abbott, Williams et al. 1999 (a)) The study is unique in that interviews were held with 143 people who originally participated in the Phase two parts of the 1991 study, and were identified then as having problems with gambling. Participants were asked in this study about their current pattern of gambling, including expenditure and possible problems.

Maori participants were involved in this study and the results suggest that individuals assessed as having a lifetime estimate of either problem or pathological gambling can change and overcome problems with gambling. Participants stated that they reduced their gambling because of lack of finances, change of environment or lifestyle, increased awareness of age, marriage and having a family. On the other hand those who still had problems gave boredom and opportunities to gamble as the reasons they continued. (Abbott, Williams et al. 1999 (a))

The results of this study are important, as unlike other chronic health problems, pathological gambling does not have to be a lifetime condition, because people can change their behaviour. With altered life circumstances influenced by Government policies and interventions, Maori problem gamblers could adapt their behaviour so that gambling was not relied upon to provide the main income or focus in their life but instead they could find meaning through their families, jobs relationships and general life.

3.4.5 Prevalence of Problem Gambling amongst New Zealand Male Prisoners

Two reports on the prevalence of problem gambling amongst male and female prisoners, serving the first year sentence of their sentence, have been released. These two studies involved using the same questionnaires as used in the community prevalence study. (Abbott and Volberg 2000 (a); Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c)) In the information released by the Department of Internal Affairs disseminating the findings of these studies, there was no mention of the significant to Maori imprisonment. (Department of Internal Affairs 2001 (c))

Unlike the community study, Maori are disproportionately represented in these studies because they make up 50% of all sentenced prisoners and over 45% of those receiving community-based sentences. Excluding the Pacific population, Maori are sentenced or remanded to prison eleven times more than Pakeha or other New Zealanders
and six times more for community sentences, and the prison population is predicted to grow from around 6,000 to almost 7,000 prisoners by 2010. Prisoners have a high rate of re-offending in New Zealand with at least a third being re-imprisoned within a year, and those on a community-based sentence at least two thirds will re-offend within five years and over a quarter will be imprisoned. (Department of Corrections 1999)

This profile is similar to that of other indigenous populations who experience high rates of imprisonment, such as, Aborigines in Australia, and First Nation American Indians in America and Canada. (Durie 2001) Almost no research has been undertaken with indigenous peoples on the role imprisonment contributes to the under development of indigenous peoples and the maintenance of power and control of those who have a vested interest in the status quo. (Abbott and Volberg 1999 (b))

The male prisoners in Abbott and Volberg study included 357 recently sentenced men from four prisons of which over half of the participants (51%) identified as Maori. (Abbott, McKenna et al. 2000 (b)) It was found that 15 % of the participants reported having committed at least one crime, such as burglary, theft, robbery or fraud to obtain money to gamble or pay gambling debts, nine percent of the men indicated they had been convicted for a gambling related crime and of this group half of the men reported five or more convictions, the average being 14 convictions related to gambling. Ten percent of the sample also said that they were in prison because of charges related to gambling, and it was found that a third of the male participants were assessed as having experienced significant gambling problems in their life, that is “life time prevalence”.

Just under a quarter had problems with gambling at the time of their current imprisonment, identifying “current prevalence”, and these rates were significantly higher than the New Zealand community prevalence rates discussed earlier. (Abbott and Volberg 2000 (a)) Similar findings have been reported in other prison studies and can be concluded that pathological gambling is a significant but a hidden problem among prison populations. (Rosenthal and Lorenz 1992)

It is often asked whether problem gambling has led to crime or arises as part of anti-social behaviour. If the latter occurs then gambling is considered secondary to the real issue, criminal offending. To some extent, this view has been espoused by Abbott and colleagues and has been used to lead to the conclusion that problem gambling is not a
significant issue as it impacts only on a small proportion of the total population.\textsuperscript{33} (Department of Internal Affairs 2001)

It has also lead to the view that there is no need to consider the impact gambling has had on Maori or any relationship it has to Maori imprisonment, Maori criminal offending and re-offending, or the effects of imprisonment as a form of intervention to change unacceptable behaviour. (Department of Corrections 2001) As gambling within prison occurs significantly in New Zealand prisons it is highly possible that some inmates will develop problems whilst inside and continue this behaviour on release. (Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c))

The acceptance of problem gambling in prison is symptomatic of New Zealand’s gambling culture and indicates a supportive environment, that gambling is acceptable to be used to fill a void, to combat boredom or stress and to increase one’s personal resources. (Grant 1994; Abbott, McKenna et al. 2000 (b); Department of Internal Affairs 2001)

A simple causal approach to understanding problem gambling, its impact, and the pathway that leads to influencing individual behaviour is limited. The behaviour patterns of individuals are dynamic and reactive and need to be understood within the context of lives and relationships. The pathways of causality, which lead to problem gambling, could be the subject of a longitudinal study. (Productivity Commission Report 1999) This longitudinal study should focus on Maori families, or Maori youth so that the impact gambling on being Maori over time can be observed and measured. (Durie 2001)

At any time it is estimated that 6% of male prisoners in their first year of sentence are in jail for reasons directly related to their gambling. (Abbott and Volberg 2000 (a); Abbott, McKenna et al. 2000 (b)) A study of 100 male prisoners in a central North Island facility has found similar results. Three quarters of the prisoners, who identified as Maori, had gambling problems, high levels of other addictions and recognized that gambling influenced their re-offending and imprisonment. Almost half (46%) were interested in doing something about their gambling problem. (Sullivan 2001(b))

\textsuperscript{33} This view was presented by Abbott and McKenna at the National Seminar on Gambling Research, Policy and Practice at the Auckland University of Auckland, 10 December, 2001 and was severely challenged by participants present.
Researchers in Australia have found similar results of problem gambling in prisons and they conservatively estimate that 30 to 50% of pathological gamblers use crime to support their gambling. The degree of gambling-related crime is significantly under-reported and thus invisible. It is estimated in Australia, that one in ten problem gamblers has committed a crime because of their gambling and two thirds of problem gamblers in counselling have admitted committing crime to finance their gambling. The criminal offences are mainly non-violent, such as, fraud and misappropriation. At least, 40% of gambling offences go unreported and only 40% result in a conviction. (Productivity Commission Report 1999) This data, although Australian, has some compatibility with New Zealand and if research were undertaken, it is likely that similar results would be found. To increase the visibility of the impact of problem gambling in New Zealand on crime and imprisonment comparative research should be undertaken.

In New Zealand, it is likely that over time, the number of prisoners in jail related to gambling will increase, as sentencing is allied to community views. In New Zealand there is strong political and community support for increased length of sentences especially punishing individuals who invade peoples’ homes and commit burglary, especially with violence. This has implications for gambling as increased opportunities to gamble especially in continuous forms, will likely increase criminal offending and therefore imprisonment. (Abbott 2001)

3.4.6 Prevalence of Problem Gambling amongst New Zealand Female Prisoners

From interviewing 94 female prisoners it was found almost half had at some stage significant gambling problems in their lifetime and over a third had such problems at the time of their current imprisonment. Of this population surveyed two thirds of the sample were Maori women. (Abbott and McKenna 2000 (c)) There are approximately 238 female prisoners in New Zealand but the number is expected to grow with women increasingly committing crimes similar to men. (Department of Corrections 1999)

From the results of this small survey it would seem that female prisoners had the highest rates of lifetime and current prevalence of prison problem gambling, supporting Abbott and Volberg (2000) findings that current prevalence for problem gambling for women is rising.
This study is important as it is the first worldwide to focus on the prevalence of problem gambling amongst recently sentenced female prisoners, it includes a significant indigenous female population. The results of the prevalence of problem gambling are among the highest recorded in any previous gambling survey, apart from surveys of people seeking or receiving treatment for pathological gambling. (Abbott and McKenna 2000 (c); Department of Internal Affairs 2001 (c))

The findings align closely with those from a recent unpublished study of the prevalence of problem gambling in a predominately male prison survey in Australia which is reported by the Productivity Commission in 1999. (Abbott and McKenna 2000 (c)) However, comparing the prevalence of problem gambling for female prisoners with male prisoners has been questioned in Australia as gender differences in patterns and experience of gambling are then ignored. A female model of support for women in prison with gambling problems has been developed which recognises women’s cultural needs. A similar model needs to be developed in New Zealand which not only recognises the needs of women, but in particular the requirements of Maori women. (Brown 2000)

Abbott and McKenna (2000) also suggest that, although the results from the female prison study are important, the population studied is atypical, and further prevalence figures from these two prison studies cannot be generalized to represent the wider Maori population due the demographic profile of the prison population and the way Maori identity is defined. Individuals can choose to be either sole Maori or Maori as one of the ethnic groups they identify with, or have Maori affiliations.

Nevertheless, they consider that the degree of problem gambling seen in prison is serious and is comparable to that of clients receiving specialist gambling treatment services. This indicates that gambling industries have a responsibility to provide sufficient funding to fund specialist gambling treatment services in prisons and for those sentenced in the community. (Department of Internal Affairs 2001)

3.4.7 Implications of Problem Gambling Amongst New Zealand Male and Female Prisoners

The results from both prison studies surveying males and females are extremely important to Maori and those actively involved in reducing Maori crime and imprisonment. There are approximately 6,000 prisoners at any time in New Zealand
prisons. A third could have a lifetime probable pathological gambling problem adding at least 2,000 additional people to the community lifetime probable pathological figure, increasing the population requiring treatment to 19,700 to 39,100. (Abbott and McKenna 2000 (c))

As Maori account for approximately half the prison population and assuming that problem gambling of inmates is the same for Maori as for non Maori, it is assumed that of the 2,000 lifetime probable pathological gamblers that at least 1,000 would be Maori. Therefore, a further 5,000 Maori or non Maori are affected indirectly by pathological gambling and including the Maori prisoners overall 6,000 people are affected. (Sullivan 2000 (b))

Women and men from both studies were aware that they had problems with gambling and some had even tried to seek help before being imprisoned. This suggests that a number of prisoners were willing to look at their behaviour and consider lifestyle changes. (Prochaska, Diclemente et al. 1992) Willingness to consider change by Maori is important for successful health outcomes. The results suggest that there are real issues related to treatment services for Maori in prison and in the community. If gambling treatment services were widely promoted and available in Maori communities, a greater number of Maori could seek help early and this may reduce Maori imprisonment.

Abbott also suggests that information about problem gambling should be given to all prison inmates as this may assist in reducing Maori re-offending. (Abbott and McKenna 2000 (c)) Prisoners may not have a problem with gambling prior to being sentenced but due to imprisonment they could develop problems to help cope with boredom, loneliness and trauma of being in custodial care. These are recognized “triggers” which can lead to problem gambling. (Blaszczynski, McConaghy et al. 1990; Productivity Commission Report 1999)

Male and female gamblers in prison reported that prior to being sentenced they often gambled to win money, for excitement, fun, to socialize, to support worthy causes and to relieve boredom. Women ranked gambling to support worthy causes higher than men. (Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c)) This difference perhaps reflects Maori women’s wider involvement in the community and their support for Housie. With widespread availability of gambling machines it is possible that Maori
women's attitudes towards gambling are changing. Focusing on a gambling activity which is not so social, which does not involve being part of a collective activity and is an isolated activity with individuals able to keep their winnings.

In both studies prisoners reported that members of their family gambled a lot. (Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c)) Female prisoners also reported that they often played cards and gambling machines and frequently they played for long periods of time, losing significant sums of money. They also reported that they would sometimes gamble instead of committing a crime, suggesting there may be other reasons underlying Maori women's pattern of gambling and crime.

Results from the prison studies, also found that Maori men and women were more likely than non Maori to have a history of hazardous drinking, and a history of conduct disorder. Those who had a pattern of both hazardous drinking and problem gambling were more likely to be in prison for violent offending. (Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c))

Problem gambling in Maori and probably in other indigenous populations does not exist in isolation but is part of a complex range of interacting issues with alcohol or substance abuse significantly involved. (Elia and Jacobs 1993; Durie 2001) The issue of alcohol abuse in prison has also been identified in a recent study of mental health morbidity of 1248 remand and sentenced prisoners in 1997/98 in New Zealand in which fifty per cent of the population identified as Maori. Problem gambling was not assessed but researchers found that prevalence rates for alcohol and substance abuse and mental health disorders were higher than the general population rates. They also found that imprisonment was a major entry point for people with a mental illness and that whilst imprisoned, some people also become mentally unwell. (Department of Corrections and Ministry of Health 1999)

Only 15 % of the prison population surveyed did not have an alcohol or substance abuse problem. (Department of Corrections and Ministry of Health 1999) As mentioned previously the prevalence of problem gambling was not identified in this population. However, the degree of other mental health problems, such as depression and personality disorders could be used as a substitute indicator of the possible level of problem
gambling as they are common mental health problems which problem gamblers often experience. (Templer, Kaiser et al. 1993; Crockford and N 1998; Abbott 2001)

Maori-specific information from this study has not yet been released by the Department of Corrections. Release of such information could have informed the recent review of penal services in defining the range of health and related services which should be available to Maori prisoners and recommending the funding required. (Department of Corrections 2001) This study although not focusing on problem gambling, has increased the visibility of the need for adequate funding for forensic mental health services, and the need for Maori involvement in the development of such services. (Department of Corrections 2001)

A systematic review of mental health studies involving 23,000 prisoners, including New Zealand data, has revealed that prisoners have seven times the risk of depression and psychosis and ten times the risk of depression of the general population. This study focused only on the serious mental health illnesses of prisoners and although problem substance abuse and problem gambling are important mental health issues, they were excluded. Once again the prevalence of problem gambling in prisons and the relationship between co-addictions has been ignored. (Fazel and Danesh 2002)

Due to the invisibility of problem gambling in prisons those in need of help are likely to be over looked and will experience difficulties in accessing health services. Their needs are likely to be considered of less importance than those individuals who have been identified as having severe life threatening mental health problems such as inmates who are diagnosed to be psychotic or suicidal. (Bero 1989)

Attempted and committed suicide or "whakamomori", for Maori in prison is an issue. Between 1971 and 1995, 47 Maori inmates committed suicide. The number of Maori who either attempted or committed suicide whilst in prison led to a national inquiry into the relationship between mental health and justice services and resulted in support for the development for coordinated forensic and community mental health services with special recognition of the needs of Maori. (Mason 1988; Gardiner 1996) Though problem gambling was not identified then as a possible factor that influenced Maori being imprisoned or being compulsorily committed to a mental health service it should be considered now.
Overall, the results from three New Zealand prison studies and the national mental health prison study are important. Imprisonment is often the end result of individual behaviour. Prior to sentencing, individuals will often acknowledge that they have committed offences or have become involved in activities of which they now feel “whakama” or ashamed as their behaviour impacts on their families, children and significant others. If they had sought help earlier, possibly imprisonment could have been avoided.

Early intervention, such as screening to identify and address problem gambling, is important for Maori as it provides an opportunity to discuss this problem within a Maori context. At such a time the possible consequences of gambling like imprisonment, a community sentence or impact on mokopuna (grandchildren) could be explored fully.

Behaviour patterns of prisoners reflect society’s values, including the socio-economic and political position of prisoners within the wider society, and their families’ patterns, learnt through role modelling. The prevalence results of problem gambling in the community and prisons in New Zealand should not be dismissed, but should be a major concern for all organizations, Government, health workers, Maori and iwi organizations, which are involved in improving Maori health and wellbeing. Research findings from the three gambling prison studies provide an indication of the degree of problem and pathological gambling for Maori and should be seen as the tip of an “iceberg”, with wider problems reflected in the community. People imprisoned have similar behaviour patterns as many in the community, especially Maori and therefore cannot be dismissed and considered as atypical. (Durie 1998; Abbott and McKenna 2000 (c))

The prevalence of problem gambling in prison for both men and women provides a real warning. Expansions of gambling will likely increase Maori risk to problem and pathological gambling and lead to increased Maori imprisonment, re-offending and re-imprisonment. No separate Maori analysis of the data from the prison studies or the community prevalence studies has yet been reported but implications for Maori are significant. (Abbott 2001)34

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34 Personal Communication with Max Abbott, 26 March, 2001
It can be seen from these three prison studies that many Maori are in prison due to their gambling problems. Drawing upon the work of Abbott and his colleagues, the Department of Internal Affairs has made the following comment:

While the extent of problem gambling among prisoners is extraordinarily high, only a relatively small number of inmates began their criminal careers in response to problem gambling. Most were offending prior to developing gambling problems, often associated with childhood conduct disorders. However, problem gambling appeared to play an important role in the continuation of their criminal careers once problems had developed’, Professor Abbott said the study also highlights the significant costs of problem gambling to the community by way of gambling related crime. (Department of Internal Affairs 2001)

Results from the prison studies require policy makers to reconsider the effects of gambling and Maori imprisonment. Currently, there is little awareness of the relationship between Maori gambling, crime and imprisonment and is an area which requires ongoing research. (Lynch 2002)

### 3.4.8 Whanau Implications of Problem Gambling

The implications of problem or pathological gambling within whanau are substantial. The American National Research Council (1999) has shown that many families of people with gambling problems experience financial, physical and emotional problems. (National Research Council 1999; Productivity Commission Report 1999) Spouses of problem gamblers have been found to have serious emotional problems, often resorting to drinking, smoking, over eating or impulse spending to cope with the situation. (Lorenz and Shuttlesworth 1983; Abbott, Crammer et al. 1995; Abbott and Volberg 2000 (a)) Their children and other family members of problem gamblers are at an increased risk of developing gambling problems.

The intergenerational effect of the normalisation of gambling and problem gambling is a real issue for Maori. The Australian Productivity Commission has claimed for every new case of problem gambling, there is potential for further cases:

*Problem gambling - like a variety of other social ills - has intergenerational consequences. People whose parents have had a problem with gambling are more*
likely to develop a problem themselves. This means that the potential cost of a new case of problem gambling is greater than might be expected - because it increases the likelihood of future cases. This strengthens the argument for preventative approaches to problem gambling. (Productivity Commission Report 1999)

Proactive government policies are needed urgently in New Zealand to reduce the number of new cases of Maori problem gambling, for each new case has implications for the next generation.

Children of compulsive gamblers are more likely to smoke, drink and use drugs, report that their childhood was an unhappy period in their life and experience sadness, anger and depression. Verbal and physical violence is often common in households as problem gamblers are likely to manipulate others, especially family members, to gain money to pay debts or to continue gambling. Telling lies is common amongst problem gamblers. This leads to other problems, such as, loss of trust or respect between partners, loss of self esteem and ultimately the dissolution of family relationships creating considerable issues for children and significant others who are affected by the problem gambler. (National Research Council 1999; Productivity Commission Report 1999)

The impact of problem or pathological gambling on Maori children is largely unknown but many Maori families seek help with budgeting and food parcels, use women’s refuge services and require child and family support. Increasingly Maori children are requiring specialist mental health services. (Health Funding Authority 1999; Child Poverty Action Group Inc. 2001) Many of these issues are discussed in New Zealand in relation to Maori poverty and the state of Maori whanau, and there is no mention of gambling as a possible underlying factor or a contributor. (Durie 1997; Ministry of Health 1998; Ministry of Health 2001 )

The Productivity Commission has estimated each year in Australia there is 1600 gambling-related divorces. The number of gambling-related divorces or family break-ups for Maori or non Maori is unknown. However, if the New Zealand Government wishes to strengthen families to address social inequities and build social capital the impact of gambling should be assessed.
Strengthening Families is a Government initiative established in 1998 to encourage inter-sectoral collaboration across specific Government agencies to assist families and each year the Government allocates around $18 million to this programme. (Walsh 2001) The Department of Corrections is not part of this initiative even though criminal offending and sentencing has a significant impact on families. (Department of Corrections 1999)

A community or whanau which has a high level of social capital is described as one in which there is a high level of self esteem amongst members, trust, a high degree of connection, and networking across members, reciprocal and supportive relationships and a high degree of civic participation such as involvement in community activities. (Kawachi, Kennedy et al. 1996; Baum 1998) Many Maori communities have a high level of social capital as a by-product of extensive social relationships and involvement in community activities. (Ministry of Social Development 2002)

Gambling proceeds have been used a means to build these relationships but gambling and problem gambling can destroy trust between members of whanau, erode relationships and can increase the risk of crime in communities thus increasing fear and uncertainty. (Morrison 1999)

Gambling and problem gambling can reduce social capital and is an area, which requires further research and should be included in Maori whanau studies, such as “Te Hoe Nuku Roa”. Maori participation in gambling is discussed in this study, and it is reported that, in general, a third of households are involved in some form of gambling on a weekly basis. (Foster, Fitzgerald et al. 1998)

Although gambling can reduce social capital, the Government proposes the opposite view in that it considers it contributes to the development of social capital by way of providing community benefit. This is the primary rationale for legalising gambling in New Zealand. (Department of Internal Affairs 2001) The Public Health Association of New Zealand has criticised this rationale and considers that “community benefit”, should not be the primary reason that gambling should be allowed to expand in New Zealand. (Public Health Association of New Zealand, Inc. 2001)
Government has allocated funding, unrelated to gambling, to build social capacity in Maori communities, such as, by the creation of new Maori businesses and organisations. (Te Puni Kokiri 2000) Gambling and other associated policies may reduce the benefits of capacity building as discretionary funds from whanau and local communities may be gambled or gambling may encourage crime, destroying or damaging local businesses. (Department of Internal Affairs 2001)

Reviewing the capacity of communities to cope with the expansion of gambling in Australia, the Productivity Commission has noted that gambling outlets are likely to be sited in low-income areas where there are more people who are willing to gamble. (Productivity Commission Report 1999) The New Zealand Lotteries Commission has acknowledged that its Lotto advertising has in the past been designed to increase Maori and Pacific participation and outlets are in places such as supermarkets where most members of the community can easily access Lotto and other products. (Cabinet Policy Committee 2001)

There is no comprehensive gambling regulatory framework in New Zealand which actively protects low income, disadvantaged communities and particularly Maori from being exploited by gambling operators. With the exception of casinos and gambling machines, gambling operators with minimum community consultation, can establish outlets wherever they decide. (Select Committee on Government Administration 2002) There is a need for a process in New Zealand to identify where new gambling outlets are to be situated, the impact they have on local communities, especially specific ethnic communities, and what provisions should be in place to allow communities to have input into the control locally of all areas of gambling. This would support the proposed decision by the Government that communities through territorial local authorities will be able to be involved in “whether and where they will permit high risk gambling venues“ and will be able to veto the placement of gaming machines in designated sites. (Select Committee on Government Administration 2002, (clause 91))

Expenditure on gambling is usually income-related. In Canada it has been found that low-income households spend more proportionately on gambling than higher income households and are often targeted by gambling operators to encourage gambling activity.
Expenditure on gambling by the poor or disadvantaged groups, especially the purchase of tickets in state run lotteries, is a form of regressive taxation as many Governments are now dependent upon gambling income to support or implement their priorities. (Rubner 1966; Borg, Mason et al. 1991; Goodman 1995; Korn 2000)

This finding has relevance to Maori. Although self reported expenditure on gambling is likely to be under-reported, Abbott and Volberg (2000) have identified that a small proportion of the New Zealand adult population (11%) gambles continuously and this group spend on average $152 per month on gambling. In contrast, non-continuous gamblers, which account for 30% of gamblers, spend on average $42 per month. (Abbott and Volberg 2000 (a))

Maori are both continuous and non-continuous gamblers and are part of a group which spends the most on gambling but on average have lower personal and household incomes than non Maori. (Te Puni Kokiri 2000; Abbott 2001) The Productivity Commission reviewing gambling in Australia has estimated that gambling industries contribute between a net loss of $1.2 billion to a possible net benefit of $4.3 billion. The large difference in estimating cost or benefit is due to the difficulties of costing fully the emotional costs such as loss of trust which is associated with problem gambling. The Productivity Commission has also estimated that the cost of problem gambling in Australia ranges from A$1.8 billion to A$5.6 billion per annum. These figures take into account the costs associated with bankruptcy, productivity loss, job changes, criminal justice system, distress of family and parent break-ups, divorce, violence, depression, suicide and counselling services. (Productivity Commission Report 1999)

No specific cost assessment has been made by the Productivity Commission of the impact of gambling on Aboriginal and Torres Strait Islanders, although, as with Maori, gambling has become part of their cultures. With increased access to gaming machines these populations are experiencing gambling-related problems which are impacting on their families and communities and adding to the already significant addiction problems they experience. (Ayers 1998)

Information is needed in New Zealand as in Australia, to identify the real costs and benefits of gambling and in particular in this country its impact on Maori. This
information should then be considered in relation to current and future Government economic and taxation policies, the licensing and regulation of gambling, and the level of taxation or levies paid by gambling operators. This information is not available publicly even though this was one of the terms of reference of the gaming review (2000). (Department of Internal Affairs 2001)

The Committee established by the Government in 2000 to review tax policies has recommended that gambling, alcohol and tobacco should be treated in a similar manner and should not be subject to an excise tax. (Inland Revenue 2001) This advice has not been accepted but if endorsed would have significant implications for public health, as the cost of these items influences consumer choice and consumption of these products. At present, the Government considers that the gambling industry should pay for health care costs associated with problem gambling through a levy. (Department of Internal Affairs 2001; Department of Internal Affairs 2002)

Tax as a public health intervention strategy to reduce gambling requires further public discussion. Increasing the cost of cigarettes or alcohol for Maori has not been a successful mechanism alone to reduce Maori consumption but it may have changed attitudes and behaviour such as reduced willingness to share cigarettes with others or drink less or use other substances to get “high”. (Te Puni Kokiri 2000) Maori participants interviewed regarding gambling were not supportive of the Government using gambling as a means for revenue. (Department of Internal Affairs 2001)

If the full cost of gambling-related harm for Maori were quantified, a basis could be provided for Maori to negotiate direct relationships with gambling operators and with the Crown, to reduce gambling-related harm. Durie has proposed this arrangement in relation to the sale and licensing of alcohol and it has applicability to gambling. (Durie 2001)

3.5 Maori Issues Related to Health Services and Research Implications

3.5.1 Maori Imprisonment and Intersector Links

The Department of Corrections and the Ministry of Health have developed a set of principles to guide collaboration and determine responsibilities for provision of health
services for prisoners. These principles are: inmates are entitled to the same range of health services as the general population, humane containment should include access to health care, reducing re-offending creates specific health care needs and the health needs of offenders are greater than those in the general population. (Department of Corrections 1999) These principles address only Article III of the Treaty of Waitangi and do not incorporate the current Government’s health policy for Maori as outlined in “He Korowai Oranga”, nor do they include the responsibilities of the Crown to actively protect Maori. (Ministry of Health 2002)

Both agencies have agreed upon a shared view that the health sector is responsible for ensuring that the health needs of prisoners are identified and services provided within resources available, while the Department of Corrections is responsible for ensuring appropriate management of offenders’ sentences. In accordance with Government policy regarding the Treaty of Waitangi, both agencies have responsibilities to improve justice and health outcomes for Maori prisoners. Boundaries of care and responsibility are important policy areas for Maori and call for ongoing surveillance and research.

New Zealand prisoners in general have high health needs but have limited ability to advocate for health services that will improve their health status. (Dow 1999; Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c)) (Department of Corrections and Ministry of Health 1999; Sullivan 2001(b)) Health advocacy for prisoners is dependent largely upon their whanau or penal reform groups agitating for social change within the prison or justice system. In general, Maori prisoners receive limited public support and compassion for their situation and as a consequence the inverse care law applies, that is “those who are most in need of health care are least likely to have least access to care”. (Mason 1988; Department of Corrections 2001) This experience is common for Maori in other health areas but is especially so for Maori in prison. (Pomare, Keefe-Ormsby et al. 1995)

To gain insight into the impact of gambling and Maori imprisonment there is a need for a study which allows each person entering prison or a community sentence, says for a decade, to be screened for problem gambling and other addictions and interviewed to identify their attitudes, expenditure and patterns of gambling. This would provide
important information on the degree of problem gambling and the pattern and interaction of co-addictions, especially for Maori within a defined cohort population.

This would be a unique study, as no information is available worldwide on the prevalence of problem or pathological gambling within a defined population over a defined period of time. It would identify those who could benefit from information, counselling or support. The population would include a significant sized indigenous component, which is integrated and lives within the wider community. (O’ Donoghue, Howden-Chapman et al. 2000) This research would be of interest not only to New Zealand but to other countries with indigenous populations where the effects of problem gambling are still largely invisible. Prisoners on release could be interviewed and screened to identify whether problem gambling still exists after a defined period of time or has developed whilst imprisoned. This may assist in reducing re-offending and re-imprisonment.

Information from this study would be valuable in understanding the relationships of being Maori, gambling and imprisonment. This study could be undertaken with the support of the Ministry of Health, Department of Internal Affairs, Ministry of Justice, Department of Corrections and Te Puni Kokiri and would provide valuable information for policymaking and appropriate public health interventions. Such proposed research could be integrated within the Criminogenic Needs Inventory, which is being developed by the Department of Corrections. This inventory will have a specific component that focuses on Maori cultural needs. (Maynard, Coebergh et al. 1999; Department of Corrections 2000)

3.5.2 Ethics of Health Screening And Research

The level of gambling and health related morbidity identified in four recent prison studies in New Zealand is significant and stresses that researchers have responsibilities to their participants to become advocates on their behalf for appropriate health care. (Department of Corrections and Ministry of Health 1999; Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c); Sullivan 2001(b)) From a public health perspective it is unethical to screen for specific health problems without offering some form of effective intervention to improve individuals’ health. Interventions may include the provision of health information, the offer of counselling, support to change personal
lifestyle, pharmaceutical assistance or medical help. (Baum 1998) Maori also consider that no screening should take place unless Maori are involved in defining solutions to improve their individual or collective wellbeing.

Maori who come under the care and responsibility of the Ministry of Health and the Department of Corrections have a right to expect that if approval for research is given which includes screening and individuals agree to participate through informed consent then appropriate healthcare should be provided in accordance with recognised public health screening principles. (Gardis 1996) This arrangement would ensure participants do not become victims and labelled as having specific health problems with little opportunity to change their personal situation. Participants should also be consulted actively in the development of interventions to address their situation.

Maori often feel that they are “over-researched” and have become merely subjects for research. The Health Research Council has released guidelines as to how research should be undertaken in partnership with Maori. (Health Research Council of New Zealand 1998) The guidelines are not mandatory but they provide direction to investigators as to how they should conduct research. The guidelines should be validated by other government agencies, involved in health research, such as the Departments of Corrections and Internal Affairs. If endorsed, these guidelines would support Maori in becoming part of the whole research process and involved in action-oriented research.

Individuals who have accessed a health or disability service are protected in New Zealand under the Code of Consumer Rights for Health and Disability Services. This code has a specific requirement that researchers should only undertake research only with the informed consent of participants. Generally, it is considered that there is a dividing line between the responsibilities of researchers and the responsibilities of organizations, which support research. (Health and Disability Commissioner 1999)

Research in general is not seen as part of healthcare but participants who are studied for specific health issues, as part of research should be treated with the same respect and dignity as other health consumers as if they were accessing professional health care. This places responsibilities on agencies involved in research, like the Department of Corrections and Ministry of Health, to ensure appropriate health care
services are available for those who are screened following research for specific health conditions. (Health and Disability Commissioner 1999)

A paper prepared by the Department of Corrections (2000) titled “Health Issues In the Corrections System In New Zealand”, has no mention of the rights of prisoners in relation to the Code of Consumer Rights for Health and Disability Services, because it is assumed that offenders are entitled to the same rights to healthcare as the general population. (Department of Corrections 1999; Health and Disability Commissioner 1999)

There is also no mention in this paper of Maori rights as a Treaty of Waitangi partner with the Crown even though it is recognised that prisoners have high health needs and often access health services by way of prison. (Department of Corrections and Ministry of Health 1999)

Inmates can access health services only if approved. Health providers cannot provide health care to prisoners without the agreement of the Department of Corrections and management staff. So any new health arrangements to provide health care for the general population may not necessarily reach prisoners. For example, there has been no discussion by the Ministry of Health or district health boards of the need to establish a specific a Primary Health Care Organisation (PHO) for prisoners even though this population group has real primary health care needs and there are plans to build new prisons in Auckland and Northland.

Access to health services for prisoners is difficult due to poorly defined areas of responsibility between government agencies and because the health needs of prisoners are often overlooked and accorded a low priority than other health consumers. This is obvious in the lack of recognition of this population within the national New Zealand Health Strategy or in the national Maori health strategy. (Ministry of Health 2000; Ministry of Health 2002) Low priority means that district health boards with a prison in their region will allocate minimal health resources even though they are responsible for this population. Communities are also unlikely to be interested in the health of prisoners but are more likely to be concerned with their health needs and community safety. A national health strategy for prisoners, with a Maori focus, is required to ensure appropriate services are available for this particular population.
3.5.3 Importance of Dissemination of Gambling Research Findings to Maori

Dissemination of information from research is an important responsibility of researchers as knowledge can inform people, help make decisions and empower disadvantaged groups. Specific guidelines for researchers on how to disseminate information have been developed by the Health Research Council. (Health Research Council of New Zealand 1999) Despite media releases about the community and prison prevalence studies and the holding of an international conference on gambling, research findings of studies conducted in New Zealand have not been disseminated nor communicated in a way that Maori can understand, respond to or use easily to negotiate Maori participation in all levels of policy making related to gambling. (Dyall 1998)

To ensure that Maori are part of any process, which shapes gambling policy, specific information with a Maori focus should be released. Without appropriate Maori information, such as the recently released national strategy to foster research regarding tobacco, alcohol and gambling, Maori are unlikely to be interested. (Applied Behavioural Science 2002) No information was included in this discussion document on the effects of drugs and gambling on the health of Maori and implications for the future. A Treaty of Waitangi framework for developing research capacity in New Zealand was missing from the proposed national strategy. Instead the focus was on building research capacity rather than on defining the range of issues which should be investigated enabling Maori involvement in designing the research questions and determining the appropriate solutions.

The latter would be consistent with recognition of the principles of protection, partnership and tino rangatiratanga inherent in the Treaty of Waitangi and would ensure that current knowledge of the effects of gambling and addictive substances on Maori is considered and shapes any further research and health interventions. Maori direction and participation in research is an integral part of the development of Maori.

As a strategy to stimulate greater Maori interest in reducing gambling and other addictions current research information related to gambling should be disseminated to Maori such as through Maori media, hui, and networking with key Maori key stakeholders. For example, a Maori gambling advocacy group aimed at reducing gambling-related harm, should be resourced to disseminate gambling research
information, to raise Maori and iwi awareness of the risks associated with gambling, to assist with the development of Maori health and gambling related interventions, and to help Maori develop their own research agenda.\textsuperscript{35}

3.6 Summary

Maori and non Maori participation in gambling, attitudes towards gambling in New Zealand and the extent of problem and pathological gambling for Maori and non Maori have been discussed in this chapter. In general, Maori have a higher level of participation and expenditure on gambling than non Maori and participate in those forms of gambling in which they believe they have a fair chance of winning. Maori are both continuous and non-continuous gamblers.

Despite new opportunities for Maori to gamble with the establishment of casinos and sports betting, total Maori expenditure on gambling has declined while those who do gamble are spending more and are involved in more gambling activities. Maori have definite views on gambling and indicate support for interventions, to assist individuals and communities to reduce gambling-related harm.

Available information indicates clearly that problem gambling is an emerging issue and warrants consideration as a public health issue for Maori. Using the 1999 estimates of problem and pathological gambling in New Zealand approximately 7\% of the Maori adult population would have had a problem sometime in their life with gambling. This figure is at least three times the rate of non Maori and if the passive effects of problem and pathological gambling were considered, they would have affected the lives of just over 103,000 people.

If the 1991 figures were taken into account as these are considered to be more accurate then the scale of the problem gambling increases significantly. In 1991, it was estimated that 16\% of the adult Maori population was affected sometime in their life with problems with gambling and applying this figure to the 1996 Maori adult census population, it is estimated that 47,161 people would have had problems. Multiplying this

\textsuperscript{35} A Maori Reference Group on Gambling was established December 2001 which includes representation from iwi, Maori health groups and individuals with an interest in gambling. The investigator is a member of this group and has been involved in its establishment and has provided information on Maori and gambling.
number by five to cover whanau and other passive involvement, the figure increases to almost 235,805 affecting a total of 282,966 people.

Using the Maori adult 2001 census population the figures it is estimated that just over 47,000 Maori would have had problems and collectively have affected the lives of at least 239,200 people.

These figures do not include the number of Maori in prison who are there directly or indirectly as a result of gambling. This is approximately 1,000 people, who would then have affected the lives of a further 5,000 people. A further 6,000 people, therefore, are affected by Maori problem gambling.

For planning and funding of health services for Maori the 1991 best estimates for current problems should be used. At least 3.3% of the adult Maori population has a problem with gambling at any time. Applying this figure to the 1996 and 2001 Maori census populations approximately 8,867 to 9,727 Maori would have had a problem, which in turn affected approximately 44,000 to 48,000 people. Including Maori problem and pathological gamblers the population increases to between 53,202 to 58,362 people. Planning and funding for gambling treatment and related services for Maori should focus on this at least 50,000 people affected by problem gambling even though all may not identify as Maori.

Problem gambling does not have to be a lifelong chronic health problem. People can change. Life events and the availability of discretionary income are key factors which influence whether problem gamblers continue to gamble or change their pattern of behaviour to controlled gambling or to abstain completely. Identification of events which can increase or decrease the risk of problem gambling are important and should be considered in the development of intervention measures for Maori. Problem gambling for Maori cannot be considered in isolation from the under-development and position of Maori in New Zealand.

Identifying as Maori or a Maori woman is now part of the profile of a problem gambler either in the community or in prison in New Zealand. If the results of available local and international research are applied to the Maori population, it can be predicted that unless significant socio-economic and cultural changes occur, Maori problem
gambling will not decline but will probably be maintained at least the same level or may even increase as the Maori population is both young and aging, new forms of gambling are being created and new gambling outlets are being established which can be accessed readily by Maori.

Problem gambling significantly affects the wellbeing and social capital of Maori whanau, hapu, iwi and local communities as their valuable resources such as human time and financial resources are expended on gambling. Gambling destroys social capital by weakening family relationships, destroying trust and increasing crime in communities. At the same time, Maori organisations and communities are dependent on gambling for developing and operating essential social, sport and cultural services.

It is concluded that gambling overall, especially problem and pathological gambling, are producing significant health consequences and this addiction can be considered as an emerging public health issue for Maori. New areas of research which would assist the development of Maori in relation to gambling have been identified, such as the need for longitudinal cohort studies, the effects of gambling positively and negatively on Maori whanau, hapu, iwi and Maori communities, the effects of gambling on Maori imprisonment and re-offending and the need to consider the effects of non-casino gambling machines on Maori women’s health and wellbeing.

The next chapter considers current services available for the treatment of problem gambling in New Zealand, the use of gambling treatment services by Maori and Maori problem gambling in relation to other indigenous populations.
Chapter Four:
Maori and Gambling - Links with Gambling Treatment Services and Indigenous populations

4.1 Introduction

This chapter considers the links between Maori gambling and treatment options available for the treatment of problem or pathological gambling from either a medical, mental health or psychological perspective. A brief overview is presented of gambling treatment services available both nationally and in Auckland in 1999-2002. This provides a context in which to consider the views of Maori problem gamblers’ on the effects of problem gambling on their health and their significant others and the outcomes they are seeking from gambling treatment services.

Maori utilisation of gambling treatment services nationally and locally is discussed and provides an assessment as to whether gambling is an emerging health issue for Maori. Further, it explores whether Maori utilisation of gambling treatment services mirrors the estimated prevalence of problem gambling for Maori in the community and in prisons. (Abbott and Volberg 2000 (a); Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c))

The effectiveness of gambling treatment services is briefly discussed and in particular, whether counselling and telephone helpline services are adequate to treat and reduce problem gambling for Maori.

Section two of this chapter considers the prevalence of problem gambling for Maori in relation to other indigenous populations. This provides another perspective from which to consider whether Maori gambling and problem gambling is similar to that of other populations or groups, which occupy a similar status as Maori in their own country. Gambling research which has been undertaken with or by indigenous populations is reviewed. Although this study has been critical of the limited number of Maori who have participated in New Zealand gambling prevalence and gambling participation and expenditure research, these studies are important. Such studies provide significant
insights into the effects of normalisation of gambling on an indigenous population which is part of a wider population with which there is constant contact and interaction. They also describe the effects of gambling on a population, which traditionally did not gamble and has been exposed to this social hazard only since the 1840. Similar national information is not available from other countries which have indigenous populations.

After discussing funding arrangements and reviewing utilisation and effectiveness of gambling treatment services and indigenous gambling research, this chapter discusses the extent to which gambling is an emerging health issue for Maori. In particular, it considers whether a mental health service which focuses on the treatment of problem and pathological gambling is adequate to address gambling and problem gambling for Maori.

4.2 Gambling Treatment Services in New Zealand

4.2.1 Funding and Purchasing Arrangements

Problem gambling treatment services are funded by major gambling industries through the Problem Gambling Committee, which has been established by the Government. Each year gambling industries collectively determine the level of funding each industry should pay voluntarily over and above other compulsory levies or taxes. (Easton 2002) This arrangement will continue as part of government policy in relation to reducing gambling-related harm. (Select Committee on Government Administration 2002) At present non-casino gambling machine licence holders are required to make the largest contribution to gambling treatment services as they are considered to create the most pathological gambling problems for individuals.

In New Zealand, this approach is not taken for funding of health services by industries which are known to create adverse health effects, such as alcohol or tobacco. (Yaffee and Brodsky 1997) Gambling industries accept current funding arrangements because they recognise it is in their interest to manage problem and pathological gambling to minimise community and Government opposition towards gambling, to ensure licensing regimes and regulations governing gambling are not too restrictive, and to enable gambling to be promoted as a recreational activity which creates minimal harm in the community and for individuals. (Leach 2002)

The Ministry of Health is supportive of the policy towards funding of gambling services outside Vote Health and in 1996, released guidelines for the treatment of
pathological gamblers. (Ministry of Health 1996; Earp 1997) These guidelines were developed from a mental health treatment perspective, which has limited the liability of funders of gambling treatment services and defined problem gambling as a medical, rather than a health issue. No provision was made in the establishment of these guidelines for funding services, which focused on community education, health promotion, early intervention through primary health care services or the development of specific Maori health services.

Instead, guidelines were focused on the treatment of people defined as pathological gamblers. These gamblers are generally out of control and are experiencing severe problems with their relationships, management of money, and their own health. (Compulsive Gambling Society of NZ Inc. 1997) They have often committed crime to maintain gambling. (Productivity Commission Report 1999) These guidelines were developed with minimum Maori input even though the first prevalence study showed clearly, that Maori had three times the risk of problem gambling of non Maori and clearly a case could have been made for the development of guidelines to address specifically Maori problem gambling. (Abbott and Volberg 1992)

Lack of recognition of the size of the problem for Maori demonstrates that the Ministry of Health then, and to some extent even now, does not consider this an important health issue for Maori. This is in line with the Government’s decision then that the responsibility of addressing problem gambling was not a responsibility of the health sector. (Earp 1997) Generally, the Ministry of Health takes a leadership role in raising awareness of a health issue, if there is clear evidence of a problem. Further, the Ministry of Health ignored this population where it has been shown that problem gamblers frequently have a high level of alcohol and substance abuse and other mental health problems. (Crockford and N 1998) Funding services for people with addictions other than gambling is through Vote Health and is the responsibility of mental health services in New Zealand.

Guidelines for the care of people who are pathological gamblers were developed at the same time as it was seen that mental ill health was a major health issue for Maori. Although problem and pathological gambling are recognised as being as legitimate mental health diagnoses, and that alcohol abuse and problem gambling are often
interrelated, these factors were ignored in the development and funding of mental health services for Maori. Consequently, the onus is placed on Maori to argue that gambling is an emerging health issue for Maori, for appropriate funding to be provided and for a comprehensive public health approach to be taken. (Mason 1996; Compulsive Gambling Society of NZ Inc. 1997; Ministry of Health 2002)

The decision on the quantum of funding required from gambling industries individually and collectively, is made in consultation with gambling treatment providers, and is based upon their assessment of the number of people who have, and are likely to seek help in the next year and on their expectation of the degree of severity of gambling problems with which clients may exhibit. These two different factors influence the number of counselling or support services required for each client. Both factors thus influence the mix and level of funding required for gambling treatment services. (Paton-Simpson, Gruys et al. 2001; Paton-Simpson, Gruys et al. 2002)

Current funding arrangements between gambling industries and gambling treatment providers create tension and conflict. Gambling industries have an interest to under-estimate the degree of problem gambling, focussing more on providing help to those who are considered to have a pathological gambling problem. In contrast, gambling treatment providers have an interest in improving gambling treatment services and receiving resources sufficient for each client. Gambling treatment services are like other health services they are driven by providers. Once clients are engaged in services they are encouraged to continue to seek help, as providers funding is linked to client numbers and counselling sessions. There are no co-payments to be paid by clients. Gambling clients can be referred to other health providers with no requirement to transfer funding with clients. Funding for clients who are referred comes from Vote Health.

The Problem Gambling Purchasing Committee (PGC) through the Problem Gambling Purchasing Agency (PGPA) purchases gambling treatment and related services. This is a private organisation, established in 1996 to bridge and meet the needs of both gambling and treatment providers. Maori involvement in either the PGC or the PGPA is limited. There is no statutory requirement to be met in terms of Maori representation, consultation or improvement of Maori health outcomes. Further, there is no independent statutory reporting requirement for either the PGC or the PGPA to report
to the Government on problem gambling services delivered or outcomes achieved for specific groups linked to Government policies such as building capacity in Maori communities, or addressing disparities between Maori and non Maori.

This omission demonstrates the invisibility of problem gambling for Maori and requires Maori with an interest in gambling to continually lobby for the purchase and funding of Maori gambling treatment services in relation to need. Such lobbying can create conflict with Maori Members of Parliament who may have differing views on gambling and who, if they are part of the Government, are required to support current policy. (Dyall 2002)

Current funding arrangements have both advantages and disadvantages for Maori problem gamblers and whanau. While clients are not expected to pay for gambling treatment, there is an expectation that clients will be able to access and use a telephone to seek help through the national telephone help line or alternatively, they will have transport or the means to pay to reach gambling counselling services. Many Maori do not have access to a telephone, which they can use on a confidential matter, nor funding to present for help, thus limiting access. (Durie 2001)

Funding arrangements are based upon current and expected utilisation of gambling treatment service and many barriers affect Maori utilisation, such as lack of awareness of the signs and symptoms of problem gambling, the effects of the normalisation and intergenerational influences of gambling on whanau, hapu and local communities, and limited access to services in both urban and rural areas. Some problem gamblers cannot present for treatment as they are in prison, in mental health services or other addiction services where problem gambling is either ignored or the costs are met through other avenues of funding. These issues will continue if the current legislative proposals for determining the problem gambling levy are enacted, because there will be insufficient funding to provide gambling treatment and related services at a level which meets Maori needs. (Select Committee on Government Administration 2002, (clause 287))

4.2.2 Development of Problem Gambling Treatment Services

Problem gambling treatment services have evolved in New Zealand since the 1990s, beginning with a national telephone helpline initially supported by the Lottery
Grants Board and counselling services developed in all major cities when voluntary gambling funding became available in 1997/8. Outreach services have been established in some outlying areas sometimes in association with other addiction services.

When this study commenced there were two major providers of gambling treatment services: the Compulsive Gambling Society Incorporated which is now the Problem Gambling Foundation of New Zealand and Oasis Centres for Problem Gambling run under the auspices of the Salvation Army. With Maori advocacy, Maori treatment services have evolved, with services in Auckland at Wai Health (West Auckland), Te Atea Marino (Regional Maori Addictions Service under Waitemata District Health Board) and Te Rangihaeata Hauora in Hawkes Bay. In 2001, consultation was initiated with selected iwi groups to become involved in gambling treatment or in raising Maori awareness about gambling and a Maori Reference Group on Gambling was established.

When Maori gambling treatment services were first established few clients self-presented but by working in collaboration with other providers, especially with the national helpline, the number of problem gamblers and whanau members presenting for help has increased. This pattern of utilisation is not unusual for Maori, as there is a need to raise awareness about issue, to reduce “whakama” or stigma, in having a gambling problem and for individuals and whanau to gain confidence in local Maori services before they are willing to refer others for help. The Maori kumara vine provides an important way of promoting a service.

Local hui in 1997 and 1998 leading to the national gambling treatment conferences in Auckland, (1998, 1999, 2000, 2001), the dissemination of resource information about problem gambling and the promotion of the national 24 hour helpline through local radio, have all been used to inform Maori about the effects of the normalisation of gambling and about where to seek help if experiencing problems with gambling. (Gambling Problem Helpline 2002)

At the time this study was commenced in 1999, there were no Maori gambling counsellors employed in Auckland gambling treatment and telephone helpline services but since then Maori counsellors have been employed. Maori cultural needs were recognised as important when services first established but were ignored because of the
skills of staff and so services were focused on the assessment and treatment of problem gambling.

Maori clients have always been significant users of gambling treatment services with one in four clients being Maori even though the Maori adult population is only one tenth of the national adult New Zealand population. This pattern of utilisation indicates that gambling and problem gambling are a health issue for Maori who present for help even though mainstream gambling services have had few Maori staff employed as counsellors or workers.

Funding for gambling treatment services has increased since the establishment of PGC and approximately $8.6 million was spent on gambling treatment services 2002/2003. Of this budget, approximately a million was spent on the purchase of services for Maori clients. (Paton-Simpson, Gruys et al. 2001) This level of funding is below Maori utilisation of gambling treatment services and is inadequate for the level of problem gambling which exists for Maori in the community and in prisons. If Maori services are to be adequately funded for current and potential Maori clients, additional funding or reallocation of funding is required which may jeopardise the infrastructure of current gambling treatment services. The need to support the development of mainstream gambling treatment services was used by the purchaser to support contracts with a few providers instead of open contracting or providing “ring fenced” funding specifically for the development of services for Maori. The size and the effects of problem and pathological gambling for Maori are not adequately reflected in the funding, purchasing and delivery arrangements for gambling treatment services in New Zealand.

4.2.3 Maori Use Of Specialist Gambling Treatment And Related Services

There has been a steady increase in Maori utilisation of Maori utilisation of the national telephone helpline. (Abbott 2001) This service offers assessment, crisis management, advice, motivational counselling, support and referral, Maori counsellors and it aims to provide first point of contact with problem gambling services. Budgeting advice is also offered as well as support in monitoring and following up clients.

In 1999, 2000 and 2001, just over a quarter of all telephone callers identified themselves as Maori and although the number of calls decreased slightly from 2000 (28.3%) to 2001 (27.3%), Maori have twice the rate of utilisation that might be expected
from the size of their total adult population. Despite this high rate, Māori still under use this service in relation to estimated prevalence of problem or pathological gambling for Māori in the community and in prisons.

A similar decline in seeking telephone help has also been observed for Pakeha clients. This leveling off suggests that the expansion of gambling has reached saturation point and supports the view of Abbott (2001) that problem gambling in the community is not increasing but that problem gamblers are involved in more than one form of gambling, and are spending more and creating greater damage to themselves and others who are associated with them. (Potenza, Marvin et al. 2000)

The percentage of Māori whānau members who seek telephone help is relatively stable (12.6% in 2001) and is similar to the proportion of Māori in the adult New Zealand population. Such help is accessible to a wide group in the community. Almost half of all telephone callers were under 35 years of age, and here this group is different from those seeking counselling. This indicates the service is accessible to young adults, many having their own mobile phone.

The telephone helpline is fulfilling its purpose of early intervention and first point of call. It is an important, anonymous service for Māori avoiding “kanohi ki te kanohi”, (face to face contact), and provides easy access to confidential help. It also provides valuable information, referral to other services and support for clients who may be suicidal or wish to address their criminal offending related to gambling. (Abbott and Volberg 2000 (a))

Calls come from all over the country with over a third from Auckland. Just over 80% (81.6%) report problems with non-casino gambling machines. In 2001, an equal number of males and females sought telephone help, a change which mirrors the New Zealand gambling prevalence data where women, including Māori women, are experiencing increasing problems with gambling. (Paton-Simpson, Gruys et al. 2001)

The national telephone helpline is providing support to individuals and whānau who feel comfortable with this service evidenced by the number of people who maintain contact with this service. It has been used as a model for the development of other health services such as the Quit-line to help people who wish to quit smoking. With more Māori having access to mobile telephones and text messaging this form of communication could
provide easy access to information, counselling and ongoing support in the future. Telephone contact is especially important for the 10% of gamblers who report they have considered suicide in the past twelve months. The New Zealand Lotteries Commission has proposed that the telephone is a suitable medium to offer games of chance and this development could affect the helpline as a support service for problem gamblers.

The utilisation of the telephone helpline supports prevalence data that Maori have a greater problem than Pakeha with gambling, but suggests that at least one third of Maori with such problems have not sought help through this first contact national service as Maori utilisation is not three times greater than non Maori.

Face to face counselling services are located in major cities throughout the country and outreach clinics are provided in different locations. Since the establishment of counselling services new clients have increased and in 2001 they made up three quarter of all clients (74.7%). Increasingly there are a growing number of clients who are continuing to seek (19.6%) help and clients (5.7%) who are returning for further help. (Abbott and Volberg 2000 (a))

Maori enrolled in counselling services comprise just over 25% of clients, twice the proportion of Maori in total New Zealand population. The number of Maori seeking help has increased each year since 1997 indicating that, as outreach services extend outside of the major cities Maori utilisation of counselling services will increase and may explain why telephone calls from Maori have decreased.

Just over 40% of gamblers seeking help gave non-casino gambling machines, casino gambling machines, track betting, and New Zealand Lotteries Commission products as the major forms of gambling which have created problems. Sports betting and Housie were also cited as problems for a small group of gamblers. Non-casino gambling machines caused most problems for all age groups with young people less than 20 years of age and older adults increasingly seeking help. This supports previously reported research although the last prevalence study did not sample adequately these sub-population groups. (Paton-Simpson, Gruys et al. 2001)

Non-casino gambling machines created most problems for both Maori men and women but there were some gender differences. Maori females are likely to have problems with gambling machines in or outside a casino, while for men it is likely to be
non-casino gambling machines, track betting and casino tables. The number of women seeking help has increased in 2001 and since establishing a national database, the number of women seeking help has quadrupled and has increased by 257.0% since 1997. (Paton-Simpson, Gruys et al. 2001) Although the ethnicity of women is not presented in the national utilisation data, it is likely that Maori women would make up a significant proportion of women seeking help. (Abbott and Volberg 2000 (a)) This supports previous research that the number of women with gambling problems has increased in New Zealand. (Abbott and Volberg 2000 (a))

Just over 10% of Maori clients in 2001 seeking counselling help were Maori whanau members, who sought help to deal with the damage associated with a person close to them. Although Maori whanau members present more often than those from other ethnic groups, this group is significantly under-represented as problem gamblers affect the lives of, conservatively, at least five others. (Howland 1994) For Maori this group should be encouraged to attend as often, there is more than one problem gambler in a whanau.

Assessment of problem gambling using an amended Southern Oaks Gambling Screen it has shown that those who present for counselling help already have a severe problem with gambling. Males generally have a slightly higher score than females, which may relate to exposure and involvement in gambling. Almost all gamblers (80%) report that that their gambling was out of control prior to seeking help.

Individuals who present with problems associated with gaming machines generally had high Southern Oaks Gambling Screen scores and which supports the view that continuous forms of gambling increase gambling risk. However, those who presented with problems associated with Lotto had the highest level of severity, refuting the myth that this form of gambling is benign and creates minimal harm. (Department of Internal Affairs 2001)

Maori problem gamblers reported they spent just over $1200 on average on gambling during four weeks before seeking help. This figure is less than the amount spent by other ethnic groups, reflecting the lower incomes of Maori. It is probable that this figure under-reports the real situation. (Paton-Simpson, Gruys et al. 2002)
On average males lose more gambling than females possibly reflecting a higher male income, crime and easier access to finance. Differences between genders are reducing if “one off”, big losses are excluded. A follow-up of clients from all ethnic groups after five months of contact with gambling counselling services found that two thirds of clients were assessed as having a lower rate of problem gambling, just over 20% reported that their problems with gambling had not improved and most clients reported that their expenditure on gambling had reduced. Most gamblers report some benefit from gambling counselling services even though they may still be assessed as having a pathological gambling problem and their gambling may still be out of control. Although expenditure on gambling may have reduced as a result of counselling, it may still be substantial and continues to affect the wellbeing of the gambler and others. (Paton-Simpson, Gruys et al. 2002)

Maori seeking help, either through the telephone or with counselling, gave their major problems as gambling machines inside and outside casinos, track betting, casino tables and Housie. In 2001, a greater number of Maori women in (177) sought help with counselling than Maori men (122). Gambling machines are currently creating the most problems for Maori overall and for females they accounts for 96% of their gambling problem and for men 91.5%. (Abbott and Volberg 1992; Abbott and Volberg 2000 (a); Paton-Simpson, Gruys et al. 2002)

Each year the number of Maori seeking counselling help has increased and now Maori make up over a quarter of all clients. Maori use of gambling treatment and helpline services is proportionately twice their representation in the New Zealand population, thus supporting the findings of the two community prevalence studies conducted in New Zealand which identified clearly that Maori have a greater risk of problem gambling than non Maori. (Smith, Barnfield et al. 2001)

Although Maori use gambling treatment services more often than non Maori, Maori under-use services given that Maori have three times the risk of problem gambling than non Maori. Clearly there are many Maori with problems with gambling who do not seek help. This challenges the view that gambling treatment services do not need to be adequately funded in relation to need as a significant group in the community will not present even though they have severe problems or that services are available. (Abbott
1999; National Research Council 1999; Oakley- Browne, Adams et al. 2000) Limiting the need for funding or service delivery does not address the intergenerational effects of gambling on whanau and the importance of opportunities for early intervention. (Productivity Commission Report 1999)

Pakeha clients (excluding Pacific) in 2001 seeking help account for over half of the gambling telephone help calls (57.8%) and of those seeking help with counselling (57.5%). Almost all clients (95%) seeking counselling help in 2001, were aged between 20 to 64 years with the majority (63.2%) between 25 and 44 years, ages when many adults are establishing and supporting young families.

A third of those seeking help (33.8%) were from Auckland. This could reflect telephone access, location of gambling treatment services, the distribution of New Zealand’s population, the placement of gambling opportunities and counselling provided in outreach sites. (Paton-Simpson, Gruys et al. 2001) Changes in rural and provincial areas in relation to services or the introduction of new casinos cannot be differentiated within the presentation of national data. This has implications for Maori, as many Maori live in rural areas where gambling is often a major recreational activity along with sport. Casinos increase the prevalence of problem gambling. (Australian Institute for Gambling Research 1998) This has specific implications for Maori who live in Te Waipounamau (South Island) where there are four casinos.

4.2.4 Effectiveness of Gambling Treatment Services

Recent reviews of gambling studies focussing on treatment services have been critical of the lack of scientific rigour, methodologies used to assess different treatment interventions, and selection of participants. Often the number of participants involved in gambling research studies is so small that the results are inconclusive. (Elia and Jacobs 1993; Hewitt, Hodgson et al. 1994)

Few studies have reported indigenous participation thus little information is known about gambling treatment interventions and their effectiveness with indigenous populations. There is recognition that problem gambling is likely to be higher amongst individuals of indigenous identity where there is excessive alcohol use, thus creating co-morbidity health problems. (Abbott M and Volberg 1997; Volberg and Abbott 1997;
This relationship between alcohol abuse and gambling leading to the development of co-addictions for Maori has already been previously discussed.

A review of the effectiveness of different forms of intervention, such as counselling or family involvement, it has been found that Gamblers Anonymous alone is not successful. Almost all participants (70-90%) who participated in this form of intervention dropped out within a year and only 8% of attendees were able to achieve a year or more of abstinence from gambling. (Zitzow 1996) Few Maori problem gamblers are involved in Gamblers Anonymous but presentation by Maori gamblers at gambling conferences in New Zealand has indicated that for some individuals, involvement has been healing, as spirituality is a strong component, as is compliance with a defined code of behaviour.

Lesieur and Blume (1991) studied outcomes of gamblers treated in a combined alcohol, drug and gambling programme. Of 121 patients admitted with gambling problems, 72 were interviewed 12 to 14 months after discharge and it was found that their gambling problems had decreased significantly and 64% of patients had achieved abstinence. (Lesieur and Blume 1991) As Maori gamblers are likely to have co-addiction problems, this treatment option may be effective for some Maori.

The effectiveness of involving spouses or significant others in the treatment of problem gamblers, has been found by researchers to have limited success. This finding is attributed to the dynamics of the families of problem gamblers in that they are often in chaos, and have to cope with the multiple issues problem gamblers create. (Heineman 1992; Steinberg 1993) A whanau treatment approach is therefore likely to have mixed success for Maori. There is a need to provide support and treatment to the significant others affected by problem gambling. This population is larger than that of problem or pathological gamblers.

Cognitive-behavioural therapies have been found to have varying success. Cognitive-behavioural therapies can assist some clients, and desensitisation has been found to be helpful for those who have problems with the gambling machines. (Echeburua, Baez et al. 1996) Desensitisation as a therapeutic intervention for problem gambling has not been reported in New Zealand but as gambling machines are the major
source of problem for the majority of problem gamblers in New Zealand, this form of treatment is worth investigating. (Paton-Simpson, Gruys et al. 2002)

The effectiveness of different drug treatments for problem gambling has been found to have varying results as problem gamblers often have multiple health problems. Depression or anxiety, for example, may be the result of problem gambling or may contribute to a person’s pattern of gambling. Medication can relieve distress but further research is required to identify which drugs are most effective for clients with different health problems. Research should also be part of drug treatment interventions to ensure specific populations or groups are not being used as “guinea pigs” for drug companies. Maori mental health consumers are critical of the use of drug treatment for the management of mental illnesses and ask for a wide range of interventions to be used including rongoa Maori. (Dyall, Bridgman et al. 1999)

Personal counselling to control or manage gambling is generally the main therapeutic option offered in New Zealand. The effectiveness of this treatment option to address gambling for Maori is still unknown. (Sellman, Huriwai et al. 1997; Huriwai, Potiki et al. 1998) Given that boredom, loneliness, looking for excitement and to escape from personal problems are some of the key reasons which increase risk of problem gambling, counselling services may address only the symptoms, not the underlying causes of problem gambling. (Blaszczynski, McConaghy et al. 1990; Abbott and Volberg 2000 (a); Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c))

In Australia the Aboriginal Drug and Alcohol Council is investigating therapeutic treatment options that are effective for combating people’s dependence on gambling machines. (Aboriginal Drug and Alcohol Council 2001) This is an area of research which could have significance for other indigenous populations.

4.3 Maori and Indigenous Populations

4.3.1 Maori Problem Gambling In Relation To Other Indigenous Populations

An overview of the prevalence of problem gambling found in the following different indigenous populations based upon different studies: New Zealand Maori, North Dakota Native Americans, Puerto Rican and Montana Native Americans has been reported. (Abbott and Volberg 1999 (b))
Table 4.1

Current Problem And Probable Pathological Gambling Prevalence Rates: Indigenous Populations

<table>
<thead>
<tr>
<th>Year</th>
<th>Sample</th>
<th>Current Problem</th>
<th>Current Prob/Patho</th>
<th>Current Total%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>NZ Maori</td>
<td>4.6</td>
<td>2.2</td>
<td>6.8</td>
</tr>
<tr>
<td>1992</td>
<td>North Dakota Native Americans</td>
<td>5.8</td>
<td>6.5</td>
<td>12.3</td>
</tr>
<tr>
<td>1997</td>
<td>Puerto Rico</td>
<td>4.4</td>
<td>6.8</td>
<td>11.2</td>
</tr>
<tr>
<td>1998</td>
<td>Montana Native Americans (living on Flathead Reservation)</td>
<td>6.5</td>
<td>2.8</td>
<td>9.3</td>
</tr>
<tr>
<td>1998</td>
<td>Montana Native Americans Household sample</td>
<td>3.8</td>
<td>7.6</td>
<td>11.4</td>
</tr>
</tbody>
</table>

These figures place Maori within an indigenous context and show that Maori experience of current problem gambling is similar to that of First Nations Native Americans, particularly those not living on reservations. In a study with First Nations people in Montana, it has been found that those living on the Flathead Reservation and who were socio-economically better off than those living off the reservation or living on


37 No current estimates on the prevalence of problem and pathological gambling for Maori were produced from the 1999 national New Zealand gambling prevalence study Abbott, M. and R. Volberg (2000 (a)). Taking the pulse on problem gambling and problem gambling in New Zealand: A report on phase one of the New Zealand gaming survey, Wellington, Department of Internal Affairs.
other reservations had a lower rate of problem gambling. (Abbott and Volberg 1999 (b)) This suggests that within an indigenous population there may be sub-cultures which have a different risk with gambling and that those with lower incomes are more likely to be involved in gambling. It is also likely that gambling is positively sanctioned in these marginalized populations, as it can increase income, can change individual, family or tribal status and increased income can contribute to a wider communal social good.

This finding suggests that different hapu; iwi or Maori communities may have different levels of risk depending upon personal incomes, whanau and tribal values, and overall tribal or collective assets. It is a worthwhile area to investigate whether different tribal groups have different risks with gambling.

It appears that Maori share problems with gambling similar to those of Sioux and Chippewa American Indians living in North Dakota. They also have a similar socio-economic profile as these two First Nation populations. It is concluded these indigenous populations are more likely than other population groups where they live, to gamble on a regular basis, spend more on gambling activities, and have significantly higher current and lifetime prevalence rates for problem and pathological gambling. (Abbott M and Volberg 1997; Volberg and Abbott 1997)

It would be interesting to know whether regular participation in gambling from an early age, educational achievement and participation in continuous forms of gambling are the predominant factors which increase the risk of problem gambling in indigenous populations in comparison with cultural or genetic factors. Low economic status, historical trauma, unemployment and lack of social alternatives are also worth investigating to see whether they increase indigenous risk of problem gambling. (Zitzow 1996) Overall, reviewing the similarities between tribes in North Dakota and Maori, Abbott and Volberg conclude that both these indigenous groups are very vulnerable to the development of serious gambling problems. (Volberg 1994; Abbott M and Volberg 1997)

This view is supported also by findings of the first study in America comparing the prevalence of pathological gambling Native Indian and Caucasian who were previously war veterans and were being treated in hospital for alcohol dependence. (Elia and Jacobs 1993) Using the Southern Oaks Gambling Screen for the first time with an
indigenous population, researchers found that the indigenous patients had a higher rate of pathological gambling (32 out of a total of 85) and almost half of all surveyed admitted some difficulty with gambling. The results of this study supports previous comments that alcohol abuse masks problem gambling and unless especially screened for, is invisible. (Elia and Jacobs 1993)

People with alcohol problems have a substantially higher risk of problems with gambling and those hospitalised with substance abuse have an eight to ten times higher chance of being problem gamblers than those of the general population. (Lejoyeux 2000) This has implications for Maori as alcohol abuse or dependence is a major cause or factor for Maori admission to mental health facilities, yet problem gambling is not routinely screened for and as discussed, and has not been considered important in development of mental health services for Maori. (Te Puni Kokiri 1996; Ministry of Health 2002; Ministry of Health 20001)

A study of 149 native problem gamblers on reservations in Alberta, Canada, found that almost half were gambling and drinking together and 10% reported gambling as a way to help remain abstinent suggesting it is used as a coping strategy. Almost three quarters of the problem gamblers were smokers. Researchers involved in this study conclude, "that you can always smell the booze, hear the slurred speech of the drug addict smell the smoker but there are no similar symptoms for gambling". (Kezwer 1996) Only one study has been found which has reported indigenous experience of problem gambling on their life, health status, its effects on other people and the views of First Nation problem gamblers. (Dyall 2002)

Similar results have also been found in two tribes in North Dakota, the Devil’s Lake Sioux and the Turtle Mountain Chippewa, compared with the general population. Both these tribes had recently opened casinos and it was found that the indigenous participants surveyed from these tribal groups had a higher prevalence of problem gambling than that of the general population. There is a need for indigenous research to identify the effects that gambling has on First Nation development, the effects of problem gambling and the opportunity costs if indigenous groups become involved in the ownership and operation of casinos or large scale gambling enterprises. (Cozzetto and Larocque 1996)
This information indicates that Waikato/Tainui alone or with other iwi and Maori groups need to commission ongoing research which identifies the impact of the operation of casino in Hamilton.\textsuperscript{38} Tribal groups, such as Ngai Tahu, which live in areas where four casinos have been approved without any real ongoing involvement in the management of these facilities, could also initiate similar studies to identify the costs and benefits of these establishments and if damage has been found to have occurred, could seek compensation in accordance with the Treaty of Waitangi and Crown responsibilities for protection of Maori. (Durie 1998)

Alongside the identification of the negative effects of gambling on indigenous populations, there are reports of the growing wealth of some Indian tribes, which have become involved in gambling which has changed substantially their socio-economic and position. Gambling for some tribes in America has become described as the "new buffalo", providing new economic independence and a wide range of social and health services. (Anders 1996; Cozzetto and Larocque 1996)

For example, the Mississippi Band of Choctaw Indians in the State of Mississippi has established strategic business partnerships and has substantially reduced Indian unemployment. The tribe also operates the state’s second largest casino, the Silver Star. As a result of these strategic business decisions, the household incomes of those living on the reservation have risen to more than $US24,000, where two decades ago the average income was $US2,500 and unemployment was over 80%. In addition to economic wealth, the tribe has improved their social standing in their state and as a group now have political influence as their investments affect the wealth of Mississippi.\textsuperscript{39} (Bloomberg 2001) This level of wealth and influence is a position that some Maori leaders, acting on behalf of their iwi, would like to achieve through the ownership of a casino. (Short 2002)

\textsuperscript{38} The Health Research Council of New Zealand on behalf of the Problem Gambling Committee has requested proposals to evaluate the Manukau and Waikato Community Action on Gambling Demonstration Projects. The purpose of these projects is to develop an understanding of the impact of gambling activities in these communities, to develop co-ordinated approaches to manage gambling impacts and to develop policies, guidelines and actions on gambling issues Health Research Council (2002). Problem Gambling Research Initiative- Request for Proposals 2002 Evaluation of the Manukau City and Waikato Community Action on Gambling Demonstration Projects. Auckland, Health Research Council.

\textsuperscript{39} It should be noted as a result of the Choctaws' casino business growth the tribe is attracting criticism from religious Mississippians over the morality of gambling.
4.3.2 Maori Women And Problem Gambling In Relation To Tribes In North Dakota, America And In Australia

Maori as a population group have a different profile of problem gambling from that of tribes in North Dakota. (Abbott M and Volberg 1997) In the Maori profile, there is a greater visibility of Maori women who are problem gamblers in comparison with problem gamblers in North Dakota. Indigenous women often experience twice the effects of marginalisation by being both a woman and belonging to an indigenous population group. (Zitzow 1996) Maori should investigate the role that gambling plays in the lives of women and the interventions that would be effective for this group. (Lesieur and Blume 1991; Morrison 1999)

Research in Victoria, Australia, has found that female problem gamblers often report higher levels of loneliness and alienation than do non-gambling women. They are also likely to be involved in social networks where gambling is normative but it is unclear whether the sense of alienation occurs before gambling or arises from it. (Trevorrow and Moore 1998) Normalisation of family gambling is obvious in the description given by New Zealand female prisoners who identified as having had problems with gambling sometime in their life. (Abbott and McKenna 2000 (c)) Gambling for some women may be more than a recreational or social activity. It may be a means of coping with their personal or wider social situation. (Blaszczynski, McConaghy et al. 1990; Abbott and McKenna 2000 (c)) Asking indigenous women to moderate or control their gambling may be pointless unless it is asked why these women need to gamble.

4.3.3 Maori and Aboriginal And Torres Strait Islanders

Although studies have been undertaken of the prevalence of problem gambling among Australian Aboriginal groups the findings that prevalence is high have not been published. (Abbott and Volberg 1999 (b)) It is not possible to compare Maori prevalence of problem gambling with Aboriginal and Torres Strait Islanders. However, like Maori, Aboriginal and Torres Strait Islanders have experienced a high rate of imprisonment and considerable abuse by white settlers, similar to Maori. (Mc Kendrick J. 2000; Durie 2001) There is also concern that gambling machines have been purposefully placed in
Aboriginal communities adding to their existing social and economic problems. (Hunter and Spargo 1988; D'Abbs. P 1998)

There is a need for further analysis of the similarities and differences which exist between Maori and Aboriginal and Torres Strait Islanders in view of the comments Abbott and McKenna's (2000) that the prevalence of problem gambling amongst women prisoners in New Zealand is one of the highest in the world. (Abbott and McKenna 2000 (c))

As New Zealand often models policy developments or uses research which has been undertaken in Australia, the potential of Australian policies or research for Maori needs to be considered carefully. (Dyall 2001) Research in New Zealand with Maori may also be beneficial to Aboriginals and Torres Strait Islanders in considering the effects of widespread gambling opportunities and the development of interventions which may be helpful to indigenous gambling. It has been reported that Native Americans significantly under-use gambling treatment services. This is likely to occur in Australia and already discussed exists in New Zealand. (Volberg 1994)

In Australia, the significant social and economic costs of gambling have lead to community groups protesting against any further expansion of gambling machines in their communities and seeking more effective harm minimisation strategies. (Productivity Commission Report 1999) Similar developments are occurring in New Zealand in communities where there is a significant indigenous population. Maori community leaders such as Ms Maureen Waaka and Ms Matewiki Karehana have contested the placement of gambling machines in local Maori communities, without adequate Maori consultation and community support. (East & Bay Courier Eastern Bays 2001) This

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40 Ms Maureen Waaka has become well known for her views on gambling and has publicly questioned her local iwi (Ngati Whakaue) interest in becoming involved through Pukeroa Oruawhata to establish a casino with another First Nation Indian group. Compulsive Gambling Society of NZ, (1998) (Inc) Proceedings from the National Gambling Treatment Workshop, Novotel Hotel, July, Auckland, Compulsive Gambling Society.

41 It is worthwhile to note that on February 27, 2002 that the Department of Internal Affairs advertised for a Senior Policy Analyst (vacancy:0ZltiZ+1 with a key role to advice on Treaty issues relating to both the Local Government Act and Review of Gaming Issues. Department of Internal Affairs (2002). Effectiveness For Maori Advisory Team. The Dominion. Wellington: 36, 27 February 2002.
experience is important for other indigenous populations, and should be shared so that mutual strategies and research developments can evolve.

Interest in the licensing and regulation of gambling by Maori coincides with Maori challenging the lack of Maori representation as of right on local elected councils and proposals to delegate considerable legislative authority to such bodies without any recognition of the Treaty of Waitangi. (Department of Internal Affairs 2001; Department of Internal Affairs 2001 (b))

Local authorities are being drawn into the debate about gambling in their communities and it has been suggested that they should oversee and distribute profits from local community gambling. Local government involvement in gambling distribution would place elected bodies in the same dilemma as elected governments in that they become dependent on gambling revenue for income revenue. Decentralisation of authority by government to local states or councils has real implications as governments can avoid their responsibilities (both elected and treaty obligations) and place indigenous populations in a vulnerable position. Increasingly it is being recognised that there is a relationship between increased opportunities to gamble and the development of problems with gambling. (Korn 2000)

4.3.4 Pacific Nations

No information is available of the degree of problem gambling in specific indigenous Pacific populations or non-resident in New Zealand other than the information collected in New Zealand which nevertheless has implications for the development of Pacific peoples in this country, and Pacific nations themselves. (Abbott and Volberg 2000 (a)) People of Pacific Island identity have the highest lifetime rate of problem and pathological gambling in New Zealand with 11% of the adult population at risk to problems with gambling. (Abbott and Volberg 2000 (a))

They present for help at a rate above their representation in the New Zealand population and account for just over 6% of callers to the telephone helpline and approximately 5% of counselling clients. When assessed for pathological gambling they have a lower level of severity but spend more on gambling than Maori. (Paton-Simpson, Gruys et al. 2002) Gambling has become part of the culture of people from the Pacific who live in Aotearoa/New Zealand. There is rising concern about the effects of gambling
on people from the Pacific in New Zealand, especially in Auckland and increasingly there is concern about its effects on Pacific housing, Pacific debt and family deprivation.

4.3.5 Indigenous Populations And Co-addictions

Indigenous populations often experience problems with alcohol, which can lead to the development of co-addictions. The few studies cited have identified real risks for indigenous people if gambling is widely available, normalized and accessible and when alcohol is so readily available. (Elia and Jacobs 1993) Although there has been a focus on the effects of alcohol abuse on indigenous populations, no real attention has been devoted to the impact of gambling even though it has been predicted that it has the same potential to create similar levels of distress and loss of human potential. (Dyall 2001) A single focused approach on one issue for an indigenous population is limited and there are often co-addictions involved with gambling.

New Zealand gambling research is extremely important and shows clearly the impact of gambling on an indigenous population with Maori the case study and provides evidence and a clear warning to other indigenous populations to be concerned if their Governments or tribal leaders support increased opportunities for gambling because there are exceptionally high opportunity costs involved. (Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c))

4.4 Summary

Funding and purchasing arrangements for gambling treatment services in New Zealand currently disadvantage Maori, as there is no legal requirement to consult and involve Maori in key decisions or to ensure that services contribute and achieve positive health outcomes for Maori linked to other health and government objectives. Current arrangements support the status quo. Gambling industries have a vested interest in presenting a conservative estimate of problem and pathological gambling in New Zealand as it affects the amount they are required to contribute.

Very often gambling treatment providers have an interest only in the problem gambling aspect of a client's life, ignoring their cultural needs and the context in which gambling takes place. Maori gambling and problem gambling cannot be reduced significantly in New Zealand without support for the positive development of Maori and structural changes to occur in a New Zealand society which recognise the Treaty of
Waitangi and the relationships between: Maori and the Crown, Maori and the Government and Maori and government and non-government bodies established to achieve defined functions.

Current funding arrangements inhibit the development of Maori specific health services, which could accommodate the context and reality of the lives of Maori gamblers and their whanau. At least a third of Maori with gambling problems do not present for help and this figure does not take into account the passive effects of gambling on others. Whanau of Maori problem gamblers under-utilise gambling support services available and no significant funding is available to address the passive and intergenerational effects of gambling on Maori. Proposed new levy arrangements fail to acknowledge that many barriers impede Maori problem gamblers and whanau access and use of gambling treatment services.

Overall, current telephone help and treatment services provide support but they do not achieve the desired outcome for clients as no longer being defined as problem gamblers or being able to abstain from gambling. A mental health approach to addressing problem and pathological gambling is limited and effort is needed to address the broad effects of gambling and problem gambling for Maori in New Zealand.

Problem gambling within an indigenous context shows that Maori do not have the highest rate known but there is a relationship with socio-economic status and different rates of problem and pathological gambling within a specific indigenous population or hapu or iwi. Where casinos are being considered, there is an increased risk of problems, which provides a warning for indigenous populations to be concerned about such developments locally or nationally and to negotiate involvement with the licensing, regulation, monitoring of such establishments or other similar forms of large scale gambling. Alongside this fact, some indigenous populations have improved their socio-economic position and quality of life through being involved in these projects.

Few studies have involved an indigenous population in screening for problem or pathological gambling in different settings and within different populations groups. It has been found that members of an indigenous population who have been assessed as having a defined alcohol abuse problem have an 8 to 10 times higher chance of having a gambling problem than those without this problem. The size and the effects of problem
and pathological gambling are often invisible masked by alcohol misuse or substance abuse and often overlooked as a factor affecting indigenous imprisonment. Gambling by indigenous women is an area for concern and is now visible in the profile of Maori problem gamblers. Co-addictions are a real issue for indigenous populations and so a focused approach on a single issue such as gambling or alcohol has shortcomings.

No information is available to compare and contrast the position of Maori in relation to Aboriginal and Torres Strait Islanders even though gambling policies in New Zealand are often modelled on developments in Australia. Information on the prevalence of Maori problem gambling and Maori utilisation of gambling treatment services is important for Maori and provides a case study of the effects of gambling on a significant size indigenous population which interacts and reacts with the wider New Zealand population. Further work including research is required with, and for, indigenous populations so that indigenous populations can be empowered to be involved in the development of gambling policies, locally, nationally and internationally, share information and develop strategies and interventions which work to reduce gambling-related harm from an indigenous perspective.

The next chapter discusses the need for a wider approach when addressing gambling and problem gambling for Maori, as current interventions have limited success.
Chapter Five:

Public Health and Gambling - Implications for Maori

5.1 Introduction

The purpose of this chapter is to consider the opportunity a public health perspective offers to address the broad effects of gambling-related harm for Maori individuals, whanau and communities. A public health perspective is more than a mental or medical frame, which generally includes diagnosis and treatment of a recognised health issue. Public health includes the provision of a wide range of health and related services covering prevention, early intervention, treatment, rehabilitation and ongoing social support.

This chapter has four sections. The first section is an introduction. Section two discusses the reasons for a public health approach and considers gambling as a social hazard. Models of health promotion and public health interventions are discussed. Models of health promotion, which have been proposed by Maori, and current government policies for Maori health, are reviewed. These provide a context to consider the views of Maori problem gamblers and the solutions or strategies most likely to be supported by different Maori and Crown related interest groups.

Section three of this chapter discusses the importance of policy as a key public health tool to facilitate health change in preventing and reducing the effects of gambling-related harm. The roles of different key government agencies are discussed.

Overall this chapter discusses and summarises the benefits in taking a public health approach to addressing gambling and problem gambling for Maori and considers whether the proposed policies reflected in the Responsible Gambling Bill, now recommended being called the Gambling Act, are likely to make a difference in recognising gambling as an emerging public health issue for Maori. (Select Committee on Government Administration 2002)
5.2 A Public Health Perspective to Reducing Gambling-related harm

5.2.1 Gambling: Social or Health Problem

The intimate relationship between health and politics is demonstrated in the way a problem is defined and in the medicalisation of social issues. When the Gaming Review (2000) was first announced, the then Minister of Internal Affairs considered that problem gambling was not a health issue but a social problem. (Burton 2000) However two years later when decisions were announced that would form the basis of the Responsible Gambling Bill, problem gambling was redefined and seen as a public health issue. (Department of Internal Affairs 2002)

The way in which an issue is defined is important. It influences an individual’s perceptions of that issue, their behaviour and their perceptions of others who may exhibit certain behaviours or who are defined as having a particular health problem. As an example, if an issue is defined as a personal or an individual problem, such as obesity, a person may be considered personally responsible for the condition. Alternatively, if an issue is defined more broadly and is seen as a collective problem affecting the health of populations, then community interventions are likely to focus on the protection of different groups and provision of support for those in need of help. (Disley 1997)

Rosecrance (1985) has developed a theory of how social issues such as gambling are defined and redefined from initially being considered socially deviant, to being legitimated and considered a medical or health issue. (Rosecrance 1985) This theory proposes that social issues often pass through four phases in being defined and redefined as a medical issue. Firstly, the behaviour is considered socially deviant, such as those transmitting HIV/AIDs, and affected individuals seen as a threat to a community’s safety or considered abnormal. (Te Puni Kokiri 1994) Secondly, if the possibility of medical discovery exists, such as the use of a drug, the problem is then looked at differently. The third stage generally involves debate between medical and non-medical interests whether, for example, problem gambling is an addiction or a social problem. Fourthly, the social problem is redefined and institutionalised within a medical framework and recognised as a legitimate medical problem. The process is referred to as the medicalisation of social problems.
It may be redefined again and seen as public health issue, which requires both medical and wider social interventions. As part of this theory, it is proposed that as more people from the middle or upper classes of a society are directly or indirectly affected by a problem, the more likely it is to be considered as a health concern. (Rosecrance 1985; Lloyd 2002) The process of reframing social issues as recognised medical issues is important and helps explain why health issues considered a priority for Maori are often ignored until they affect middle class non Maori or until influential Pakeha advocate on behalf of Maori, exemplified by the effects of infant mortality or Hepatitis B infection. (House of Representatives 1995; Dow 1999; Dyall 2000)

Issues that Maori consider important public health problems are not necessarily the same issues that the Crown or its agents such as the Ministry of Health consider significant. As a consequence, Maori health issues are often ignored or reframed as diseases, risk factors for diseases or the responsibility of other agencies. (Dow 1999)

For example, when Maori present with health problems such as unemployment, substandard housing, pollution of the environment, or poor quality education or poverty, these matters are defined by the Crown and health agencies as the social determinants of health. (National Health Committee 1998; Ministry of Health 2001) They are then considered to be factors, which can cause such health problems as diabetes, heart disease, asthma or sudden infant death syndrome. While recognition of social-economic determinants of health is increasingly becoming important in New Zealand, in practice, the health sector remains influenced by the dominance of medicine. It is still largely centred on the treatment of diseases or reduction of risk factors, rather acknowledging the primary reasons which affect the health of Maori. (Crampton, Salmond et al. 2000; Durie 2001)

Reframing Maori issues by the medical and health professionals currently supports their self-interests. The health sector’s budget is protected and justifies continual investment using a medical or related paradigm, avoids the need for structural change and redistribution of power within New Zealand society, and places responsibility on Maori to negotiate with other agencies and the Government to redress their issues of concern, such as using the Waitangi Tribunal to resolve environmental issues or encourage the Government to address the state of Maori employment or housing. The Ministry of
Health and the health professionals have a powerful role influencing the definition of issues in New Zealand and determine which issues are on the health agenda at any point in time. In performing this role, consciously or unconsciously, the health sector acts for the Crown as an agency of social control of Maori. (Dow 1999; National Health Committee 2002)

Further research in this area is needed to elucidate the social dynamics which exist within New Zealand society, like the previous Government’s decision to change its focus on closing the gaps between Maori and non Maori to developing policies which assist all low income groups including new migrants. (Department of Social Welfare 1986; Pomare, Tutengaehe et al. 1992; O’Donoghue, Howden-Chapman et al. 2000; Signal and Durham 2000) Social dynamic issues are now important as the demographic and ethnic profile of New Zealand is changing rapidly. (Collins 2002)

5.2.2 Gambling and Problem Gambling: A Public and Mental Health Issue

The fact that problem gambling is now on the New Zealand health agenda suggests that middle class New Zealanders are increasingly being affected in some way by gambling and problem gambling. This is evident in the growing concern about the size and effects of problem gambling in New Zealand. (Department of Internal Affairs 2001) The focus to date has been on the development of generic specialist gambling treatment services for people who have a pathological gambling problem and limited support for people who are affected by the behaviour of problem gamblers. (Ministry of Health 1996; Paton-Simpson, Gruys et al. 2001)

This perspective has both strengths and weaknesses. It has legitimated problem gambling as a mental health problem, has provided the rationale for the development of specialist gambling treatment services in New Zealand, has enabled specific mental health services, such as alcohol and drug services, to work in partnership with specialist gambling treatment services, has provided assistance to clients with gambling problems and has helped problem gamblers to see themselves not as social deviants but as people with a legitimate mental health problem who are entitled to health care and support (Ministry of Health 1996).
On the other hand, it has overlooked the effects of normalisation of gambling and has allowed the focus to be placed on the problem gambler while ignoring the impact of problem gambling on other people. It has overlooked the effects of problem gambling on the quality of life of families, communities and specific population groups, has failed to recognise the significant effects of gambling and imprisonment and ignored the effects of stigmatisation associated with having a mental health problem. A national mental health destigmatisation program has been funded by the health sector to address the discrimination which mental health consumers experience, but problem gamblers have not been identified as a key group in shaping this initiative to assist those with problems with gambling. (Health Funding Authority 1999)

A mental health framework has also allowed successive governments to expand opportunities for legalised gambling and to avoid seeing normalised gambling as a major contributor to problem gambling. (Kezwer 1996; Korn 2000) This is evident in the Responsible Gambling Bill which has a limited purpose and no guiding principles to develop or implement gambling policies. (Dyall 2002)

Problem gambling, it will be recalled, is not a new issue for Maori. Prior to the introduction of casinos and widespread non-casino gambling machines in the community, Maori were identified as having two to three times the risk of problem gambling as were non Maori. (Abbott and Volberg 1991; Abbott and Volberg 2000 (a)) A mental health frame has enabled the situation of Maori to become totally invisible with a focus only on those who present with obvious problems or who call for help. The significant impact on others has been ignored and the Government has been able to develop gambling policies and structural arrangements that exclude Maori from being involved in key gambling policy decisions.

A mental health frame therefore has limitations, especially for marginalised indigenous populations, as it ignores their position in their own country, history of contact with settlers and social, economic, cultural and political position.

5.2.3 Advantages of A Public Health Approach

A public health perspective offers the following advantages: a broader health perspective, it allows for a wider range of clinical and prevention interventions, it sees
people within a social context rather than focusing on individuals and allows exploration of the influences of cultural, family and community values on behaviour. It also considers how systems, organisations and political groups act and react to each other allowing analysis and examination of the interactions between and across different public policies, such as education, employment, taxation, tourism and Maori development policies. (Korn and Shaffer 2000; Durie 2001; Shaffer and Korn 2002)

Further, it allows health behaviour to be seen and managed along and within a continuum so that areas of risk, resiliency, protective factors and conditions can be identified and explored. A public health perspective allows for the development of an integrated approach where a wide range of relationships and interventions can be considered and implemented within a system. The focus is on the interaction of systems, processes and organisations, which can be changed or managed by a wide range of different interventions in or outside the health system. (Durie 2001)

The public health approach recognises that social systems are not static but are dynamic and require comprehensive policies and monitoring arrangements, guided by overarching principles, to manage competing and conflicting interests aimed at reducing harm. (Markland 2002) A public health approach provides an opportunity to ask new research questions, to develop new interventions for different groups and for public health and indigenous researchers to become actively involved in policy issues.

A public health approach is not value free but is generally guided by implicit or explicit values and beliefs of the quality of life people should enjoy within their society. It focuses on people, generally as members of different population groups, but is also concerned about the wellbeing of individuals. (Low 2000; Ministry of Health 2002) Overall, a public health perspective is like a prism. It allows an issue to be seen from many different angles and for groups which may have been excluded in the past to be included, and for their concerns to be placed on the policy agenda so that the full impact of a health problem can be considered.

As stated by Skinner:

*The enduring value of a public health perspective is that it applies different 'lenses' for understanding gambling behaviour, analysing its benefits and costs, as well as identifying strategies for action.* (Skinner 1999, pg286)
The Ministry of Health in New Zealand has now indicated support for a public health approach to address problem gambling. (Ministry of Health 2002) This is over a decade since the results from the first New Zealand prevalence gambling study carried out in 1991 became available, almost 10 years after the Canadian Public Health Association identified gambling as a public health issue and after persistent advocacy by the New Zealand Public Health Association.

With recognition that gambling is an emerging health issue it is now appropriate to re-frame problem gambling from a mental health perspective and consider the advantages of taking a public health approach for Maori. (Dyall 2002) Bringing a public health perspective to gambling in New Zealand opens up and creates new opportunities for Maori. It gives tangata whenua a legitimate role to be involved in the development and implementation of gambling policy, it allows for the Treaty of Waitangi to be included in policy development, for Maori to receive a fair share of benefits from legalised gambling in New Zealand, for disparities between Maori and non Maori to be addressed, for gambling revenue to be invested in Maori and iwi development, and for recognition that problem gambling is a symptom of under development and cultural alienation and that gambling impacts on Maori, hapu, iwi and overall New Zealand health development. (Te Puni Kokiri 1996; Dyall 1998; O’Donoghue, Howden-Chapman et al. 2000; Dyall 2002; Dyall and Morrison 2002)

5.2.4 Limitations of A Public Health Approach

Using public health approach to address gambling and problem gambling has limitations. (Korn and Shaffer 2000) It can raise new ethical issues which challenge accepted values, for example, whether New Zealand’s cultural, sport and community infrastructures should be significantly dependent upon the proceeds of gambling or linked to a casino.

Backlash to reframing gambling as a public health issue is becoming visible in New Zealand as gambling operators such as the New Zealand Lotteries Commission seek media attention to highlight this agency’s declining profits and the impact this will have on community beneficiaries including key government cultural and sporting bodies which are required by statute to receive funding from this body. (Alley 2002) The Government has received a warning from operators of non-casino gambling machines that it should
not impose severe restrictions as it “may kill the golden goose that now lays the golden egg”, which now provides significant funding to the public purse and to community groups. (NZ Press Association 2002)

An analysis of the profits distributed from four of the six largest non-casino gambling trusts in 2001, revealed that funds from community gambling are not fairly distributed, 60% were allocated to sport, 30% to the community, 20% to education and 10% to other activities. Almost all of the funding allocated went to sporting activities and in particular rugby, confirming the links between hotels and sports groups, and male dominance in the allocation of funds for community benefit. (NZ Coalition For Gambling Reform 2002) Similar findings have been found by previous research. (Reid 1996)

In opposition to the normalisation of gambling, there is growing concern that key community establishments, such as a proposed conference centre in Auckland linked to a casino, should not be supported by Auckland City Council funds. It is considered this decision would distort community values, undermine the image of the city and would give the wrong impression to locals and visitors that casino gambling is integral part of living in Auckland. (Sinclair 2002) Perhaps local opposition has influenced the Auckland City Council to decline funding to Skycity, although it has been announced that this organisation will proceed with plans for a hotel and conference facility as part of its business portfolio.

The debate around normalisation of gambling is becoming more evident in other communities and settings in New Zealand, such as in South Auckland. Here there is growing concern for the state of health and wellbeing of Maori and Pacific families. This relates to the numbers of Maori and Pacific adults who now play the gambling machines regularly, the effects of household income being spent on gambling and the increasing number of children who are being left outside gambling venues without supervision.

To counteract community concerns of the growth of non-casino gambling machines in the South Auckland community, benefits are being promoted, such as the funding for a children’s playground in the city, which just happens to be outside a gaming bar. The Mayor of Manukau City considers that gambling is a serious public health issue in Manukau and believes that local authorities should have the statutory authority to
restrict the number of machines and gaming outlets in communities (Television Program Channel One, Sunday 1 June 2002).

The Responsible Gambling Bill proposes that local authorities be required to develop a plan for the siting of gambling machines and under the new local government legislation local authorities will have wide power to establish bylaws for their communities which promote their social, cultural and environmental wellbeing. (Select Committee on Government Administration 2002) These proposals relieve the Government from taking local gambling decisions and shift decision-making responsibility to local communities and local politicians.

This will require communities to identify the views of different populations and groups regarding gambling and problem gambling and the social, economic and cultural costs of gambling and options to replace or reduce dependence on gambling. (Dyall and Morrison 2002; Robinson 2002; Shaffer and Korn 2002)

Increasingly stakeholders are working together to promote the perceived benefits of gambling and alcohol, playing down their social and economic costs. (Alcohol Advisory Council of New Zealand 2002) As a consequence of these associations, prominent community and sport leaders are now reluctant to speak out about the ethics of receiving funds from gambling or alcohol as they fear they will be blacklisted or that their sport will be disadvantaged. (Mahony 2002)

Goodman suggests that the establishment of a casino in any community should be carefully evaluated. He advocates an opportunity cost approach to considering the benefits of gambling, for in the medium to long term a casino may decrease the social and economic wealth of a community, even though some groups such as First Nation tribes may receive real financial benefit. (Goodman 1995; Productivity Commission Report 1999) A similar approach needs to be developed in New Zealand as the so called “community benefit”, may be less than social, economic or cultural costs received in local communities.

It is reported that New Zealand has one of the highest concentrations of gaming machines per head of population with one machine for every 158 New Zealanders. Machines are not distributed evenly. In some areas such as the Otorohanga District, which has a high concentration of Maori, the number is one machine per 50 people. (New
Zealand Press Association 2002) To allay public concern regarding the number of gambling machines and distribution in New Zealand, the Gaming Machine Association has stated that although New Zealand has one machine per 158 people, this figure is not excessive compared with other countries such as Australia, which has one machine per 100 people. (New Zealand Press Association 2002(b))

When public health advocates challenge the normalisation of gambling they are likely to be labelled as moralistic, restricting people’s fun and limiting individuals’ personal freedom. (Grant 2002) Gambling organisations and groups which receive gambling funding are likely to promote the view that gambling helps reduce personal stress, provides legitimate leisure and entertainment for adults, provides local employment and supports economic development. (Shaffer and Korn 2002)

To counteract public health views on the effects of normalisation of gambling, gambling interest groups like the liquor industry are likely to use research to support their position. For example, red wine has been promoted as an intervention to reduce individual risk of coronary heart disease by the alcohol lobby. Beneficial research findings are used by the alcohol industry to promote liberal policies governing the sale and licensing of alcohol. (Casswell 1997) Research is needed in New Zealand on how gambling and alcohol is normalised in various communities and on their sale, licensing and marketing.

Maori interest groups are expected to resist reframing gambling as a public health issue. This has been evident in the presentation of different Maori views as part of the Review of Gaming. (Cabinet Policy Committee 2001) In common with other groups, Maori have been concerned that without gambling funding, many of their sport and cultural groups will struggle and marae developments will be limited. (Dyall 2002)

Challenging the normalisation of gambling within Maori whanau and Maori communities is also likely to affect the roles and status of individuals within their social networks. For example, gambling provides a means for some Maori individuals and groups to increase their mana (prestige) as significant resources can be contributed to a whanau or community initiative.

Individuals can earn significant status by winning a jackpot from gambling machines or from being a Lotto winner. Such people are often sought out within their
whanau or community to help solve financial problems or provide funding for business ventures. Lotto jackpot winners often lose or spend most of their winnings within a short time frame.

There are parallels between tribal groups receiving significant assets from the settlement of Treaty of Waitangi grievances and from gambling. Without careful management of funds from the settlement of Treaty of Waitangi grievances, money may be won or lost from risky business investments. This pattern of investment has already occurred in relation to Waikato Tainui investments, resulting in considerable financial losses, and creating conflict amongst tribal leaders and disillusionment amongst beneficiaries who see they will receive little personal benefit from tribal assets. (Gardiner 2002)

To minimise Maori opposition to the normalisation of gambling, the Government may re-consider its gambling policy and its relationship with Maori and offer a proportion of the gambling sector to tangata whenua such as a defined quota of non-casino gambling machines. These licences could then be owned by Maori community groups and if not used, sold to other groups similar to the allocation of fish stocks to Maori by the Crown. When casino licences are reviewed or changed under the new proposed Gambling Commission, licence holders may also be required to work in partnership with Maori. This may minimise opposition to the continuation or extension of casinos and other forms of commercialised and community gambling.

5.2.5 A Public Health Approach Requires Leadership and Effective Use of Research

Changing the locus of a social or health issue can generate considerable conflict as it affects political influence and control of resources. (Committee on Problem Gambling Management 1998; Stockdale 1998) Although the PGC has endorsed a public health approach to gambling, this position is likely to create conflict amongst stakeholders, because there are different views on the role and place of gambling in New Zealand, the size and effects of gambling-related harm and how different population groups should address problem gambling.

For example, the Maori Reference Group on Gambling, has challenged the Public Health Section of the Ministry of Health, on the limitations of a harm minimisation
approach to addressing problem gambling for Maori. (Maori Reference Group on Gambling 2002) To minimise loss of influence, the PGC has proposed that an advisory body similar to itself should be established by the Government to provide advice on gambling so that there is a coordinated view amongst interest groups on gambling, especially between gambling providers and gambling treatment services. (Gerdelan and Parton 2002)

In reframing gambling in New Zealand as a public health problem, it is predicted that similar developments that have occurred in reorienting efforts to reduce alcohol abuse, tobacco consumption and the misuse of drugs, will occur in relation to gambling. (Ministry of Health 1998) Many lessons learnt from these other health issues can be applied to gambling and problem gambling, so that a coordinated public health strategy is implemented supported by appropriate legislation. For example, public health advocates need to be aware of the importance of working with policy makers such as those officials within the Department of Internal Affairs and Ministry of Health, to ensure that appropriate research information is used effectively to develop a public health approach to gambling. (Casswell, Stewart et al. 1993)

Further, there is a need for public health advocates to concur on research findings so that conflict between interest groups can be avoided. (Shaffer, Dickerson et al. 2001) Differences in views amongst public health advocates can lead to ineffective policy decisions, for example, the decision by the Advertising Standards Association of New Zealand to adopt a self-regulation code of standards governing advertising of alcohol. While this decision supports the interests of the alcohol industry it limits protection of the public, particularly specific population groups, such as young people and Maori, who are vulnerable to the effects of the normalisation of alcohol. (Casswell, Stewart et al. 1993)

Agreed standards for advertising gambling have not yet developed. Originally, the Government proposed that standards should be developed and overseas gambling sites should not be advertised in New Zealand. (Select Committee on Government Administration 2002, (clause 11)) SkyCity has challenged the policy, as it considers it limits its ability to offer package trips to New Zealanders, which includes a visit to their casino in Adelaide. It has been proposed instead that a new clause be included in the legislation allowing for the promotion of an overseas gambling site where it is incidental
to the principal purpose of the advertisement. (Dann 2002; Maori Reference Group on Gambling 2002; Select Committee on Government Administration 2002.)

Promotion of gambling is a significant contributor to advertising revenue in New Zealand and if there were restrictions imposed this would certainly affect the income of advertising and media agencies. (New Zealand Press Association 2002) Lotto is advertised in many different ways and as with alcohol, gambling researchers will be encouraged to present evidence for or against the harm of gambling advertising in different settings, and whether gambling advertising promotes normalisation and consumption of different forms of gambling. (Leach 2002)

Currently gambling is advertised in New Zealand on television, associated with sports games and community events, on local buses and bus shelters, on billboards and in local newspapers. Gambling promoters will argue that the promotion of gambling through advertising does not increase gambling-related harm and gambling providers should be able to continue to advertise their products, venues and sponsor sport and community activities as do alcohol companies.

There is considerable opposition in New Zealand, from the alcohol industry to further restriction in advertising. They consider that the role of the Health Sponsorship Council in New Zealand should not be expanded to include funding for the replacement of alcohol sponsorship similar to tobacco. Advertising is a key mechanism for consumers to develop brand recognition and the acceptance of alcohol in different settings and it influences consumers' alcohol choices. (Alcohol Advisory Council of New Zealand 2002) The same is true of advertisements for gambling.

There are real similarities between the Sale of Liquor Act 1989 and the Responsible Gambling Bill (2002). If the latter becomes legislation it will provide the framework for licensing, regulation of gambling and the development of host responsibility requirements for gambling operators. Durie suggests with such similarities between the Sale of Liquor Act 1989, the measures contained within the Responsible Gambling Bill will not reduce the risk of problem gambling for Maori. (Durie 2001) In response to new legislation, Maori may develop their own patterns of gambling to avoid host responsibility requirements, e.g. if Maori problem gamblers are
banned from gaming or TAB bars for playing non-casino gambling machines, they may turn to internet gambling.

Using a public health approach to gambling is a complex matter and requires public health advocates to have a broad understanding of both the complexities of the social and economic environments in which they live and the behaviour of different communities, as well as specialist skills to assist groups, communities and the public to make informed decisions. (Casswell, Stewart et al. 1993; Laugesen and Swinburn 2000)

For any public health strategy to be successful in reducing gambling-related harm in New Zealand, the position and involvement of Maori must be a key focus. Otherwise it is possible that health changes will occur for the total New Zealand population generally, but no real change will occur for Maori. (Dow 1999)

5.3 Frameworks and Approaches For A Public Health Perspective

5.3.1 Risk Management

To recognise that diverse views related to gambling public health advocates could adopt a set of principles which have been developed to assess and to determine risk. They are: the probability of harm, the seriousness of potential harm, the degree of reversibility of harm, the impact on others, the certainty of intervention outcome, the degree of choice promoted, the intrusiveness of the proposed intervention and the administrative cost of the intervention. (Dworkin 1983)

These principles can be used to justify or restrict gambling developments. Communities, for example, could use these questions to decide whether current and additional licences for non-casino gambling machines should be approved or rejected or whether proposed harm intervention strategies will reduce risk. In assessing risk and the value of an intervention the interaction and reaction amongst policy decisions must be considered. (Durie 2001; Dyall 2001) The Government has proposed, as part of responsible gambling, that there should be a limit of nine gaming machines on new sites, local communities should be consulted and be able to veto new applications, and each territorial local authority will be required to develop a venue policy for gambling machines by 1 January 2003, although this date is now extended as legislation is still in the process of being approved. (Select Committee on Government Administration
It is now recommended due to Maori advocacy that Maori should be consulted along with other groups regarding such decisions. (Select Committee on Government Administration 2002, (clause 91A)) In principle, responsible gambling proposals support community involvement in local gambling policy but without a clear agreed framework for decision-making amongst key stakeholders, these legislative proposals may have minimal impact, especially in communities where there is significant normalised gambling and a sense of alienation or polarisation of views on gambling. (Department of Internal Affairs 2001)

In making a decision to remove machines or decline licences, for example, community leaders and public health advocates are likely to be challenged as being paternalistic, by those who benefit directly or indirectly from the operation of the machines (Television program, Channel One Sunday 1 June 2002). Ownership, administration and rental of space for gambling machines is now big business as owners of pubs and clubs can legally charge up $150 per week rental for each machine and can also advertise machines.

In the future, however, they will not be able to offer incentives to community benefit grant recipients to patronise their premises, such as, offering grants to sports and community groups which patronise their establishments. (Select Committee on Government Administration 2002) This will be difficult to monitor.

**5.3.2 Maori Assessment of Risk**

Maori have defined values and beliefs and have used them to develop their own principles for assessing and managing social risk such as the four-part framework, which has been developed to assist Maori assess environmental and cultural risks and to have input into resource decisions under the Resource Management Act 1991. (Matunga 1994) This framework uses the following principles: respecting and protecting all taonga (treasures), recognising Maori tikanga (customs and values), recognising the mauri (life force) of all objects and kaitiakitanga (guardianship) responsibilities of mana whenua and tangata whenua. These principles, although developed for protecting the physical environment, can also be applied to protecting social interests, and in particular, safeguarding the health and wellbeing of current and future generations of Maori.
Any social framework designed to manage risk for Maori must also include recognition of the Treaty of Waitangi, provide opportunities for Maori whanau, hapu and iwi development and support Maori and tribal expression and achievement of tino rangatiratanga. (Durie 1998)

5.3.3 Gambling Recognition as A Social Hazard

Gambling can be considered a social hazard from a public and environmental health perspective. (Dyall 2001; Shaffer and Korn 2002) The term “hazard” is used broadly to recognise the risk or “gamble” that is taken when new substances or activities are introduced, as it is unknown how they will act, react, interact or create changes within a social or physical system. (Shaffer and Korn 2002) In New Zealand, no new biological or chemical hazards can be introduced without an assessment of the impact each new hazard may have on New Zealand’s unique environment.

Legally, new biological and chemical hazards can be introduced into New Zealand’s environment only under the Hazardous Substances New Organisms Act 1996 (HSNO). This legislation provides an advisory and a risk management framework, governed by a defined purpose.

*To promote the environment and the health and safety of people and communities, by preventing or managing the adverse effects of hazardous substances and new organisms (Section 4) (HSNO Act 1996).*

The Act has three overarching principles: to protect New Zealand’s ecosystem, the public’s health, and to maintain and enhance the capacity of people and communities to provide for their own economic, social and cultural wellbeing and for the reasonably foreseeable needs of future generations. There is a statutory requirement to recognise the position of Maori, the right of Maori to protect their physical environment and all other taonga (treasures) and to recognise the principles of the Treaty of Waitangi when undertaking any activity related to this Act (Sections 5, 6, 8) (HSNO Act).

This Act provides an ideal legislative framework, which should also be in place to protect Maori and other New Zealanders from the introduction of social hazards such as gambling. No such legal structure exists for the introduction and management of social hazards in New Zealand. Instead each substance or activity that is known to create social harm, such as alcohol, tobacco or cannabis, is considered separately, resulting in diverse
legislation with no clear or connecting purposes, principles or framework for assessing and managing social risk.

Such an approach creates confusion as there are no agreed set of values which all New Zealanders hold as important and opens the way for political parties and interest groups to promote their views for political or economic ends, such as the differing views of the release genetic engineered organisms into the environment. (Randerson 2002)

There is a real need in New Zealand for gambling to be considered as a social hazard. Before any gambling policies are introduced which support expansion of gambling, or enable new gambling products to be introduced such as new interactive forms of gambling, video gambling or telephone text gambling, these should be considered by an independent body to assess likely effects alone and in combination with other social hazards, such as alcohol and also to consider whether the product is safe and if not what conditions should be attached to ensure gambling-related harm is minimised. (Durie 2001)

The Responsible Gambling Bill (2002) has been carefully framed to protect the interests of gambling industries by defining specific gambling areas where each industry can expand, excluding Maori and Treaty of Waitangi issues, proposing that legalized gambling is a community benefit and failing to establish an independent body to oversee the introduction, management and monitoring of current and new forms of gambling similar to that set up under the Environmental Risk Management Authority. (Tenbensel and Gauld 2001; Curtis and Wilson 2002) The Environmental Risk Management Authority is an independent body that has a statutory responsibility to manage and monitor the introduction of new biological and chemical hazards and recently it has been criticized for restricting economic growth in the New Zealand.

No similar role has been proposed for the new Gambling Commission, which currently has a limited statutory function. It can review only existing casino licences, agreements made between licence holders able to operate a casino and gambling machines applications which have been declined by the Secretary of the Department of Internal Affairs and exercise a limited advisory role despite numerous submissions to the Select Committee on Government Administration for this body to have a wide public health, and licensing role. (Select Committee on Government Administration 2002,
No provisions have been made for this body to provide independent advice to the Government, to be involved in community education and community development, to be accountable for reducing gambling-related harm in New Zealand or to support the development of Maori so that tangata whenua does not become dependent upon gambling. Nor is there provision for this body to be able to commission independent research so that information is available for informed policy development and the implementation of public health interventions which are likely to be effective for specific populations, communities and groups at risk to the effects of gambling-related harm. (Dyall 2002)

Any Gambling Commission established to oversee gambling in New Zealand should be required to address the current effects of gambling on Maori, to include Maori representation on the decision making body, to support Maori development and to implement the principles of the Treaty of Waitangi in all activities. (Dyall 2001) The Select Committee on Government Administration, reporting to Parliament (November 2002) has rejected this view as it considers that sectional interests may capture this body. It has instead recommended that members appointed to the Gambling Commission should be on the basis of their "knowledge, experience and expertise of potential gambling commissioners" rather than "experience and skills". (Select Committee on Government Administration 2002, (clause 196 (1))

The Select Committee on Government Administration responsible for reporting back to Parliament on new gambling legislation has also recommended that the title of the Bill should change to focus on gambling, in particular the licensing and regulation of gambling with harm minimisation arrangements an integral part. (Select Committee on Government Administration 2002) Another reframing has occurred with the focus on responsible gambling becoming invisible and subsumed as part of gambling licensing.

5.3.4 Epidemiological Triangle

Public health is a unique discipline in that it has available a range of skills, theories and frameworks which can be used to create and changes which improve peoples' health or reduce health risk. Epidemiology is a key tool, which is used in defining and monitoring the size of a public health issue, such as the prevalence of problem or pathological gambling. It is:
The study of the distribution and determinants of health related states or events in specified populations and the application of this study to the control of health problems (Last 1995, pg 55).

Epidemiology can also be used as a framework for deciding where interventions can best occurs. For example, the epidemiological triangle has been used as a model to explore the interactions and interrelationships that exist with the host in this case the (the gambler), the vector (money or goods able to be wagered) the environment (including the influence of family, culture and wider environment) and the agent (defined in terms of the “action from gambling”). (Politzer, Yesalis et al. 1992; Shaffer and Korn 2002)

In this model it is suggested that the “host,” the gambler becomes fixed on the action of gambling such as playing non-casino gambling machines by using or requiring money which then creates a response such as excitement and this response is supported by the wider social environment through gambling advertising, gambling prizes and rewards for winning, placement of gambling activities and the legal age of being able to play different forms of gambling. These activities alone and together support the normalisation and expansion of current and new forms of gambling.

Using this model as a framework, public health interventions can be introduced at any point or part of the triangle and a wide range of interventions may be implemented. The model allows for an issue to be considered from either a micro or macro perspective allowing focus on individuals, families, communities and society as a whole. The model also recognises that others shape the behaviours of individuals, so within a family there are likely to be others added to which, are intergenerational effects. (Politzer, Yesalis et al. 1992)

This model also recognises that any changes within the system can create positive or adverse effects. It challenges public health advocates to explore all of the variables within the system, their interactions and ongoing research as each new introduced or altered variable is potentially hazardous.

Using this model it has been shown that increased pathological gambling is closely related to the expansion of legalized gambling and there is a relationship between access to gambling and consumption and development of problems with gambling. (Politzer, Yesalis et al. 1992; Kezwer 1996; Korn 2000) Abbott and Volberg also
proposed a similar hypothesis in 1991, that problem gambling in New Zealand would increase with new opportunities to gamble, such as access to casinos and non-casino gambling machines.

This hypothesis was not verified in the 1999 study and has led to Abbott and Volberg to conclude that, although problem gambling in New Zealand has not increased, gamblers and problem gamblers have changed their pattern of behaviour with more gamblers playing different forms of gambling, more spending on gambling and more women are developing problems with gambling. (Abbott and Volberg 2000 (a); Abbott 2001)

The epidemiological triangle model shows that any sustainable health change will require interventions at one or more points of the triangle and this may include, for example, counselling, restriction of access to different forms of gambling and a restriction on advertising.

For Maori, the epidemiological model provides for a wide range of interventions, at various parts of the triangle and at different levels. For example, at the population or tribal level, a focus on whanau connections and development is required and at an individual level, provision of counselling and social support which recognises the uniqueness of each person and their personal journey through life. Specific interventions should be developed for special Maori population groups, which have been identified as particularly vulnerable to gambling such as youth or women and older Maori. (Abbott and Volberg 2000 (a); Durie 2001; Young 2002)

5.3.5 Harm Minimisation

Harm minimisation has been defined as:

A comprehensive approach integrating supply control, demand reduction and problem prevention strategies. It takes into account the interaction of the person, their environment and the host in the development of problems and their associated harms (Alcohol Advisory Committee of New Zealand 1998)

Although this definition is proposed as a summary of the philosophy and strategy for harm minimisation, for example reducing alcohol or tobacco abuse, harm
interventions are often focused at changing the "host", in which individuals are challenged to change their behaviour, such to quit smoking, or to drink moderately.

By taking this approach individuals can be seen by others to be at fault as they have not changed or controlled their behaviour adequately. The focus on the “host” allows key stakeholders such as the Government and those who sell or market harmful products the opportunity to discredit individuals for not taking greater responsibility for their behaviour, while ignoring the social and cultural environment which they as stakeholders have helped to create. The cause of health problems is thus defined is a result of an individual’s lack of self-discipline or control. Problem gamblers are often as categorised as having a “compulsive impulsive” disorder by this means.

Focusing on the “host” denies the possibility of a wide range of interventions which could be introduced into the environment or in association with the agent. Interventions at the host, agent or the environment level are generally politically determined after balancing competing interests and decisions reflect the values and beliefs of those who have political influence. (Rosecrance 1985)

Taking the focus off the individual would encourage groups, communities, society and elected governments to take greater responsibility for the personal and social circumstances of individuals. It also allows groups to be creative in their responses and to consider alternative options which could be used in their personal or local situation, such as requesting the removal of gambling machines from local pubs and clubs or boycotting local gambling venues.

The Government has defined “harm” broadly in the Responsible Gambling Bill. (See chapter two). However, in terms of funding arrangements planned, the definition of harm is not reflected in the proposed problem gambling formula levy. (Select Committee on Government Administration 2002,(clause 286 &287)) Current funding arrangements focus only on the problem gambler and the proportion of people anticipated to seek help. No funding is required to be paid by gambling operators to address the broad effects of gambling-related harm within the community, across generations or for individuals or groups unable to present for help, such as those imprisoned or in mental health or related services. (Dyall 2002)
Gambling harm minimisation interventions planned for introduction in New Zealand could victimise and isolate the problem gambler as being socially deviant rather than focusing attention on the affected others and the effects of the normalisation of gambling in New Zealand society. Consequently, proposed harm minimisation proposals may not reduce gambling-related harm but instead encourage problem gamblers to change their behaviour and participate in forms of gambling which are illegal, unregulated or not defined as gambling.

Responsible gambling or harm minimisation proposals currently outlined in the proposed legislation define the legal age of participation in different forms of gambling, require casino and gambling machine licence holders to develop and display their policies for identifying problem gamblers, require operators of gambling machine venues to identify problem gamblers on their premises and require operators to ban such individuals from entering their premises for up to three years. Breaking the ban can result in a legal fine and a criminal offence. The Government has announced that it will develop harm minimisation regulations including such matters as limiting the maximum prize limit for different forms of gambling and the frequency which different games can be played and setting out the information which must be provided to players. (Select Committee on Government Administration 2002) Although there is recognition of the need to define problem gambling as a public health issue in New Zealand, emphasis is still placed on changing the behaviours of gamblers and modifying only slightly the gambling environment and the agent. No interventions or statutory requirements are required which change New Zealanders’ views neither on gambling nor to review the long-term consequences of dependency upon gambling revenue to provide essential community, sport and social services in New Zealand.

The legislation implicitly supports the status quo environment of expansion and normalisation of gambling. All community and sports groups dependent upon gambling funding will require increasing resources to expand or meet rising costs of providing their services. As stakeholders they are likely to oppose restrictions on the growth and siting of non-casino gambling machines, limitations on the New Zealand Lotteries Commission outlets or gambling products or any harm minimisation regulations that reduce income.
Harm minimisation, as a public health approach, is likely to have limited success for Maori. It does not recognise the formal ongoing Treaty of Waitangi relationship that exists between Maori and the Crown, the ongoing effects of colonalisation and globalisation on Maori and the intergenerational effects of being Maori within a whanau and within New Zealand. (Durie 1998; Durie 2001) The Government proposed statutory defined definition of gambling harm however, gives Maori considerable leverage to identify Maori gambling-related harm and to seek financial compensation possibly through the Waitangi Tribunal. (Moran 2002)

5.3.6 Maori Public Health Approaches

Maori have traditional public health concepts, which they can use in relation to the epidemiological triangle to protect themselves from gambling-related harm. Tribal and Maori groups, for example, can impose a rahui (ban) on individuals visiting their local casino or gaming venue site for a specified period of time. (Durie 1998) The concept of rahui, can be extended further by a tribe, a community or Maori groups specifically banning individuals in from visiting a local casino or gambling machine site invoking the Trespass Act 1980. (Select Committee on Government Administration 2002, (clause 279)) Maori who are dying could give an “ohaki”, (speech) requesting that gambling be minimised in Maori life such as having gambling free marae.

Maori can also use the concepts of tapu (sacred) and noa (clean) to warn of risk, such as by declaring gambling venues as unsafe. This then gives Maori the opportunity to define the kaitiakitanga requirements which need to be in place to ensure Maori are safe and protected from gambling such as by empowering Maori wardens or other designated personnel to remove Maori from specific gambling venues. (Dyall and Morrison 2002)

Pukeroa Oruawhata Holdings Ltd, for example, has already advocated that it would take this approach if it were given a licence to operate a casino in Rotorua. This body considers that it has a responsibility to protect local Maori by banning tribal and associated members from gambling at their local casino. (Pukeroa Oruawhata Holdings Ltd 2002) This may be considered a breach of human rights but some countries have denied locals from visiting casino, allowing only those with a foreign passport to be able to gamble and casino and TAB workers in New Zealand are not allowed to gamble where they work.
Maori leaders could also take an active role in encouraging Maori organisations and community groups to use funding other than gambling proceeds to secure self sufficiency or greater economic independence. Maori models of health promotion can be used to inspire Maori to avoid dependency on gambling and poverty. (Durie 2000; Ratima 2000)

Maori individuals and groups can consider litigation against the Crown and gambling industries for the gambling-related harm they have created directly and indirectly through supporting the provision of gambling without real warnings of the risks involved. For example, a Maori woman who has since died has received approval for Government legal aid to take civil action against British and American tobacco companies and WD&HO Wills for becoming an addicted smoker and subsequently developing cancer. Her suit is for loss of life in that she will not be able to be a grandmother for her grandchildren. Despite her death, her lawyers on behalf of her family are seeking more than $300,000 in damages. (New Zealand Press Association 2003) Advocates in New Zealand promoting smoke-free environments, including the Government, have supported the provision of legal aid for her case and Maori could use a similar approach to address gambling-related harm (Jacobson and Warner 1999)

The use of Maori tikanga and icons in the promotion or association with gambling is an area, which requires further consideration by Maori. For example, the use of Maori whakairo (carvings), at the entrance of the Skycity casino in Auckland may give Maori and non Maori visitors the impression that this venue is safe, gambling is benign and that the casino is supported by local Maori. Involvement and inclusion of Maori, including blessing by kaumatua in the opening of gambling venues can be seen to support gambling irrespective of the social, economic or cultural costs they create in the community. (Bayly 1999; Hendery 2000) The investigator has also raised with the Department of Internal Affairs the use of a Maori weaving pattern by this government agency to promote the gaming review. This suggests that there is link between gambling and Maori culture. (Dyall 2001) Pukeroa Oruawhata Holdings on the other hand considers that the establishment of a casino in Rotorua will enhance and showcase Maori culture to an international audience. (Pukeroa Oruawhata Holdings Ltd 2002) Use of Maori icons, promoting normalisation of gambling, must be considered in any public health strategy
addressing gambling-related harm for Maori, Maori public health concepts and Maori icons should be used in the development of interventions to protect tangata whenua from gambling-related harm.

5.3.7 Te Tipu Ora o te Rata

The Rata is proposed as a model to promote and support interventions to reduce gambling-related harm for Maori and this is outlined in chapter nine as recommendations. The Rata, especially the Northern Rata, has been chosen. It is known in the ngahere (forest) for its beautiful red flowers which bloom each summer and provides valuable food for nectar feeding birds. The Rata is special, it grows from one or more seeds which land on large trees such as the Rimu and find places to grow. The Rata is an epiphyte and it sends its roots down the side of the host tree to the ground. The roots of the Rata become intertwined surround the trunk of the host tree and it becomes a tree itself. Overtime the host tree is restricted in its growth or dies from lack of light and nutrients. (http://projectcrimson.org.nz/rata-fact-sheet.html 2003).

The Rata is used as a model to reduce gambling-related harm for Maori, as gambling has become a major tree in Aotearoa/ New Zealand by the way it supports many Maori and community services and provides funding to different stakeholders. The community benefits of gambling are promoted by the Government to justify legalised gambling while the adverse effects are wide reaching and go unnoticed.

This is because the effects of gambling-related harm are invisible similar to the roots of the tree. Only the fruits and the growth of the tree are seen, but gambling substantially withdraws resources from whanau, hapu, iwi and communities. To reduce Maori dependence upon gambling and Maori gambling-related harm new seeds need to be planted. These seeds need to provide new opportunities for Maori, new funding for Maori development, new arrangements for Maori participation in gambling developments including recognition of the Treaty of Waitangi, new health and related services and the Government taking a major role in co-ordinating policies to improve Maori wellbeing.

5.3.8 Health Promotion

Health promotion is a philosophy and a tool which can be used by public health advocates facilitating health change. It is defined as:
A process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. (http://www.hpforum.org.nz/wishprom.htm 2001)

Health promotion aims at empowerment of individuals, communities and societies to have the necessary resources, skills, knowledge and good health which enable them to exercise control over their own lives. Health promotion is grounded in a value base which focuses on addressing social injustices, ensuring community participation in decision-making, reducing health inequalities and encouraging decisions which do not adversely affect the wellbeing of future generations.

Health promotion is also based upon the United Nations’ declarations and conventions for human rights and these values are incorporated in the purpose and views on health of the World Health Organisation (WHO). (World Health Organisation 1978; Te Puni Kokiri 1994; http://www.hpforum.org.nz/wishprom.htm 2001) The United Nations has also developed a Draft Declaration on the Rights of Indigenous Peoples with indigenous participation. (Te Puni Kokiri 1999) Maori have played an important role in the development of this declaration and it has provided an opportunity for Maori to participate in an international forum and to consider how Maori constitutional rights are recognised viz, other First Nations peoples. (Durie 1998)

The Ottawa Charter is a key framework used in New Zealand to develop health promotion programs and strategies and has been considered ideal for addressing gambling and problem gambling from a public health perspective. (Korn and Shaffer 2000; Shaffer and Korn 2002) Maori public health advocates have reframed health promotion and the Ottawa Charter to support the development of whanau, hapu and iwi aspirations for tino rangatiratanga and the recognition of the Treaty of Waitangi in the health system, by challenging health agencies to be accountable for the health gains they achieve for Maori and by negotiating for the development and provision of health services by delivered Maori for Maori throughout the country. (Ministry of Health 2001)

The Ottawa Charter has formed the basis of “He Korowai Oranga”, which has been discussed previously. (See chapter two) This framework is broad and it provides an ideal structure for a public health intervention program which addresses both gambling and problem gambling for Maori individually and collectively, supports Maori
participation at all levels of decision making, requires the development of appropriate health and related services for Maori and requires government and related agencies to work together to support Maori development. (Ministry of Health 2001; Turia 2003) The framework also allows for the incorporation of Te Pae Mahutonga: A Model for Maori Health Promotion. (Durie 1999)

Health promotion as a framework for achieving health gains for Maori has both strengths and limitations. Many Maori, may know about an issue and be aware of the risk of certain behaviours to their health but overall find it difficult to make sustainable life changes and behaviours, which may be different from those of their whanau or groups they associate with.

A review of Maori health promotion activities for example by Ratima (2000) has identified Tipu Ora, a wellness child and family program in the Bay of Plenty, as a successful Maori health promotion initiative. Ratima has based Tipu Ora’s success on having clearly defined principles which focus on Maori development and self determination, strategies which involve and utilise community leaders and resources, processes which enhance access and use of services by Maori whanau and Maori and health indicators and outcomes which aim to secure identity and Maori wellbeing. (Health Promotion Forum of New Zealand 2000)

Successful Maori health promotion programs should be considered in the development of health promotion programs to address gambling-related harm for Maori. New health promotion programs should be developed by Maori for Maori to address the broad effects of the normalisation of gambling in Maori whanau and communities and the effects of problem gambling on the “host” and affected others. Gambling or health funding will also need to be flexible to address the broad range of interventions which need to be implemented to reduce Maori gambling-related harm. He Korowai Oranga is an appropriate framework for the development of a strategy to reduce gambling-related harm for Maori. (Turia 2003)

5.3.9 Mental Health Promotion

Mental health promotion incorporates the theory of health promotion and public health. It focuses on both the macro and micro environment and recognises that for people to have good mental health or to recover from a mental illness require a range of
coordinated interventions which recognise the needs of an individual, their biological makeup, their family and wider social relationships.

Factors that have been found to contribute to mental disorder include genetic make up, alcohol and substance use, nutrition, stress and exploitation, as poverty, sexism, racism, alienation, abuse and violence. Protective factors, by contrast, which support mental wellness, are abilities and skills to cope with difficulties, including communication and conflict resolution skills, based on sense or pride or self-esteem, with social and family supports systems in place and an ability to address issues which create exploitation.

Interventions which focus on reducing violence, enhancing educational and personal skills, reducing social isolation, increasing self esteem and improving personal control over individual and community life have been found to be effective in preventing and reducing the risk of mental disorder as well as in helping people to recover from mental disorders. (Disley 1997)

These findings, which decrease the risk of mental illness or help people to recover from a mental illness, are important for Maori as tangata whenua live in an environment which is exploitative. Due to the social and economic position of Maori in New Zealand, many individuals and whānau have limited resources and capability to ensure wellness and therefore become victims. Maori may use gambling to cope with their poor quality of life and limited access to meaningful employment, income and material assets. (Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c)) A reduction in the level of Maori engagement with gambling would require public and mental health advocates to develop alternatives which Maori could use to replace this so called “leisure activity”. These could include new recreational and sporting opportunities, cultural development, assistance with the costs of tertiary education and the development of life skills.

Currently problem gamblers and affected families are almost invisible in mental health services and until recently have not been encouraged to seek help at these services and as consequence problem gamblers are not visible in mental health consumer support networks. The national destigmatisation program “Like Minds”, funded by the health sector to reduce the discrimination mental health consumers experience in the community
currently does not have specific initiatives which actively involve and include problem gamblers to address the stigma they experience as a result of their gambling. (Ministry of Health 2002) An effective mental health promotion program for problem gamblers would require a broad range of mental health and public health interventions which address the factors that create un-wellness and provide support to individuals, whanau and communities, to develop skills and resources to recover and gain control over their own lives. (Shaffer and Korn 2002)

5.3.10 Community Development and Capacity Building

Public health, health promotion and mental health interventions often aim to strengthen the social and economic infrastructure of different groups as a strategy to achieve sustainable social and economic change. The Government through Te Puni Kokiri has provided funding for capacity building for Maori organisations and groups. (Te Puni Kokiri 2000) This development can be seen from a health promotion perspective as building supportive environments and giving whanau, hapu and iwi resources to develop their own social and economic initiatives and hence autonomy.

Government funding will be required for capacity building for Maori for some time yet in order to address the under-development and dependence of Maori on gambling funding.

5.4 Policy and Government Agencies

5.4.1 Public Health and Policy

Development of healthy public policy is one of the major strands of the Ottawa Charter to assist populations and communities to improve their health. The World Health Organisation (1988) defined healthy public policy as those policies or decisions, which are characterised:

*by an explicit concern for health and equity in all areas of policy and by accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to live healthy lives. (World Health Organisation 1988)*

Healthy public policies may be developed and implemented at an international, national or community level. Successful health public policies: are multi-sectoral, involve
different government and non government bodies, identify and recognise those issues that are international and not just local, aim to be educational and persuasive, encourage populations and groups to make easy healthy choices, involve different communities and recognise that policy is inherently a political activity. (Draper 1991)

Healthy public policy generally needs the health issue of concern to be clearly defined, evidence of adverse effects on health, effective lobby groups to support the development of policies and legislation to reduce or control the adverse health effects, opinion leaders in place which are supportive and willing to lead change, supportive bureaucratic players who are in key positions, and an overall policy environment which is supportive of public health interventions. (Baum 1998)

Before the content of a public policy can be defined and politically negotiated, considerable advocacy and research is required to create a supportive environment. (Abbott 2001) Indeed a supportive environment and the development of healthy public policy are intimately linked; one cannot proceed in isolation from the other. These are the two main strands of the Ottawa Charter, which provide the context and justification for the further three strands required for effective health promotion and improvement of public health.

The Responsible Gambling Bill is the result of the third review of gambling policy in New Zealand since 1995 and is the latest of a number of different legislative proposals which have been introduced into Parliament advocating gambling policy changes. (Department of Internal Affairs 1995; Department of Internal Affairs 1996) No legislative changes have been passed to date. This suggests that a healthy policy environment for gambling has not yet been achieved.

5.4.2 Key Agencies Involved in Gambling Policy in New Zealand

This section briefly defines the role of different stakeholders, which have a role in the development of gambling policy.

Department of Internal Affairs: The Department of Internal Affairs is responsible for the oversight of gambling legislation in New Zealand. It is currently responsible for ensuring that the Racing Act 1971, the Gaming and Lotteries Act 1977, and the Casino Control Act 1990 are administered appropriately. It provides independent
policy advice through the Gaming Policy Section to the Minister of Internal Affairs and Minister of Racing. The Department of Internal Affairs has a wide range of different functions and operates a number of different business units, which are linked to gambling.

The Department of Internal Affairs influences not only gambling policy but is involved in ensuring that casino and non-casino gaming is fair and honest. The Gaming Licensing Office of the Department of Internal Affairs licenses and audits all non-casino gaming, issues certificates of approval for casino employees, receives licence fees for non-casino gaming, has inspectors who supervise the conduct of gaming and operation of each casino and is involved in community development by encouraging community groups to apply for gambling funding through the New Zealand Lottery Grants Board.

The Department of Internal Affairs, like other Government agencies, has a statutory responsibility to recognise the Treaty of Waitangi and is required to have specific outputs and performance measures which report on effectiveness for Maori. (Auditor General 1998; Te Puni Kokiri 1999) This Department has a number of different business units, each with their own degree of autonomy. A principal adviser has been appointed to advise on how to improve the Department’s effectiveness for Maori, particularly in relation to addressing inequities between Maori and non-Maori. (Department of Internal Affairs 2002)

Already it has many different relationships and networks with Maori although these networks were not obvious in Maori attendance and participation in the regional hui organised to seek Maori views on the gaming review. (Department of Internal Affairs 2001 (a)) Advice offered by the Department of Internal Affairs on Maori views to the Gaming Review was limited and this may explain the invisibility of Maori in the proposed provisions for responsible gambling in New Zealand. (Cabinet Policy Committee 2001)

Proposed legislation gives the Department of Internal Affairs ongoing authority to continue its current activities as a policy adviser, a regulator and an agency, which approves non-casino licences, and audit non-casino gambling activities. There is no requirement for the department to involve the Ministry of Health or any other government and non-government agencies in the development of gambling regulations
even though healthy public policy requires inter-sectoral collaboration. There is also no requirement to involve Maori in the development and implementation gambling policy and activities.

Legislation and operational activities of the Department of Internal Affairs must address Maori invisibility.

**Casino Control Authority:** The Casino Control Authority operates under the Casino Control Authority Act 1990, and is a Crown entity, so has some independence from government. (http://www.casinocontrol.govt.nz/legisl/toplr.htm 2003) It is responsible for the licensing and regulation of casinos. (Markland 2002) Currently there is a moratorium on further casinos under the Casino Control (Moratorium Extension) Amendment Act 2000. It has been proposed that a new body called the Gambling Commission be established to replace the Casino Control Authority with a similar status to that of a Commission of Inquiry. If established, this new statutory body would have the authority to consider renewal of licences for casinos, agreements made between casino operators and licence holders and appeals of decisions taken by the Department of Internal Affairs in relation to gambling machines and undertake other functions as directed by the Minister of Internal Affairs. Maori should have a statutory right to be represented on this body.

**Ministry of Health:** The Ministry of Health is the principal policy adviser to the Government on public health matters. It operates in relation to a number of different Acts, which focus on public health protection and the funding and delivery of public health and disability services. (Ministry of Health 1996) For example, the Ministry of Health oversees the New Zealand Public Health and Disability Act 2001, which provides the structural and funding arrangements for the establishment and operation of 22 District Health Boards, supports community and Maori participation in health decision making, and provides arrangements for the Minister of Health to give and receive policy advice from different health agencies or health bodies established.

There is no requirement in this legislation to recognise the Treaty of Waitangi in any health activity. (Dyall, Hankins et al. 2000) The Ministry of Health operates through different sections and currently the development of problem gambling policy and
treatment services is shared between the directorates of mental health and public health with input from other sections which have an interest in this issue.

Public healthy policy is complex and drawn out. Although broad Maori policy statements are made and agreed upon at a Ministerial or Cabinet level, they are often not followed by specific funding tagged for the implementation of Maori policy. (Ministry of Health 2001) Funding for Maori health activities is frequently dependent upon Maori and health sector advocacy.

Current funding arrangements for problem gambling may result in no specific funding being allocated to address Maori gambling-related harm, as there is no statutory requirement for this to be met, nor is there a requirement for Crown, Maori and non-government agencies to recognise the Treaty of Waitangi and to work in collaboration in the development of healthy public policies to reduce gambling-related harm.

**Te Puni Kokiri - Ministry of Maori Development:** Te Puni Kokiri is the Crown's primary adviser to Government on Maori issues. As a Crown agency it has a statutory responsibility to facilitate Maori improvement in health, education, employment and training and economic development and to monitor and liaise with government agencies that provide services to or for Maori to ensure their adequacy. As a Crown agency its primary roles include providing policy advice, monitoring Maori outcomes in different sectors and supporting the capacity and development of Maori.

The input of Te Puni Kokiri in the provision of advice to Government on gambling is unclear as the Cabinet papers prepared which form the decisions that have led to the Responsible Gambling Bill include little discussion on Maori views on gambling. There is no recognition of the Treaty of Waitangi as the basis for the development of gambling policy, and no discussion of the impact gambling and problem gambling has on Maori health and overall Maori development. (Bevan-Brown 998; Cunningham 2000)

Te Puni Kokiri should monitor the effects of gambling and problem gambling on the development of Maori and consider the potential gambling offers to support Maori aspirations for tino rangatiratanga and self-sufficiency, without compromising the development of future generations of Maori.
5.5 Summary

This chapter has discussed the social and political process that reframes social issues from individual behaviours being defined as socially deviant to individuals, groups and populations being seen as having a health problem which warrants medical investment, the use of health resources to treat or address the risk factors, which are considered to cause the disease or disorder and ongoing research. The length of time it takes for social issues to be redefined as medical issues is a disadvantage to those groups, communities and populations that are marginalised, as they have limited influence in shaping the health agenda.

Problem gambling is not a new health issue for Maori and was present in Maori communities prior to the establishment of casinos and non-casino gambling machines. The issue, however, has become more visible with more individuals and families seeking help with problem gambling, Maori and Pacific communities concerned about the effects of gambling on family wellbeing and non Maori now affected in some way by gambling.

Public health tools and frameworks such as risk assessment, social hazard consideration, the epidemiological triangle, health promotion, the Ottawa Charter and Maori models of health promotion have been discussed and critiqued. In reviewing different approaches consideration has been given as to their effectiveness in addressing gambling-related harm for Maori, their relationship to Treaty of Waitangi obligations, and the recognition of Maori aspirations for tino rangatiratanga. These issues have been ignored in the Responsible Gambling Bill but must be part of any in any public health gambling response for Maori.

The reframing of gambling and problem gambling as a public health issue in New Zealand provides new challenges, opportunities and potential for conflict. Lessons learnt from other health issues in New Zealand such as the abuse of alcohol and tobacco should be considered and applied to problem gambling and a distinct Maori public health strategy is required to address gambling and problem gambling.

The roles of the Department of Internal Affairs, The Ministry of Health and Te Puni Kokiri, which are involved in the development or implementation of a public health response to gambling for Maori have been discussed. Healthy public policy requires the development of an appropriate environment before the content of a policy can be
developed and agreed upon by different sectors. These agencies have a key role in supporting the creation of an appropriate health policy response to gambling.

Maori gambling is now on the public health agenda and is being considered increasingly important by Maori. This development requires Te Puni Kokiri to become more actively involved in gambling and to provide Crown health leadership in the provision of policy advice in accordance with its statutory responsibilities to facilitate Maori health improvement.

The next chapter outlines the methodology of this thesis. It also explains the rationale of taking a Maori perspective to reviewing existing gambling information, conducting qualitative research to provide a Maori face to gambling and recommending specific a public health strategy to address gambling-related harm for Maori.
Chapter Six:
Methodology - Maori Centred Research

Prescription for Good Health
E tipu, e rea, mo nga ra o tau ao
Ko to ringa ki nga rakau a te Pakeha
he i ora mo to tinana
Ko to ngakau ki nga taonga a o tipuna
he i tikiti ki mo te mahunga
Ko to wairua ki te Atua, nana nei nga mea katoa

Grow up o tender plant, for the days of your world
Your hand to the tools of the Pakeha for the welfare of your body
Your heart to the treasured possession of your ancestors, as a crown to your head
Your spirit to God, creator of all things

Sir Apirana Ngata 1949

6.1 Introduction

"Kaupapa Maori Research" is developing increasingly as a distinct research approach in New Zealand. It is defined broadly as investigation which is initiated by Maori for Maori, to create new knowledge which benefits the development of tangata whenua in Aotearoa/New Zealand. As an approach, Kaupapa Maori research requires recognition of Maori cultural values, Maori researchers defining and directing the research process, significant involvement of Maori participants in the study, different research approaches and processes to collect information, methodologies which are appropriate to the area of study and analysis of information from a Maori perspective. (Durie 1998) Dissemination of information in ways which empower Maori to make informed decisions to achieve tino rangatiratanga (self determination) over their lives, and overall kaitiaki (guardianship) of the ownership of information or material collected from research, was overlooked by Cunningham (2000) in his development of this framework, to assess the nature and value of research for Maori. Distribution and ownership of information is a fundamental part of Maori research. Knowledge is not an end in itself but a means to support the development of appropriate policy or interventions, which reflect and recognise the diverse realities of tangata whenua. (Health
Research Council of New Zealand 1999) No matter how important research findings are, they are of little value if people cannot use them to better understand their worldview or to negotiate the development of appropriate interventions which would improve their quality of life. (Murchie 1984)

Kaupapa Maori research is generally seen as unique to Maori, but it has similarities to the feminist movement in the 1970-80s where women took control, created their own research agenda and developed new methodologies which reflected women’s realities and aspirations for greater equality in all areas of social, economic and cultural life. The first significant Kaupapa Maori research was undertaken by the New Zealand Maori Women’s Welfare League, which investigated the health of Maori women and adopted both a Maori and a feminist perspective in the design, implementation, analysis and dissemination of the findings from this research. (National Research Council 1999; Abbott and Volberg 1999 (b))

The recognition that research is not value free is important for gambling and related research. Reviewers of gambling research have been critical of the bias inherent in many gambling studies because researchers have not declared their own attitudes to gambling nor identified their source of funding. Studies have often been ad hoc and not part of a planned comprehensive gambling research program to improve people’s lives, they have had few or inappropriate participants, and methodologies used in specific studies have not been outlined in detail. These deficiencies make it difficult to replicate studies to determine whether findings are consistent across different groups and cultures. (Goodman 1995; National Research Council 1999) The criticisms also reflect the political and academic nature of gambling research in that there are many stakeholders, including researchers, who have a vested interest and want their views to be supported. (Dyall 2002)

To reduce any such criticisms of this thesis the investigator acknowledges that this study uses a pro-Maori approach to provide a Maori face to gambling from a tangata whenua perspective. (Baum 1998; Health Research Council of New Zealand 1998; Smith 1998) Although this research has been supported by voluntary contributions paid by major gambling providers in New Zealand to the Problem Gambling Committee, this
body has not influenced the analysis, dissemination of findings or proposed recommendations, which flow from the research findings.

This chapter has three following sections. Section one discusses where this thesis fits within a framework for Maori research and how information obtained can be utilised for the development of tangata whenua of Aotearoa/New Zealand. Section two discusses the methodology of this thesis, outlining the process of how Maori problem gamblers and key informants were interviewed and how the results have been reviewed and analysed. Overall this thesis aims at integration, from a Maori perspective of new and existing information to determine whether gambling and problem gambling is an emerging public health issue and if so, proposing an appropriate public health response for tangata whenua of Aotearoa/ New Zealand. The last section summarises this chapter.

6.2 Framework for Maori Research

6.2.1 Research with Maori

Maori often question the value of research as they consider that, on many occasions they are allowed only to be subjects for study instead of being active participants involved in defining areas for research. Consequently, some Maori see research as part of the process of colonisation which has been used by power holders to obtain information, to justify their decisions and to obtain more power and influence at the expense of tangata whenua. (Te Puni Kokiri, 1994; Te Roopu Rangahau a Eru Pomare, 1995)

Maori researchers recognise the value and power of research and have developed three principles under the auspices of the Hongoeka Declaration to guide research. These principles are based upon the Draft United Nations Declaration on the Rights of Indigenous Peoples which defines internationally indigenous peoples' rights. (Anderson, 1996) For Maori effective research involves firstly, “Whakapiki Tangata”. It should support the empowerment of people by giving individuals and groups’ information, which enable them to have increased control over their own health or which leads to the improvement of their health consistent with the philosophy of health promotion. The second principle “Whakaurunga” recognises that Maori health today is a reflection of the past and will influence the future. Research priorities should therefore be developed with
communities and interest groups so that there is ownership and commitment to the findings of research. "Mana Maori", the third principle, supports Maori control and ownership throughout the research process. The National Aboriginal and Islander Health Organisation have developed similar principles with research funding agencies in Australia to protect Aboriginal people from exploitation by researchers. (Baum 1998)

Participants must feel part of the process and the research should be undertaken in a manner that recognises peoples’ cultures and values and supports their development. (Durie 1985) The advice offered by Sir Apirana Ngata to a young girl in 1949 is seen as the ideal prescription for good health for Maori. The advice is also applicable to research, if any study is to be of use to Maori, it must recognise the values, beliefs and realities of different tangata whenua groups. Otherwise, the findings will simply be dismissed.

The Hongoeka research principles have been developed further into a framework outlined in Table 6.1 This framework can be used to assess the value of a proposed study for Maori and whether it is likely to provide new information which will support Maori development. (Abbott and Volberg 2000 (a); Abbott, McKenna et al. 2000 (b); Abbott and McKenna 2000 (c)) It can also be used to assess whether a proposed study is dangerous to the health and wellbeing of Maori because the information collected may not recognise the presence or diverse realities of tangata whenua and so may result in the development of ineffective policy decisions or interventions which could contribute further to the poor health or invisibility of Maori. Criticisms have already been made in chapter three, regarding recent research carried out by Abbott and colleagues who either have had insufficient Maori participants or ignored findings which are significant to Maori. (Health Research Council of New Zealand 1998)
Table 6.1
Characteristics Of Four Identified Types Of Research, Science And Technology

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Research Not Involving Maori</th>
<th>Research Involving Maori</th>
<th>Maori Centred Research</th>
<th>Kaupapa Maori Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Research where Maori participation or data is not sought as considered not relevant for Maori</td>
<td>Research where Maori are involved as participants, part of the research team, Maori data analysed. Maori control however, limited</td>
<td>Research where Maori are significant participants and are senior members of the research team</td>
<td>Maori are significant participants. Research team all Maori. Research meets Maori expectations of quality of standards set by Maori</td>
</tr>
<tr>
<td>Example</td>
<td>Genetic engineering research, Bio-medical research</td>
<td>Research which identifies ethnic differences for specific health issues, e.g. heart disease, cancer</td>
<td>Cohort studies of Maori individuals</td>
<td>Research developed and designed by Maori communities, hapu or iwi</td>
</tr>
<tr>
<td>Control</td>
<td>Mainstream: Researchers/funder</td>
<td>Mainstream</td>
<td>Shared partnership/mainstream</td>
<td>Maori</td>
</tr>
<tr>
<td>Maori Participation</td>
<td>Nil</td>
<td>Minor</td>
<td>Major</td>
<td>Major may be totally Maori participation</td>
</tr>
<tr>
<td>Methods/Tools</td>
<td>Contemporary/ Mainstream</td>
<td>Contemporary/ Mainstream</td>
<td>Contemporary/ Mainstream</td>
<td>Maori and mainstream</td>
</tr>
<tr>
<td>Analysis</td>
<td>Mainstream</td>
<td>Mainstream</td>
<td>Maori</td>
<td>Maori</td>
</tr>
</tbody>
</table>

Adapted from Cunningham C and Durie (1998) A Taxonomy and a Framework for Outcomes and Strategic Research Goals for Maori Research and Development. Te Pumanawa Hauora, Massey University, Palmerston North.
All research funded by Crown research or other agencies should support the positive development of Maori consistent with the Crown's obligations to recognise the Treaty of Waitangi. This obligation is recognised by the Health Research Council of New Zealand that all applicants seeking research funding must identify the involvement of Maori in a study, the value of the research to Maori, and expected health outcomes from the investigation\textsuperscript{43}. (Compulsive Gambling Society of NZ 1998)

This research is predominately "Maori centred research" as from the outset of this study it has been decided to provide a Maori face to gambling. (Markland 1996; Compulsive Gambling Society of NZ Inc. 1997) When this study commenced, Maori and the health sector did not regard gambling as a significant health issue. The topic was considered "odd", as it involved reviewing the norms, values and the culture of Maori and New Zealand society. (Compulsive Gambling Society of NZ 1998)

During the course of this study which has involved interviewing Maori problem gamblers, reviewing overseas and New Zealand gambling literature from a Maori perspective, interviewing key informants, and critiquing and contributing to proposed Government gambling policy options, there have been political and social changes. There has been interest by specific Maori tribal groups in the establishment of casinos and at the same time concern by some Maori leaders about the growth of gambling and its impact on Maori. (Dyall 2002; Markland 2002) These developments have led more Maori to question the role and place gambling plays in Maori society, to consider the contribution Maori could and should play in the development and implementation of gambling policy and the economic benefits Maori should receive from gambling as Treaty of Waitangi partner with the Crown. (Ayers 1998)

New ethical issues are now arising for Maori in relation to gambling where previously gambling related decisions were not considered an issue. For example, a Maori social service provider may reconsider whether it is appropriate to take gambling funding to provide a service which aims to reduce substance and other addictions in

\textsuperscript{43} As this policy decision is not a requirement of all Crown research funding agencies, it is timely to review whether this provision has influenced the allocation of health research funding, changed research methodologies, influenced research priorities, improved Maori health outcomes, influenced tertiary institutions on how they relate and involve Maori in research or fostered research which has assisted Maori and the Crown to recognise and honour their mutual rights and responsibilities.
young Maori. Similarly, the appropriateness of a program to promote healthy messages through Maori netball taking sponsorship funding from non-casino gambling machines and from a hotel operator may be reconsidered. Maori are now in the process of reframing and re-defining gambling in Maori communities and society.

Maori now see that gambling has developed as part of the process of colonisation and along with other social hazards, has contributed to Maori dependency and poverty. Maori also recognise that there are Treaty of Waitangi obligations and as tangata whenua are likely to propose different solutions for the effects of gambling and problem gambling. Reframing of gambling by Maori for Maori will significantly focus on Maori development and this is likely to create tension between key stakeholders, including the Crown which has a vested interest in maintaining the current gambling arrangements and perceptions of gambling. Many political parties are themselves dependent upon non-casino gambling machines for their electoral campaigns. (Cunningham and Durie 1988)

This thesis aims to support a Maori construction of gambling and problem gambling by proposing a Maori focused public health strategy which increases Maori participation and influences the development of gambling policy which recognises the Treaty of Waitangi and supports the development of interventions to assist Maori to exercise control over their own lives or tino rangatiratanga. A Maori-centred approach is supportive of policy and action-oriented research and recognises that new knowledge is obtained by collecting and analysing existing information from a Maori paradigm. (Baum 1998; Dyall 2001)

Action-oriented research is appropriate for Maori as information obtained through the research process can be used to inform or empower tangata whenua to participate in the development of appropriate policy or interventions which supports Maori aspirations. (Durie 2001) Instead of waiting until the research has been completed it enables Maori to take the opportunity to have input into vital decisions, which will influence future gambling policy in Aotearoa/New Zealand. Action-oriented research also recognises that it is difficult for Maori researchers to be independent participant observers in New Zealand, for Maori are constantly interacting and reacting to the environment in which they live. (Baum 1998)
6.3 Methodology

6.3.1 Value of qualitative and quantitative research

Research methods complement one another by providing different information about a research area. (Abbott and Volberg 1991) Prior to the commencement of this study prevalence data was available on the percentage of New Zealand adults who had experienced lifelong or current problems with gambling but no analysis had been undertaken of the data from a Maori perspective. (Compulsive Gambling Society of NZ Inc. 1997) Emerging information was also available on the profile of gamblers and affected others who had sought help with problem gambling at the only national gambling treatment service. (Bero 1989) From this quantitative research and from treatment data, Maori were visible in the profile of problem gamblers and were known to be at risk of both problem and pathological gambling.

No information, however, was available to consider the effects of gambling on Maori and especially through the eyes and experience of Maori problem gamblers. There was no information to understand the context of Maori gambling, its effects on others, Maori perceptions of gambling and gaming, Maori knowledge of the signs and symptoms of problem gambling and Maori gamblers’ expectations of gambling treatment services. Further there was no information on the effects of normalisation of gambling for Maori and the impact gambling has on marae and whanau occasions. The relationship between gambling and the Treaty of Waitangi had not been explored nor had Maori become involved in operating a casino or in decisions about the ownership and placement of non-casino gambling machines on marae. These were all themes investigated with Maori problem gamblers and key informants to understand the broad effects gambling have on the health and wellbeing of Maori. It has also provided a means to understand why gamblers become “hooked on the action of gambling”, rather than just describing or recording their gambling pattern and attitudes towards gambling. (Baum 1998)

Qualitative research can help us understand a public health perspective on an issue. It can complement epidemiological information by explaining the economic, political, social and cultural factors which influence health and disease. It can help understand how people interpret health and disease and make sense of their health experiences. Further, qualitative research can contribute to the development of new
hypotheses, develop culturally relevant quantitative survey instruments and suggest new areas of research. (Oakely 1981)

Qualitative research is also empowering for Maori as it enables a partnership to be established between the researcher and the participant. Both parties can agree to answer or not to respond to questions asked. Although the researcher may use an interview schedule to guide the interview, additional questions can generally be asked to enable a participant to explain their views on a specific matter more fully.

In contrast, quantitative research is generally more prescriptive about the use of survey instruments and responses are often predetermined with the interviewer having the responsibility to tick the appropriate box or code the response. Quantitative research can provide valuable information where the questions asked have a uniform meaning across a wide range of diverse participants or where the collection of factual information is required. It can also involve participants by face-to-face interviews, by way of telephone or by asking participants to complete a survey form to be returned by mail or email. Open-ended questions can be asked by the interviewer or researcher but are often coded to provide statistical data. (Baum 1998)

Both research approaches have their own strengths and limitations and the quality of information obtained by either method is dependent upon the questions asked, the degree of rapport or interest which can be generated between the researcher and participants, the willingness of participants to give truthful information which reflects their views or situation and assumptions made in the analysis of information provided by the researchers. (Compulsive Gambling Society of NZ Inc. 1997) Both qualitative and quantitative research can empower Maori with one method enabling participants to express their views and the other providing statistical information which can be used in different ways to achieve a desired outcome. Use of both qualitative and quantitative research, through reviewing previous research, has been used in this thesis to provide a Maori face to gambling.

6.3.2 Research Design

Consultation: This thesis has arisen through consultation with Maori with an interest in gambling. At the first national gambling hui participants agreed that gambling was an emerging health issue for Maori which required a public health response.
(Compulsive Gambling Society of NZ 1998) This view was supported by Maori in further hui who wanted gambling related research to empower Maori so that they were no longer defined as the “problem”, but became part of the solution in determining the range of interventions used to address the effects of the normalisation of gambling, the effects of problem gambling on gamblers and the wider community and the link between gambling and the Treaty of Waitangi. (Richards and Blair 2001)

In the formation of this research project Dr Peter Adams and Dr Marewa Glover provided advice. Both are senior academics at the University of Auckland with an interest in the prevention, treatment and support required to assist people who have an addiction. Dr Carolyn Coggan, Associate Professor of the Injury Prevention Research Centre, has also provided advice with the study drawing upon her experience of being involved in many qualitative and action research projects.

Information has been shared with Maori and interest groups during the course of this thesis. A series of hui were organised in 2000 to provide information to assist the development of Maori gambling treatment services in Auckland, to raise Maori awareness of the risks associated with gambling and to support Maori to take greater control over their life regarding this issue. These hui provided an opportunity to share and to receive critical feedback, especially from Maori problem gamblers on findings. (Paton-Simpson, Gruys et al. 2002)

Gambling Health Providers’ Support: This study was undertaken with the support of two major gambling treatment providers, the Compulsive Gambling Society of New Zealand (CGS) and the Salvation Army through Oasis. In 1988 both provided gambling treatment services in Auckland with the Compulsive Gambling Society operating in Newmarket and Oasis in Mt Albert. Both have central city locations, employ trained counsellors and use different types of clinical practices. At the time of interviewing both services were supportive of providing appropriate support to Maori gamblers although neither service employed a Maori counsellor at that time.

Odyssey House: An inpatient residential alcohol and drug rehabilitation service in Avondale also supported this study. This agency allowed Maori clients, through an informed consent process, to participate in the study even though this inpatient service has defined rules of attendance in participation in rehabilitation sessions. This service is
different from the other two services in that it is funded through Vote Health as a specialist residential addiction service, with specialist outreach gambling treatment support provided by Oasis.

**Questionnaire Design:** Two semi-structured questionnaires were developed to provide similar information from Maori problem gamblers and invited key informants and are in Appendix I and II. Similar questionnaires were developed so responses between the two groups could be compared and contrasted. The questionnaire developed to interview Maori problem gamblers was piloted with a Maori problem gambler who was willing to consider whether the questions were too intrusive, would enable problem gamblers to share their experience and views honestly and whether the information would lead to a better understanding of the factors that lead some Maori to develop problems with gambling. Questions chosen for investigation support both a Maori-centred approach and action-oriented research with focus on experiences and views of Maori problem gamblers’.

A semi-structured questionnaire was chosen as an approach as Maori participants generally expect that specific questions will be asked and that they will have the opportunity to respond. Asking specific questions provides an opportunity for the researcher to ask supplementary questions thus establishing a closer working relationship with each participant so that they can express fully their views on gambling and the impact it has had on their life. Bero (1989) has suggested that in seeking to understand gamblers you need to look from “the inside out”. Seeing and understanding gambling from the perspective of gamblers helps the development of interventions, which are more likely to be effective in assisting gamblers to control or abstain from gambling. A semi-structured questionnaire also assists the researcher in the interview process to structure a conversation and at the same time ensure all participants are asked the same questions covering all the areas chosen for investigation.

Research themes chosen for investigation included Maori identity, views on gambling and gaming, the impact of gambling on health and wellbeing, knowledge of signs and symptoms of problem gambling, views on Maori involvement in gambling and views on gambling and the Treaty of Waitangi.
Peer Review: The Problem Gambling Purchasing Agency has a policy that all research proposals before consideration of funding must be peer reviewed. The original proposal was forwarded to the Health Research Council of New Zealand for independent peer review. Selected peer reviewers provided positive feedback regarding the study. They suggested that the sample size of the study should be increased from ten to fifteen participants to provide better information of the impact of gambling on Maori.

Ethical Approval: The Auckland Ethics Committee of the Health Funding Authority gave ethical approval for this study in February 1999. This was the first research proposal that this committee had received regarding gambling research. Approval from this Committee was sought in December 1998 as it was intended to interview Maori problem gamblers who were currently present or recent clients who had sought help with problem gambling. Information provided to the Committee included documented support of consultation with Maori and from the Compulsive Gambling Society and Oasis services which had agreed to provide assistance with recruitment of participants.

Information Sheet and Informed Consent forms were prepared and both were translated into Te Reo Maori. Ethical approval was given for the study subject to participants being informed clearly that interviews would be taped only if agreed by each participant and that participants could decline interviews being recorded and transcribed. These requirements were requested in accordance with the Code of Consumer Rights for Health and Disability Services which defines clearly the rights of consumers and responsibilities of researchers in relation to research.

Ethical approval was not sought for interviews with key informants. Participants of this part of the study were invited to participate and as in interviews with problem gamblers, information was shared about the purpose of the study and participation was by informed consent.
Maori Advisory Group: A Maori Advisory Group was established initially to support the research. The role of this group was to support the researcher and to ensure that the results of the study were appropriately presented and would benefit Maori. Members of the advisory group have included Ms Helen Moewaka-Barnes and Ms Suzanne Jackson who both have an interest in Maori gambling.

Through the course of the study additional Maori expertise has been involved. Links have been established with Ms Dianne Richards, an experienced Maori addictions counsellor at Oasis, staff of Te Atea Marino and staff of Te Whanau Waipareira Trust which were contracted by the Problem Gambling Purchaser to provide counselling and support to Maori with problems with gambling.

Findings from the interviews with Maori gamblers have been shared with Maori in different settings such as with Maori addiction staff and tangata whaiora (Maori problem gamblers) to gain feedback, to invite further discussion, to understand more clearly the personal factors which influence some Maori to develop problems with gambling and to seek help with the analysis of information obtained.

Information from key informant interviews has also been shared through conferences, hui and presentations to different stakeholder groups to facilitate awareness of Maori views regarding gambling and to support Maori involvement in gambling developments. Key informant interviews with both Maori and non Maori participants have influenced different stakeholder groups to consider Maori and gambling, the impact gambling has on the health and wellbeing of Maori and the need for the development of an appropriate response to address Maori gambling and problem gambling.

Recruitment of Maori Problem Gamblers and Key Informants: Maori problem gamblers were recruited in the study with the assistance of the Compulsive Gambling Society and the Oasis services. Any person using the Oasis or the Compulsive Gambling Society counselling services in Auckland who self-identified as Maori was invited to participate in the study. Information about the study was placed in all waiting and reception areas at both services inviting interested clients to contact the researcher if they were interested in participating or requested additional information. Auckland was chosen as the area to recruit participants as over 25% of all Maori seeking help with
gambling problems live within the Auckland regional area. (Problem Gambling Foundation and Trust 2001)

Assistance was also sought from problem gambling counsellors to help with identifying potential participants. Clients enrolling for help with gambling problems at both gambling treatment services are asked to define their own ethnic identity as well as provide demographic information. Gambling clients were also screened to identify the degree of their gambling problem using the Southern Oaks Gambling Screen (SOGS). Access to clients' therapeutic notes was sought as part of the informed consent process, but as some participants expressed concern regarding privacy, the researcher did not review notes.

At first presentation counsellors are aware of the self-defined ethnicity of clients. This information may not be correct as clients may feel whakama (embarrassed) and change their identity and details. (Elia and Jacobs 1993; Mc Phillips, Braun et al. 2001; Kiata 2002) Counsellors from both services agreed to share information about the study by providing Maori clients with a pamphlet detailing the purpose of the research and the identity of the researcher. Following the sharing of information regarding the research, the counsellor then asked whether their client was willing to be contacted further to be invited to participate in the study. This approach was taken as problem gamblers often wish to remain anonymous and may have not informed their partners, whanau or employer that they are having difficulties with gambling. Approval and instructions about where and how to contact participants were established.

Once approval to be contacted was given the counsellor then provided information to the researcher of the name of a possible participant and details of how to contact. A counsellor informed the researcher that at least one of her clients did not wish to be interviewed, as she knew the investigator and did not wish her personal situation to be known. The researcher followed up all persons who agreed through their counsellor to be contacted, and further information was shared about the study. If a person was willing to be interviewed, a time and place was arranged. At this meeting informed consent was obtained by the researcher. Prior to commencement of all interviews, participants were asked again to state their ethnic identity. Only Maori problem gamblers were interviewed in this part of the study.
Partners or significant others of problem gamblers also present for help at both gambling treatment services. Although affected others are important clients of gambling treatment services, no Maori clients from this group were interviewed. A flyer and a brochure about the study and the researcher was also placed in the waiting rooms of both gambling support services to promote the study and to recruit participants. Although no participants contacted the researcher directly, this helped legitimate the study when the counsellor raised the topic.

Recruitment of Maori problem gamblers was difficult. Counsellors were aware that some Maori clients were especially vulnerable regarding their gambling. If asked to participate in the study at an early stage of seeking help, they may not present again for counselling. Consequently counsellors have influenced this study by their judgements made about asking Maori clients whether they were interested in participating in the study.

Due to difficulties with recruitment, Maori problem gamblers at Odyssey House were invited to participate in the study. Participants at Odyssey House are different from other participants in the study because at the time of interviews all were part of a residential alcohol and drug rehabilitation program which has strict rules regarding client behaviour in relation to alcohol, drugs, gambling and other addictions. Many of the predominately male residents of this program have been referred by the justice system and clients have chosen this option to address their alcohol, drug or other addiction problems instead of going to prison.

Recruitment of Maori problems gamblers continued from May to September 1999 and a total of 15 people were interviewed. Participants were aged between 15 and 65 years, ten were male and five were female. Interviews took place in different settings and participants were invited to bring other support people if they wished. Depending on where participants lived in Auckland, the demands upon their time and the importance of confidentiality, the majority of interviews were held at the gambling treatment services before or after a counselling session, at Odyssey House in a group session, or at participant’s own home. One participant requested specifically to be interviewed at his parent’s home so he could convey his aroha (love) to them for all of the support they had
provided to him throughout his gambling problem. Demographic details of participants are presented in the next chapter as part of the findings.

Maori problem gamblers recruited as part of this study are a selective group in that participation was influenced by the relationship they had established with their personal counsellor, a counsellor’s assessment of their ability to discuss their pattern of gambling and their the willingness to share their experience of gambling and problem gambling with a Maori researcher. Although the number of problem gamblers interviewed is small, it is comparable with that in many different qualitative studies which have investigated sensitive subjects areas, is larger than a qualitative study of women’s experience of problem gambling in New Zealand and is a significant sample size when compared with other gambling studies which have involved interviewing problem gamblers (Durie 2001).

Thirty key informant participants both Maori and non Maori were recruited for this study representing three different stakeholder groups, participants involved in the delivery of Maori health services, Crown policy advisers and informants involved directly or indirectly in the business of gambling and support services. Key informant interviews were held from June 2000 to September 2002 and were held at places and at times convenient to participants such as at their workplace, at conferences. Some were interviewed over the telephone, as the researcher did not have a travel grant to interview key informants.

Recruitment of key informants were selected by the researcher on the basis of their involvement in Maori health development and service delivery, interest in gambling, involvement in the development or implementation of gambling or health policy, involvement in community or tribal leadership, and being directly or indirectly a recipient of gambling funding. All key informants agreed to participate through informed consent. Only one key informant declined to participate in the study and the reason given was so he could continue to be an independent chair coordinating problem gambling matters.

During the course of this thesis there has been a growing public and health awareness of problem gambling and Maori gambling, which may have influenced or changed the views of some informants since their interview. Key informant interviews were chosen as part of this study as they are an important contribution to action-oriented
research and Maori-centred research because participants are not static but are shaped by the interaction and reactions which occur within a system during the process. (Politzer, Yesalis et al. 1992)

All participants of this study are part of the epidemiological triangle because they are involved in one or more of the following: the business of gambling, shaping the environment for gambling, or affected in some way by gambling at an individual, whanau, community or iwi level. All views are important as they provide the basis to develop a Maori public health approach and strategy to reduce Maori gambling-related harm. (Durie 1998)

**Consideration of Tikanga Maori:** Most of interviews with Maori gamblers and key informant interviews took over two hours. This included time for the researcher and participant to establish tribal and Maori connections and to share food as a koha (gift) in accordance with tikanga Maori (respect for Maori values and customs). (Dyall 2001; Dyall 2001; Dyall 2001; Dyall 2002; Dyall 2002; Dyall 2002) All interviews were conducted in English.

**Confidentiality:** All Maori problem gamblers and key informant participants were informed that information provided would be confidential and in reporting of their views their personal identity would not be disclosed or able to recognised in the presentation of findings. Participants are therefore discussed and reported only as being male or female and their respective age. For key informants it is reported their involvement in relation to gambling, gambling policy, and health sector involvement, Maori or tribal involvement but identity is protected.

**Transcribing and Analysis of Interviews:** All interviews with Maori problem gamblers were audio-taped and transcribed and the text of each interview was sent to the participant to ensure information provided was accurate and reflected their views. Only one participant requested amendments to their interview to ensure information did not include names of prominent Maori whom the participant considered had problems with gambling.

All Maori gamblers interviews were read and reread at least five times by the researcher to gain an understanding of the issues which affect some Maori to develop problems with gambling and the impact this has had on their lives and significant others.
Information from participants was analysed by “cutting and pasting”, all responses to each question and theme investigated. Male and female transcripts were analysed separately to identify any gender differences. Overall 120 pages were transcribed from interviews with Maori gamblers.

Transcripts were analysed prior to a review of the literature, which enabled the researcher to read and reread the transcripts through Maori eyes without being influenced by previous gambling research studies. Review of the literature however, has been important for it helped identify that the experiences and views of Maori gamblers’ on gambling are similar to those of other problem gamblers.

The researcher recorded all key informant interviews and a copy forwarded to each participant who requested a copy to check for accuracy. All interviews were read at least five times by the researcher to identify the similarities and differences in views between key informants in relation to gambling and gaming, impact of gambling on Maori, costs and benefits of gambling for Maori, Treaty of Waitangi and gambling and strategies and solutions to address gambling-related harm for Maori. Overall there were approximately 100 pages to review and analyse.

Not all interviews followed the structured questionnaire as some key informants were often keen to discuss their respective views on gambling or only had a limited amount of time to spend with the researcher. A description of the key informants and analysis of key informant interviews is presented in chapter seven.

Dissemination: Results from this thesis have been shared locally, nationally and internationally as part of a commitment to support both Maori centered and action oriented research approaches.

Presentation of information has raised both Maori and Crown awareness of the impact gambling has on the health and wellbeing of Maori. (Richards and Blair 2001)

A series of hui have been held in Auckland linked to this thesis to help raise Maori awareness of problem gambling and to support Maori with problems to seek help at Maori focused gambling treatment services. (Korn 2000)

A paper has been presented on the “Globalisation of Gambling: An Indigenous Perspective”, at the XXV International Conference on Mental Health and the Law, Siena, Italy, July 2000 to raise awareness of gambling as an emerging health issue for
indigenous peoples and to encourage mental health practitioners and policy makers to place gambling on the mental health policy and service agenda. This international conference is held yearly and has a broad focus on mental health service delivery, policy and legislation. There was considerable interest in the paper presented as participants considered the role gambling now plays now in their own country supported by their Governments’ policy. An emerging international epidemic of problem gambling was discussed. (Dyall 2000; Dyall 2001; Dyall, Taurua et al. 2002) Papers have also been presented in New Zealand at the following conferences: Gambling: An Understanding & Minimising Harm An Internal Overview, Auckland, July 2001 and Weaving the Threads Conference, Wellington 2001, and at the National Workshop on Problem Gambling, Auckland, 2002. (Dyall 2002; Dyall 2002; Dyall and Morrison 2002)

A chapter in a book and two papers have been published as a result of this study to raise Maori awareness regarding gambling and the Treaty of Waitangi, to provide a Maori face to gambling and to advocate recognition of gambling as a social hazard. (Dyall 2001) A review of “Mauriora”, by Durie has also been used as an opportunity to raise awareness of the importance of Maori involvement in gambling in New Zealand. (Maori Reference Group on Gambling 2002)

A national Maori body on gambling has been established. Literature reviewed and findings from this thesis has played an important role in the establishment of this body, the development of specific Maori and iwi contracts to raise Maori awareness about gambling and problem gambling and the need for Maori oriented gambling treatment services and a specific Maori strategy to reduce gambling-related harm. (Select Committee on Government Administration 2002) Information through face-to-face presentations has also been shared with Maori health provider groups regarding Maori and gambling.

Information from this thesis has also encouraged the Government to recognise gambling as a public health issue for Maori, the need for Maori involvement in gambling policy and for the Ministry of Health to take a key role in supporting the development of responsible gambling in Aotearoa/New Zealand. (Ministry of Health 1996; Volberg and Abbott 1997)
6.4 Summary

This chapter has reviewed principles for Maori health research and a framework, which categorises different types of research to assess the value of knowledge created for Maori. This model can also be used to assess whether proposed research will be safe for Maori in determining whether there are sufficient number of Maori participants involved and whether the information obtained will enable informed decisions, which improve the quality of life of tangata whenua.

A Maori-centered approach for this thesis has been taken. Where possible principles of kaupapa Maori research have been included in the design, implementation of the research and in analysis of the information obtained. Dissemination of information obtained during course of this thesis has been shared with Maori interest groups and the Crown so that the findings can contribute to the development of effective policies and interventions which support Maori involvement in gambling policies, appropriate Maori public health interventions and help Maori reframe gambling and consider the impact it has on the current state of Maori development.

The next chapter presents the findings of interviews with Maori problem gamblers to understand “from the inside out”, their perceptions of gambling, the impact of gambling on their life and others, protections that should be in place to reduce Maori gambling-related harm, Maori gambling and Treaty of Waitangi and gambling.