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An International Charter for Gambling: The Auckland Conference and beyond

John Raeburn, University of Auckland, Auckland, Aotearoa-New Zealand.
E-mail: jm.raeburn@auckland.ac.nz

The Auckland conference presented itself as being the first international conference dedicated to the concept of public health in gambling. As the chair of the programme committee, the present author thought that a driving concept for this conference could be the consideration of an International Charter for Gambling. The purpose of such a Charter would be to draw the attention of governments around the world to the need for them to exercise their duty of care towards their citizenry with regard to gambling. It seemed that most governments with gambling in their jurisdictions were to be complicit in the promotion and support of gambling, and hence in the damage done by gambling. This complicity is due to the huge and convenient incomes governments derive from gambling activities, typically used as an alternative to the politically unpopular raising of income taxes. Therefore, governments tend to be part of the problem, and it seems necessary for those interested in the public health and societal dimension of gambling to have a consensual vehicle by which they can assert their view of how they think governments should conduct themselves responsibly with regard to gambling. In the future, such a "Charter" could, of course, be used to call governments to account. However, it needs to be said that at the present moment in history, that process of taking the Charter to international bodies such as the United Nations (UN) or World Health Organisation (WHO) is only a notional one.

The idea for such a Charter had been around for a while. Two New Zealanders, Peter Adams and Ralph Gerdelan, came up with the idea of a Charter framed as a harm minimisation document, some five or more years ago. Adams had in fact drafted a Charter, based on the European Charter on Alcohol (WHO, 1995), and had also drafted an article destined for publication in an international journal on the issues surrounding such an enterprise. He kindly

allowed us to use the draft Charter as the starting point for the conference discussions.

It was decided to have the second day of the conference, focusing on the theme of public health, arranged around the five action streams of the Ottawa Charter for Health Promotion, plus a strong emphasis on culture, which reflects the reality of public health in New Zealand. The intention was expressed at the start of this day to have the programme structured in a way that would ready people to work on the Charter, which would then be done in workshops organised around the five Ottawa Charter for Health Promotion action streams in the afternoon. The morning's proceedings were aimed at showcasing New Zealand thinking and initiatives in public health as it related to gambling. (New Zealand was claiming international pre-eminence is this area.) This consisted of brief presentations by members of panels made up of stakeholders from gambling domains relating to policy, environment, community, personal skills, and services, plus Maori, Pacific, and Asian peoples. Such an overview was felt not only to be valuable in its own right, but also for surveying the public health approach in a comprehensive way to ready conference participants (who had come from many parts of the gambling field, not just public health) for the charter workshops in the afternoon.

As with many conference processes, there was much to be done beforehand, and the preliminary work done on the Charter to ready it for the workshop process was relatively brief. A small group consisting of Peter Adams, Lorna Dyall, Ruth Herd, Maria Bellringer, and the author met a few times to work on it, and it was decided to amplify the original Adams version by adding a health promotion dimension.

A word needs to be said about this process. Gambling as a social and health issue is a very new area, since the huge growth in gambling internationally, and the realisation of the significant amount of damage done by it not only to individual problem gamblers, but also to families, communities, cultures, and whole states and countries, is only about a decade old. Therefore, there has not been a lot of time for academics and others to develop appropriate theories to conceptualise this unique area. Inevitably, then, we draw on existing theoretical approaches, and the fact that the draft Charter we were using was based strongly on alcohol and hence addiction thinking meant that that aspect was intrinsic to the original version.

One of the dominant paradigms in the addictions area is that of harm minimisation, which broadly may be conceived as a way that society looks at the consumption of "dangerous substances" which are attractive, but which have the capacity to do a great deal of harm. Usually implicit here is a kind of "drug" thinking,

which means that the substance chemically and physiologically can have an impact which can render people "helpless" in the face of its power. At the same time, most of these substances are enjoyed by a majority of the populace without too much apparent harm, and so they may well be either legal, or only mildly sanctioned. The thinking is that we cannot prohibit most of them, and therefore, the mission is to limit the harm done by them. The most obvious way of doing this is by government policy and regulation, which extends to things such as obligatory warnings on cigarette packets. In short, the concept of "harm minimisation" semantically and perhaps in practice, is very similar to that of "health protection" in the public health field. To some extent, concepts such as prevention and health promotion are part of harm minimisation thinking, but only as ways of limiting the damage done? they are the "servants" of the enterprise of reducing harm to a minimum. Indeed, the kind of harm minimisation thinking represented here renders, for example, the concept of health promotion as "demand reduction", a concept that most health promoters would view with great disdain! In short, then, there is some question about the adequacy of harm minimisation alone to provide a comprehensive base for thinking about public health in the gambling area. Indeed, it has yet to be debated fully as to whether the addictions paradigm is really the optimal one for gambling at all!

This is not the place to have a lengthy discussion on "what is health promotion?" But briefly, health promotion is anything but the kind of top-down regulatory approach implied by harm minimisation. Rather, it is about ordinary people flexing their own muscles and determining for themselves what is in their own and their community's best interests. The Ottawa Charter defines health promotion as "the process of enabling people to get control over, and to improve, their health", and it is that aspect of control that is central here. Translated into the gambling area, we in New Zealand believe this means having an aware and mobilised community, building its own strength and capacity with regard to gambling, and calling the tune on many of the major issues surrounding it, including the kind of policy involved in any regulations. The view that we in New Zealand are trying to promote is that public health in gambling involves two "wings"? one of harm minimisation (the policy, regulatory side), and the other of health promotion (the people and community self-determination side). It was with this vision that, leading up to the conference, we attempted to create a draft Charter with both wings equally represented. In the short time frame available, we took the structure as given (which had been derived from the European Charter on Alcohol), and added a health promotion dimension to each of the clauses.

Shortly, I will provide the reader with the version of the Charter

after it had been through the Auckland workshop process. This has largely retained the form of the draft as it was given to the conference workshops, and the changes made in that process were mostly to content rather than to structure. We suspect that as the Charter goes out to the world, some may question whether the present structure of it is appropriate. But for the moment, it is in the form shown here.

But before it is presented, there needs to be a word about the development process. Those who know about the public health and political scene in contemporary New Zealand will know that cultural issues are very high on the agenda. This is especially driven by the strong commitment to have the Maori dimension acknowledged and integrated into all public health and political considerations. Maori are the indigenous people of New Zealand, and comprise some 15 percent of the population. Their fundamental rights with relation to New Zealand as a total society are underpinned by the 1840 Treaty of Waitangi between Maori and the Crown (i.e., government) that guarantees absolute equal status, as well as customary rights and understandings. Because the Treaty has often been observed more in the breach than in the letter, and because Maori are a strong and proud people presently undergoing considerable cultural, economic, social, and political growth, we have to give particular consideration to the Maori and Treaty dimensions of the charter, in so far as it is currently a New Zealand-based enterprise. However, since it is often indigenous and marginalised people who are most impacted upon in a negative way by modern gambling, then what is happening in New Zealand could also be a beacon to the world. (At the time of writing, Maori were the largest group proportionately coming as new clients to problem gambling services—at a rate of 25 percent of all new clients annually).

To be brief, before the conference, the Charter was discussed with the elders of Ngati Whatua, the Tangata Whenua (local ancestral Maori) of Auckland, who gave the process their blessing and, as a symbol of this, agreed to name the Charter once it was complete. This is stated here, because if the Charter does proceed offshore, as we hope it might, then eventually it will have to return to Ngati Whatua to name it. For the moment, it is called "the Auckland Charter" (in Maori: "Tutohinga Tupono Noa Mo Te Ao Whanui"). It should be noted that a translated Maori version of the whole draft was also available to the conference. At the conference itself, the Pacific group (Auckland is the largest "Polynesian" city in the world, the term Polynesian in this context referring both to Maori and to immigrants from the Polynesian Pacific, for example, Samoa, Tonga, the Cook Islands, Niue, and so on) also made its presence known with regard to the Charter.

The view of this author is that while it is now perfectly acceptable for the Charter to go out to the wider world, we also need to be aware of its origins here, and some of the ownership felt by local groups. My suggestion is that we aim for a very general international Charter, to which there is universal buy-in as far as possible, but that each nation develop its own version of it to suit its own local cultures and considerations.

To end, then, here is the Charter as it currently stands. We are not in a position to say at this point what its future will be, or how any further process should be managed. Probably the best suggestion is that a group be reconvened in New Zealand as a first move, but with an intention of moving the charter onto the international stage in a managed way.

THE AUCKLAND INTERNATIONAL GAMBLING CHARTER
TUTOHINGA TUPONO NOA MO
TE AO WHANUI

REVISED DISCUSSION DRAFT

13 September, 2003

Principles

Principle One: Enjoyment of gambling and freedom from harm

All people have the right to enjoy responsible gambling, in the context of a family, community, and national life protected from the negative consequences of gambling.

All people have the right to be enabled to take self-determined action individually and collectively to ensure their own and their community's wellbeing with regard to gambling, and a right to be heard and to participate in a democratic fashion when it comes to the creation of policy by governments in the area of gambling.

All people have the right to have gambling issues communicated and dealt with in terms of their own culture and worldview. This includes people from indigenous groups, immigrants and refugees, those who are less well off, youth, older people, and other groups who are especially at risk or significant with regard to the impacts of gambling in a modern society.

Principle Two: Government duty of care and protection.

Gambling should be recognised by governments as a public health issue.

Governments have a duty to provide regulatory frameworks and social policy responses on behalf of all their citizens to allow enjoyment and limit harm in the provision of all gambling, within a framework of independence from parties with a financial interest in the provision of gambling. They need to ensure that regulations are enforced. Supply of gambling products known to be harmful should be controlled.

Governments also have a duty to enable communities to take action with regard to gambling on their own behalf, and to have a decisive influence on relevant policy and legislation.

Governments need to ensure that appropriate consumer and product information is supplied with regard to gambling products and practices, and that the promotion of gambling is not unduly exploitative or manipulative.

Principle Three: Community empowerment

All people have a right to effective participation in a democratic process of deciding the amount and type of gambling. Where possible, this process should be guided by research.

Where appropriate, extra consideration must be given to the rights of indigenous populations who have original occupant status in their own countries.

Principle Four: Informed consent and education

All people have the right to valid accurate, detailed information about gambling and education consonant with their language, culture and values, and about the consequences of gambling to health, family, community and society. This should start early in life. All people also have the right to information and resources which enable them to take effective self-determined and responsible action in the area of gambling at the community, regional and national levels.

Principle Five: Protection of populations from the negative effects of gambling

All people have the right to an environment protected from the harmful effects of gambling, and where vulnerabilities are not exploited in the provision of gambling. This is particularly so for population groups such as young people, older people, women, minorities, immigrants, and indigenous peoples.

They also have the right to develop their own resilience and action with regard to the potentially damaging consequences of

gambling. This includes the development of partnerships with experts, governments, and non government organisations as is deemed appropriate by those people.

Principle Six: Access to care and effective resources for those affected by problem gambling.

All those adversely affected by gambling have the right to accessible professional treatment, care and support, which acknowledges their culture, gender and sexual preference. They also have the right to community support and information resources which enable them to determine their own process of recovery and to improve their own quality of life. In the context of indigenous peoples, these processes involve recognition of those people's inherent right to self-determination.

Principle Seven: Right to abstain or limit consumption

All people who do not wish to gamble, or to gamble at only modest levels, have the right to be safeguarded from pressures to gamble, to be supported in their non-gambling lifestyle if that is their choice, and to have access to information and resources which facilitate choices and action related to such abstinence or low level participation in gambling.

Governmental Actions which Flow from the Above Principles

In a context of awareness of cultural and equity considerations, governments can be expected to:

1. Inform people about the consequences of gambling on health, well being, family, community and society, about how to prevent or minimise harm, and about how to develop individual, family and community resilience with regard to gambling. This would include the use of broad educational programmes beginning in early childhood.

2. Through appropriate legislation and policy, restrict the sale and distribution of gambling products within communities to an extent that is agreed on by professionals and communities to constitute safe levels.

3. Strengthen the capacity of communities and indigenous populations to deal with their own gambling issues in a self-determined way, by ensuring that they are provided with the best information about gambling and its impacts, and are provided with expertise, resources and support personnel which enable them to take their own action, and make their own decisions, about gambling-related matters in their own

localities.

4. Consult with such informed communities about levels of gambling that they feel are appropriate for their localities, ensuring that these communities are part of the decision-making process. This requires the development of suitable policy and legislation to support these processes, including the enabling of local governments to regulate in this area.

5. Ensure that gambling products known to have a potential for harm are clearly labelled about their risks and dangers at the point of sale.

6. Implement strict controls on direct and indirect advertising of gambling products, and ensure that no form of advertising is specifically addressed to young people, or to other recognised risk groups.

7. Ensure the accessibility to individuals, families and affected others of a range of early intervention, help-line, treatment and recovery services, using appropriately trained personnel, for people with risky, problematic or hazardous consumption of gambling.

8. Foster awareness of ethical, cultural and legal responsibility among those involved in the marketing or selling of gambling products, ensure strict control of product safety, including potential to form addictive behaviour patterns, ensure that that environments in which gambling take place are of high quality and do not foster abnormal or dissociative behaviour (e.g. by the absence of clocks and windows in gambling venues), and take measures against corrupt or illegal practices associated with gambling activities.

9. Enhance the capacity of society to deal with gambling through ensuring that there is appropriate training available for professionals in a variety of sectors, including health, social welfare, education and justice.

10. Support non-governmental and community organisations, and self-help/mutual aid groups and movements, the activities of which are aimed at strengthening resilience and health with regard to gambling.

11. Ensure that there is appropriate funding for research in all these areas, with the aim of providing knowledge for good information about gambling in communities and whole nations, monitoring the societal impact of gambling on an ongoing basis, and evaluating interventions and actions taken to benefit individuals, communities and society with regard to gambling.

12. Support from a gambling perspective other relevant national and international health and societal declarations, charters and treaties to do with health, quality of life and social well-being, including the Alma Ata Declaration for Primary Health Care, the Ottawa Charter for Health Promotion, the United Nations Declaration of Human Rights, the United Nations Convention for Children, the European Charter on Alcohol, and treaties defining the relationship of governments to their indigenous people.

Reference

World Health Organization (WHO). (1995).
The European Charter on Alcohol. Copenhagen, Denmark: World Health Organisation Regional Office for Europe.

Editor's note: In this article, the—

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—portion was not edited due to its status as a charter document.

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For correspondence: John Raeburn,
e-mail: jm.raeburn@auckland.ac.nz

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Editorial Contact: phil_lange@camh.net
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