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[This article prints out to about 15 pages.]

The history of gambling in New Zealand

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This special issue on gambling in Aotearoa-New Zealand was assembled from papers presented at a recent conference on gambling held in Auckland in September 2003. This third international conference on gambling, *Gambling through a Public Health Lens*, was jointly hosted by the Problem Gambling Foundation and the University of Auckland's Centre for Gambling Studies. The focus of the conference was intended to assist services and government agencies to prepare for the Ministry of Health's takeover of responsibility for the provision of services for problem gamblers, as it moves to recognise gambling as a public health issue. The timing of the conference was fortuitous. The three days of the conference coincided with the final reading of the Gambling Act, the first piece of legislation that provides a comprehensive regulatory framework for gambling and the culmination of a seven-year review process. The three hundred people attending the conference were continually aware that their discussions were being echoed with concurrent discussions in the halls of power.

While the conference was attended by a number of esteemed presenters (such as David Korn from Toronto and Jeff Marrota from Oregon [1]) the papers chosen for this issue concentrate specifically on the current scene in Aotearoa-New Zealand, particularly as it applies to gambling within specific cultural contexts. The intent is to enable readers in other countries to compare what is happening in Aotearoa-New Zealand with the evolution of gambling within their own cultural contexts. The rapid proliferation of gambling has had contrasting impacts on indigenous populations, migrant groups, and local communities. The papers here provide detail on these impacts and examine some potential responses. In order to set the scene, this editorial will provide information on the context in Aotearoa-New Zealand to enable the reader to better appreciate the issues discussed in the papers.

Four waves of settlement

Aotearoa-New Zealand is a small nation of approximately four million people situated low in the Pacific and at least a three-hour jet flight from the coast of its nearest neighbour, Australia. Its geographic isolation is the basis for both what constrains it and makes it unique. Its landmass covers an area of roughly the size of England and Scotland combined and it consists of two main islands stretching from north to south across sub-tropical and temperate climates. Mountain ranges run up the middle of both islands and are flanked by foothills, uplands and fertile lowlands. Its moderate climate together with its regular rainfall supports the growth of a vigorous plant life that, prior to the intrusion of humans, had supported the evolution of a unique flora and fauna.

The first settlement of Aotearoa-New Zealand by Polynesian peoples occurred sometime in the vicinity of 1250 to 1150 years ago. These "people of many islands" had mastered the skills of ocean navigation that enabled them to progressively occupy the larger islands of the south Pacific (Fischer, 2002). They arrived in a series of migrations and established small communities in coastal areas. The villages steadily expanded in accordance with the growth of their economies that either relied on hunting and fishing or mixed gardening. This enterprising people, referred to today generally as "Maori" but in reality made up of many different tribal groups (iwi), gradually established a complex system of tribal communities (hapu) linked by kinship connections and trade throughout the extent of Aotearoa-New Zealand. Their day-to-day routines were strongly organised according to status and obligations within extended family networks (whanau). By the fifteenth century a network of over 6,000 pa (fortified villages) had formed which relied heavily on transport and communication using large canoes and path systems (King, 2003).

The second settlement consisted of people from Britain who from over 12,000 miles away began their remarkable migration after Captain James Cook set foot on New Zealand soil in 1769. The first few migrants were a diverse collection of whalers, adventurers, soldiers, missionaries, traders, and early farmers who relied heavily on trade and exchange with Maori. This relationship intensified and culminated in 1849 in the signing of the Treaty of Waitangi, a critical agreement between Maori and the British Crown that recognised the rights of both parties to partnership, participation, and protection. At this stage Maori still outnumbered Europeans, but in the fifty years following the signing of the Treaty large numbers of British settlers migrated and they soon eclipsed the Maori population. At the same time the absolute number of Maori was reduced by the importation of common European diseases to which Maori had little immunity.

An estimated pre-European Maori population of between 90,000 to 120,000 fell to around 42,000 by the end of the nineteenth century (Bellich, 1996). Land wars, displacement, and poverty also played a role. By the 1890s their numbers were so low that Europeans considered the land as open to settlement and they proceeded to occupy land with little regard to what had been agreed in the Treaty. Over the course of the last hundred years Maori have gradually re-established their numbers and now comprise approximately 15 percent of the total population. In the last thirty years they have also initiated a widespread cultural renaissance that has focused on recovering their language, their land, and their customs (Belich, 2001).

The two most recent migrations to Aotearoa-New Zealand came from the Asia-Pacific region. Following World War II people from the island nations of Western Samoa, Tonga, the Cook Islands, Niue, and Fiji migrated in a steady flow to the larger urban centres of Auckland and Wellington in search of employment and a better standard of living for their children. They found employment in low-income jobs in factories, cleaning, and service industries. The new communities actively maintained their island and village connections through strong patronage of Pacific churches. Despite the emergence of a vibrant and educated second and third generation of Pacific people, their income and their health status have remained significantly lower than the remainder of the population. The more recent migration over the last two decades has come from the peoples of Asia. Similar to migrations of the peoples of Asia into other Western democracies, those who come comprise a mix of people from diverse backgrounds, arriving for different reasons and bringing with them variable levels of wealth and education. The mixture includes young couples from the Indian sub-continent, more affluent Chinese migrants from Hong Kong and Taiwan, and refugees from troubled Indo-Chinese nations. As with Pacific island people, they have settled mainly in urban communities in which they have encountered varying levels of acceptance and integration. Peoples of Pacific and Asian ethnicity each comprise approximately 6 percent of the whole population, and this rises for both groups to around 12 percent each in the urban areas of Auckland (Statistics New Zealand, 2002).

The proliferation of gambling

Gambling was not part of the way of life for Maori prior to European contact. It began when European settlers imported their passion for betting on horses and cards. Informal number games and raffles soon followed, but as the government became more organised it regulated these forms of gambling in order to prevent abuses and to ensure its share of revenue from the activity. Prior to the 1980s, gambling on horse racing had been a central part of

popular culture, particularly for men. Other forms enjoyed predominantly by women included local church and community run "housie" (bingo) and many families would purchase their weekly ticket in a national raffle called the "Golden Kiwi." Although these forms of gambling were highly popular, they were also tightly regulated and confined to a few specific times and locations (O'Sullivan & Christoffel, 1992). The population was on the whole unprepared for the world of commercialised continuous gambling that emerged in the 1990s.

In the mid-eighties a series of radical economic reforms ushered in an extended period of liberalisation of marketing and regulatory regimes. It was believed that in order for the economy to expand, the marketplace needed to be freed up from unnecessary controls by government so that consumers could exercise greater influence over their choice of product. In line with this shift, many of the obstacles constraining gambling were removed. This opened the floodgates to a liberalised gambling industry. Motivation for the change was further reinforced by attempts to reduce the size and costs of government departments and to reduce the extent of personal and corporate tax liability. This meant the government was on the lookout for alternative taxation strategies, and gambling provided a convenient source to supplement its denuding of the direct taxation base. These two factors, the liberalisation of the marketplace, and government need for alternative revenue, led to a series of changes in the regulation of gambling which progressively lifted constraints on the range, availability, and promotion of gambling products. The liberalisation in gambling legislation and its consequent increase in availability quickly led to unprecedented increases in consumer spending on gambling products. Legalised gambling swiftly became one of the major growth industries in the economy. Total gambling expenditure (money lost[2]) rose from around NZ$0.1 billion in 1979 to NZ$1.9 billion by 2003 (Department of Internal Affairs, 2003). This translates to an increased adult population per capita spend from roughly NZ$43 to NZ$500 (US$20 to US$234).

The main contributor to this rapid increase in expenditure has undoubtedly been the rise in availability of electronic gambling machines (EGMs). These were first introduced legally into the country in 1991. They quickly became a common fixture in locations with liquor licenses, in particular, bars, clubs, and societies. In the first year they accounted for about 19 percent of the total gambling spend. By 2003 this spend had increased eight-fold to comprise just over half of all gambling expenditure, more if you combine this with losses from EGMs in casinos (Department of Internal Affairs, 2003). These increases were similar in the six casinos but were not reflected in horse or lottery betting, which remained relatively stable over the period.

It was in the transition period of moving from a low-access to a high-access gambling environment that the framework for harm was established. Perhaps this has been a pattern in other nations. Successive governments were wooed by the revenue potential and were easily persuaded that negative impacts would be minor and easily contained. The previous controlled gambling environment with its low rates of problem gambling gave them little cause to think otherwise. They began by deregulating certain sectors of the gambling industries; other sectors responded with demands for similar deregulation in order to retain their market share. This led to a domino pattern of deregulation for which the general population, naïve to the effects of intense gambling, had little preparation. For example, the introduction of EGMs led the racing industry to diversify their products which in turn led EGMs to justify modifications such as higher jackpots, which in turn led to the introduction of new lottery products, and so on. After the time period from the population's first experiences with easy-access gambling to their initial discovery of the social and economic downsides, they awoke to find themselves in a world where frequent gambling is firmly established and embedded in the life rhythms of most communities. The transition period had created a ten-year window of naivety through which a vigorous gambling industry could be permanently installed.

Problem gambling

As gambling opportunities in Aotearoa-New Zealand become steadily easier to access, people increasingly perceived them as a normal part of life routines. As a consequence frequent gambling is also becoming commonplace and new sectors of society are for the first time encountering the downsides of frequent gambling. Identification of the typical frequent gambler is becoming increasingly difficult. Whereas twenty years ago frequent gamblers consisted mostly of men in their mid-forties who liked to bet on horses, more recently younger people and women are gambling in increasing numbers, particularly on EGMs; older people are exploring the new options; Maori, Pacific, and Asian people gamble more frequently and children are increasingly exposed to media promotions that normalise gambling into family life.

In parallel with the spread of frequent gambling came the escalation in the number of people seeking help as a result of problem gambling. The majority of problem gambling services are funded via a national "Problem Gambling Committee" (PGC) that administers a voluntary levy from gambling industry providers. The PGC maintains a detailed national database of people accessing these services (Problem Gambling Committee, 2003). During the year 2002 the total number of new clients using personal counselling was 2,467, up 15.1 percent from the

previous year and up 177 percent from six years earlier. New callers in 2002 to a national telephone helpline numbered 4,715, up 23.6 percent from the previous year and up 131.9 percent from six years earlier. The primary mode of gambling for those seeking help had also changed in accordance with the increased availability of EGMs. Whereas in 1999, 70 percent of new personal counselling clients and 77 percent of new telephone helpline clients reported EGMs as their primary mode of gambling, by 2002 this had risen to 86 percent for personal counselling and 90 percent for telephone helpline clients. Added to this were worrying increases in the numbers of problem gamblers seeking help in at-risk populations, particularly Maori, Pacific island peoples, and youth.

The increased diversity of people who gamble frequently is adding to the rising variations in the types of people presenting for help and consequently poses a challenge to services to develop intervention strategies that engage each group effectively in change. For example, gambling counsellors are reporting increased numbers of older people spending their life savings on EGMs. They further report on the high levels of shame experienced by older people in having to seek help. New strategies are needed that facilitate access of older people to services in order to offer prevention and education. This could involve strategies such as drop-in centres or availability through primary health care facilities. Similar access issues apply to the rising numbers of younger problem gamblers as well as specific at-risk populations, in particular the rising numbers of Maori, Pacific island, and Asian problem gamblers.

Gambling and public health

Primarily because of its isolation and its small population, Aotearoa-New Zealand has provided a convenient laboratory for innovations in social and political systems. For example, in 1893 it was the first nation to entitle women to vote, it pioneered social welfare systems during the 1930s and 1940s and, ironically, it explored, with brutal consistency, the monetarist policies of small government during the 1980s and 1990s. This role in social and economic innovation is supported by a somewhat pragmatic approach to difficult issues. Perhaps the recent migratory and pioneer origins of the population, blended with influences from indigenous cultures and coupled with a perceived isolation from the rest of the world, have facilitated a dogged self-reliance. Such an attitude, on the occasions when an initiative fails to work, leads people to then look for available alternatives, believing that they cannot rely on help from anyone else. Whatever the reasons, the government took the bold and unprecedented move of formally recognising gambling as a public health issue. On July 26, 2001, at an international conference in Auckland on *Gambling:*

Understanding and Minimising Harm[3], the Deputy Prime Minister, Jim Anderton, announced:

> I can indicate to you today that the Government will be adopting a public health model for problem gambling. This will see the Ministry of Health play a role in the coordination of services in the near future.

Six months later, staff in the Ministry of Health produced a discussion document entitled *An Integrated National Plan for Minimising Gambling Harm* (MOH, 2001) that incorporated harm minimisation, health promotion, and client service interventions into an integrated approach. They then undertook an extensive consultation process regarding how this could be implemented and are currently waiting for provisions in the new Gambling Act to enable them to proceed with the revised plan. This shift to viewing gambling as a public health issue is the first attempt at developing a systematic approach to harm from gambling. Again, because of its size and isolation, Aotearoa-New Zealand is providing a convenient social laboratory for an approach that could have international implications.

What were the drivers for coming to recognise gambling as a public health issue? Part of the answer can be traced back to the early years of the Problem Gambling Foundation (PGF)[4], an organisation that was initially set up to provide assistance to problem gamblers. During the 1990s the PGF built up a variety of client services throughout the country. These included establishing a national helpline and various face-to-face counselling and support services. However, with gambling consumption sharply on the rise, it became increasingly clear to those providing client services that they were unlikely to stem the tide or make a big difference in the surging numbers of those seeking help. Those involved with PGF began to see that the real driver for problem gambling was the increased availability and diversity of gambling products compounded by a lack of preparedness on the part of the population to handle the new environment. A different approach was required? an approach that could help shape the whole gambling environment and assist in reducing the likelihood of harm. As a response, senior members of PGF have over the last five years worked consistently at advocating for gambling as a public health issue, and have promoted this perspective in discussion documents, articles, representations on statutory committees, and through specifically targeted workshops and conferences.

Another factor influencing the adoption of a public health approach relates to shifts in the thinking of people within government agencies themselves. In the early phases of

proliferation, government agencies were reluctant to acknowledge problems associated with gambling. But in 1996 this attitude began to swing the other way. Besides the opening of the country's largest casino in Auckland, two other major events occurred that year. First, the licensing limit of EGMs in over 2,000 venues (mostly bars and clubs) was increased from 11 to 18 machines per site. As a consequence, points of access to this riskier form of gambling proliferated in a diffuse fashion up and down the country, and people began to notice the change. Second, the Department of Internal Affairs initiated what turned out to be a seven-year review process into the future direction of gambling policy and legislation. This protracted period of review led ultimately in September 2003 to passing the Gambling Act? the final reading of which occurred on the same day as the conference from which the following articles are derived. The new Act is intended as a comprehensive policy framework and identifies four key objectives:

1) control the growth of gambling,
2) prevent and minimise harm caused by gambling,
3) ensure that money from gambling benefits the community, and
4) facilitate involvement of the community in decisions about the provision of gambling. Here, clearly incorporated within these principles, are the concepts of harm minimisation and community empowerment.

In this issue: An overview of the articles

The following collection of articles focuses on the cultural and community impacts of gambling in Aotearoa-New Zealand and asks what a public health approach could mean in these contexts. It represents only a small portion of the broad diversity of people from both Aotearoa-New Zealand and overseas who presented at the conference[5]. These articles have been sought because they give snapshots of how gambling is emerging as an issue in various cultural contexts in Aotearoa-New Zealand. Some of the issues discussed are peculiar to this country, but other issues will have relevance to contexts in many other countries.

The first contribution by Lorna Dyall identifies the impact of gambling on indigenous populations as a fundamental challenge to adopting a public health approach to gambling. For Maori an effective public health approach requires not only a recognition of their needs but an acceptance that Maori are fully involved in the design and development of gambling policy for the whole country. The next article by Laurie Morrison builds on the previous article and outlines issues for Maori that have resulted from the unrestrained spread of EGMs. Her discussion is based on a series of detailed interviews with Maori on their views and experiences

with EGMs. Parallel to the plight of many other indigenous peoples, she links the problems they identify with gambling to broader issues to do with colonisation, land occupation, and poverty. She argues that these broader contextual issues need to be incorporated into the design of effective health promotion strategies.

In the third article, Sione Tu'itahi and his research team focus on the impact of gambling for one Pacific population in Aotearoa-New Zealand, people from the island nation of Tonga. They provide a general overview of the current scant information currently available on Pacific island gambling, but are able to cite enough evidence to identify Pacific people as a leading at-risk group. They then describe their research-in-progress that involves interviewing Tongans on gambling, and conclude with an appeal to ground future interventions in concepts and strategies derived from culturally specific understandings.

In the next article Samson Tse, John Wong, and Hyeeun Kim explore issues for Asian populations as they migrate into new lands with higher gambling consumption. Their discussion provides an interesting dual focus on interventions at the levels of both the individual and the community. As in the previous two articles, they present a strong case that a public health approach to gambling needs to incorporate understandings grounded in cultural concepts and practices. They identify five key principles that should guide the development of intervention strategies. They conclude the article by pointing out that for many cultures, and particularly for peoples of Asian cultures, the European emphasis on the needs of the individual could obscure understanding of the social dynamics of activities like gambling and thereby prevent appreciation of the ways gambling impacts negatively on the families and communities of Asian cultures.

The next paper by Hope Simonsen presents an analysis of how electronic gambling machine ("pokie") money is being distributed within local communities. Gambling legislation in Aotearoa-New Zealand is based on the assumption that EGM gambling should return a financial benefit to communities. By law, one third of the profits from EGMs in hotels and bars must be allocated for "community benefit purposes." This is achieved through the formation of community trusts. These trusts are often set up by the gambling providers themselves and questions have been raised as to whether the distribution is being applied in ways that profit the gambling providers (such as grants to sports clubs that tend to visit their venues). As the study points out, just over half of these funds are being distributed to sports and physical activities. This further raises the question of what interpretations of "community benefit" are guiding funding allocations.

In the final paper, John Raeburn presents a key focus of the conference, the formulation of an international agreement? the "Auckland Charter"? that attempts to set benchmark ethical standards for governments in their management of gambling. An afternoon of the conference was reserved for discussion and development of the content of the Charter. The idea of devising such a Charter began about seven years ago and has led to a number of forum discussions and presentations, and has resulted in several versions, each building on responses to the previous. The current version incorporates both health promotion and harm minimisation principles, and emphasises the government's duty of care to protect its people and its communities from the harmful effects of gambling.

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Endnotes

1 Other papers from the conference are available on the Centre for Gambling Studies website, www.gamblingstudies.co.nz

2 Figures here are reported as expenditure, meaning the amount spent minus winnings. Gross turnover (including winnings) is often used and tends to be five to ten times the expenditure depending on the average rate of return.

3 Organised by the Problem Gambling Foundation and Centre for Gambling Studies.

4 In May 2001 the Problem Gambling Foundation changed its name from the Compulsive Gambling Society. The Society was formed in 1988 to provide services to problem gamblers.

5 The full programme is available on the CGS website: www.gamblingstudies.co.nz

Statement of purpose

The *Journal of Gambling Issues* (*JGI*) offers an Internet-based forum for developments in gambling-related research, policy and treatment as well as personal accounts about gambling and gambling behaviour. Through publishing peer-reviewed articles about gambling as a social phenomenon and the prevention and treatment of gambling problems, it is our aim is to help make sense of how gambling affects us all.

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people involved in gambling as players, and family and friends of gamblers.

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Why is wearing glasses useful in New Zealand?

Paper presented at the International Conference *Gambling through a Public Health Lens*, held in Auckland, September, 2003

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Introduction

One of the consequences of aging is that often you need to get a pair of glasses to see as your eyes begin to deteriorate. Alternatively, often you need a new set of glasses which are bifocal so that you can see the world both "close up"and in the "distance."New Zealand or Aotearoa is now a country beginning to age and is now showing signs of maturity as it comes to terms with its history and legal obligations which exist between Maori and the Crown.

It is now 164 years since the signing of Te Tiriti o Waitangi (the Treaty of Waitangi) which is New Zealand's founding constitutional document. It establishes an ongoing social contract between Maori, the indigenous population, and all citizens of New Zealand, often defined as the Crown. An elected democratic government exists in New Zealand only on the basis of Te Tiriti o Waitangi (Durie, 1998).

Wearing bifocals in New Zealand is useful as it can help to understand the people of the land and the dialogue which occurs between different peoples within the country. Wearing bifocals can also help identify contentious policy issues, avoid areas where agreement cannot be reached and facilitate the development of strategies and interventions to reduce harm at either an individual or collective level.

In having available, and wearing, bifocals, it is then easy to put on an additional or new set of glasses so views of different groups in

the community, especially newly-settled migrants, can be appreciated. Having available different sets of glasses to see and to understand the world can speed up progress on understanding complex issues, and can improve communication within and across different populations and stakeholder groups, such as gambling providers.

This paper has been prepared to support the development of a public health approach to addressing gambling-related harm in New Zealand. It supports the theme of the first International Conference *Gambling through a Public Health Lens* held in Auckland, September 2003, that through a changing lens, like a kaleidoscope, an issue can be looked at through many different prisms and from each prism unusual patterns can be seen and trends recognised.[1]

The lens of this paper is to provide a Maori view on gambling to support the development and implementation of a public health approach that is appropriate for Maori. This also may contribute to improving gambling-related harm for all New Zealanders in Aotearoa. By focusing on the development of whanau (family networks), hapu (tribal communities), and iwi (tribal groups), Maori may also be able to offer support to other ethnic communities nationally and internationally of the importance of maintaining and strengthening their cultural foundations.

By sharing information across different countries we may also be able to see common themes emerge to understand the possible reasons why gambling is now increasingly being promoted as a normalised activity and a fundamental part of different governments' and communities' policies for economic and social development.

The costs and benefits of the promotion of gambling, however, have not been adequately defined and need to be defined from different perspectives or lens.

Research and community involvement must be an integral part of any public health approach to reduce gambling-related harm.

This paper will focus on the following themes:
•Te Tiriti o Waitangi as a framework for a public health approach to reducing gambling-related harm in New Zealand
•Maori historical experience of gambling
•Gambling part of the experience of colonisation
•Gambling an emerging health issue for Maori
•Need for Maori participation in gambling policy
•Maori risk of problem gambling
•Maori expenditure on gambling

•Gambling and impact on children
•Location of gambling machines
•Gambling and community involvement
•Gambling a community health benefit.
•Need for a comprehensive Maori public health strategy

Te Tiriti o Waitangi: Framework for the development of a public health approach to address gambling and problem gambling in New Zealand

New Zealand's history of recognition of the Te Tiriti o Waitangi has been chequered, at times; it has been recognised in law, and other times considered by the justice system as null and void (Durie, 1998). The High Court of New Zealand from the 1ate 1980s has been important in recognising Te Tiriti o Waitangi in legal matters, and this has led Maori to pursue recognition of their treaty rights in many different areas of public policy, and to have these rights included in legislation (Durie, 1998). Until recently, consideration has not been given to the relationship which exists between gambling and Te Tiriti o Waitangi and the implications for gambling policy, licensing, and regulation of gambling and allocation of financial benefits which flow from gamblers' losses (Dyall & Morrison, 2002).

New settlers however, arrive and settle in New Zealand within a historical and social context and, despite debate by different political parties of the place and legal status of Te Tiriti o Waitangi, there is recognition that Maori occupy a unique status. Depending upon the occasion and place, they are either tangata whenua (people of the land) or mana whenua (local guardians of land and traditional customs). There is also recognition that Maori are now entitled to seek compensation for past and current breaches of lack of recognition of Te Tiriti o Waitangi by registering a claim to be heard through the Waitangi Tribunal.

Maori also perceive that Te Tiriti o Waitangi is an ongoing social contract and there are ongoing rights and obligations to be met by both Maori and the Crown. Because of the unique status of Maori, there is a view by some interest groups in the community that Maori now have rights over and above other citizens, and that this creates inequities rather than the development of an equalitarian society where government policies and resources are structured and allocated on the basis of need or for the benefit of all New Zealanders.

Reframing and challenging the position of Maori in New Zealand society is now being carefully crafted by different political parties to compete and attract new voters who are dissatisfied with their current position within New Zealand society. Changes in policy

enhance the position of new immigrants, especially Asian and Pacific peoples who have come to New Zealand for a better life and may be unaware of the foundation of New Zealand as a nation.

Within this environment there is considerable discussion that Maori aspirations for tino rangatiratanga or self-determination should now be limited. For it is not in the interests of all New Zealanders for Maori to have policies in place with the potential to redress the effects of colonisation and change the power dynamics which currently exist in New Zealand society.

Recognition of Te Tiriti o Waitangi, however, gives Maori the right to sit alongside the Crown to determine the role, place, and size that gambling should play in New Zealand society and, if legalised gambling is accepted, who should benefit and, therefore, the share of income which Maori should receive—similar to the allocation of fishing quotas in Aotearoa.

Taking this approach, Maori may not necessarily need to own casinos like some First Nations peoples in America or Canada, or hold gambling machine licences or even buy Lotto tickets. Instead, Maori could receive a proportion of income directly from private casinos, share the revenue that government receives from gambling, or even own a quota of the gambling machine licences that could be used or leased out to generate revenues, similar to the current arrangements for fishing quotas. There are now over 28,000 machines operating in New Zealand for four million people.

With the introduction of new forms of gambling or games of chance that are increasingly being introduced in New Zealand, there should be recognition of Te Tiriti o Waitangi and rights and obligations accorded to Maori. As tangata whenua, Maori should be involved in all levels of policy-making and should benefit financially.

New mobile phones with e-mail, electronic games, pictures, and the Internet are now being used to recruit new gamblers, to normalise gambling and to create a new generation of problem gamblers. Maori youth are approximately six times more at risk for problem gambling than non-Maori. As a young population, they are now being socialised to become the next generation of problem gamblers, just as our current generation has been socialised into weekly playing of gambling machines, track betting, and buying Lotto (Dyall & Hand, 2003).

The Ministry of Health, representing the interests of the Crown and the government of the day, has recognised that Te Tiriti o

Waitangi should be the foundation for the development of gambling policies and interventions in New Zealand and that Maori have the right to be Maori in Aotearoa (Ministry of Health, 2000).

A public health approach in New Zealand to reduce gambling-related harm therefore must recognise the Te Tiriti o Waitangi and the cultural values and beliefs of Maori. A historical and cultural frame also allows for other ethnic groups' values and beliefs to be considered.

Maori historical experience of gambling

Maori are a unique indigenous population in that prior to European contact they had no history of smoking tobacco, drinking alcohol, or gambling (Reid & Pouwhare, 1992; Grant, 1994; Hutt, 1999). Tauiwi (new settlers) introduced all three social hazards to Maori and the unruly behaviour of new settlers was considered by some tribal leaders as a symptom of a population that had lost its values, its social structure, and social order.

The unruliness of Pakeha is often given as one of the reasons why a number of chiefs signed Te Tiriti o Waitangi. They sought to achieve some degree of protection, from England and in particular Queen Victoria, and to assist Pakeha to develop their own social structures based upon their culture and so to have a place in New Zealand.

Many new immigrants from Asia and the Indian subcontinent are now in the process of establishing themselves in New Zealand. Like Maori, they have their own cultural values and beliefs that have provided protection and have supported their wellbeing. However, in living in New Zealand they are now being asked to adapt and to leave behind their own traditional cultures, values, norms, and behaviour practices and to participate in a new society where gambling is legalised, is available 24 hours per day, and where there are minimal sanctions in place to provide protection for people from gambling? especially for those who are vulnerable, isolated, have limited family support, and who are struggling financially or socially.

Gambling can and does provide a means of escape from everyday life and provides for many people a sense of hope to achieve their dreams. Experiences of loss of culture, change in social norms, breakdown of families, loss of social or economic status, and a dream of a new future are often the reasons why some people move across from being a social and recreational gambler to developing problems with gambling which can affect their wellbeing and others' (Blaszczynski, McConaghy, &

Frankova, 1990; Dyall, 2002).

A public health approach to reducing problem gambling must therefore take into account the reasons why people gamble and the factors that can increase individuals' and groups' risk of problem gambling.

Gambling; part of the experience of colonisation

Ethnicity is a key indicator of likely risk for problem gambling in New Zealand. Maori and Pacific populations in New Zealand now have high rates of problem gambling and, with the exception of some Native American groups, appear to be among the highest reported internationally (Abbott, 2001).

The promotion and normalisation of gambling in New Zealand has been and is part of the ongoing colonisation process. Pakeha and dominant groups have used and continue to use gambling in New Zealand to redistribute wealth and to obtain funding to build essential community, sport, and cultural services. The stock exchange is also part of the legalised framework for gambling in New Zealand.

Maori are good at following others' behaviour and have modelled non-Maori (Pakeha) to use gambling to: build marae (traditional Maori meetinghouse), support tangihanga (funeral rituals), and operate many community activities. They see gambling as a means of achieving economic wealth through owning gambling machines or being involved in the ownership of a casino (Dyall & Morrison, 2002).

This approach has also been supported by successive governments which actively encouraged Maori to apply for Lottery Grants Board funding to support essential Maori services and to provide funding for marae or associated developments (Department of Internal Affairs, 2001a).

This policy is relatively recent; a decade ago Maori could secure funding through Vote: Maori Affairs for marae developments and even for help with community services (Gardiner & Parata, 1997).

Maori dependence on gambling at an individual and at a collective level is now government-engineered. Consideration of the exploitative effects of gambling and problem gambling on different population groups must be an integral part of any public health strategy to reduce gambling-related harm.

Any public health strategy to reduce gambling-related harm must build and strengthen different population groups' cultures, for it

has been found for Maori that a secure cultural identity and a strong cultural infrastructure such as marae, te reo (Maori language) and wairua (spirituality) are important health protectors for wellbeing (Durie, 2001).

Gambling: An emerging health issue for Maori

In 1997, the first Maori national gambling Hui (meeting) was held in Auckland to provide information to tangata whenua on the changing pattern of gambling in New Zealand and its effects on Maori, as made visible by the number of Maori beginning to seek help with problems with gambling (Compulsive Gambling Society of New Zealand Inc., 1997). The Compulsive Gambling Society (now called the Problem Gambling Foundation) sponsored this Hui from funding provided by the Committee on the Management of Problem Gambling (now called the Problem Gambling Committee). All funding in New Zealand to address gambling-related harm comes from the gambling industries, not from the crown.

At this Hui, gambling and problem gambling were identified by those present, excluding the Ministry of Health, as a new health issue that warranted serious consideration and placement on the public health agenda; even though many Maori had grown up within a whanau in which gambling was a normal recreational activity (Dyall & Morrison, 2002).

Through processes of normalisation and socialisation many Maori have learned that gambling? by way of buying a Golden Kiwi or a Lotto ticket, a wager on a horse, buying a bingo card at housie or by playing cards? provides a means to achieve your dream and to achieve a better future.

Gambling, in the past and now, gives many Maori a sense of hope (Grant, 1994). In doing so, however, many Maori have put their lives on hold and rely upon "luck"to determine their personal or whanau destiny, rather than exerting their own tino rangatiratanga or authority to achieve their own goals and aspirations.

The marketing of gambling to achieve your dreams has been a common advertising strategy used in New Zealand, especially by the New Zealand Lotteries Commission, a government agency, and by local casinos, to promote their gambling products, to increase sales and to produce an overall increase in their share of gambling losses. It has been admitted as part of the review of gaming in New Zealand that the New Zealand Lotteries Commission has purposely targeted its advertising to recruit and retain Maori and Pacific gamblers (Department of Internal Affairs, 2001a). This despite the fact that many Maori and Pacific whanau

have lower incomes than other groups in the community and government policy is meant to be framed at reducing, not increasing, social and economic inequities (Te Puni Kokiri, 2000; Abbott & Volberg, 2000; Cabinet Policy Committee, 2001).

Recognition of the profile of who buys different gambling products, and of the demographic distribution and ethnic makeup of different parts of New Zealand, has led to the decision by the New Zealand Lotteries Commission to relocate its head office from Wellington to Auckland to be closer to its Lotto clients (i.e., Maori and Pacific patrons) in an effort to compete with other gambling providers for a sustained and, where possible, increasing market share of gambling revenue (Cabinet Policy Committee, 2001).

When Lotto was first established it was marketed to become part of New Zealanders' non-discretionary income, and therefore it was and is marketed to occupy a similar status as such essential items as food or rent (Bale, 1992). This is also made visible in where Lotto outlets are situated, in that they are often placed in the front entrance of supermarkets.

The impact of gambling advertising and marketing strategies, especially Lotto, on different population groups must be considered to be part of any public health approach to reduce gambling-related harm.

Need for Maori participation in gambling policy

In New Zealand, it is government policy for the gambling sector? which represents different gambling industries, such as the New Zealand Lotteries Commission, gambling machine operators and the Totalisator Agency Board (TAB)? to identify the degree of harm their particular industry creates in relation to problem gambling and the amount of funding each industry individually and collectively will to pay to address the effects of problem gambling.

These amounts paid out are also influenced by gambling treatment services, which provide information on the profile of people seeking help with problems with gambling and the mode of gambling which creates the most harm for them (Department of Internal Affairs, 2001a). This cosy arrangement between gambling industries and gambling treatment providers has excluded Maori participation as tangata whenua in the decision-making process.

Maori and Te Tiriti o Waitangi perspectives must be part of any future framing of problem gambling in New Zealand and a public health response to reduce gambling--related harm, irrespective of which agency or body has responsibility to determine funding and

purchasing of gambling treatment and related services.

Maori risk of problem gambling

Maori now have two to three times the risk of problem gambling than do non-Maori. This has been confirmed through two studies conducted in New Zealand? one in 1991 and the other in 1999? to determine the current and lifetime prevalence of problem gambling in New Zealand by using an amended South Oaks Gambling Screen (Abbott & Volberg 1992; Abbott & Volberg 2000). These studies are important; the first was conducted before the introduction of casinos and widespread gambling machines and prior to the review of gambling legislation in New Zealand.

Both studies used a similar methodology and questionnaires. Because in 1991 the population was surveyed by way of landline telephone, however, it is considered that the 1991 prevalence figures are more appropriate for Maori (Smith & Barnfield, 2001). In this study it was estimated that the Maori lifetime prevalence for problem and pathological gambling was 16 percent, compared to 7 percent for the total New Zealand population; the current prevalence for the total population was 3.3 percent.

Research suggests that each problem gambler affects the lives of at least five people, usually family members and significant others. This population is larger than those who are assessed as having a problem (Productivity Commission Report, 1999). Considering the 1991 Maori lifetime prevalence and general current prevalence figures and applying them to the 2001 Maori adult census population (299,000), it is estimated that just over 47,000 Maori would have had problems with gambling sometime in their lifetime, and just under 9,000 Maori would have had gambling problems in the past six months. Maori with gambling problems sometime in their life would have affected the lives of at least 239,000 people, and at least 45,000 people are affected on a current basis.

Including the problem gamblers, the overall population affected by Maori problem gambling is approximately 287,000 on a lifetime basis and 54,000 on a daily basis; this equates to one in ten Maori. Problem gambling in the community is certainly a public health issue for Maori and for those who live lives closely associated with tangata whenua (Dyall & Hand, 2003).

Research has also been undertaken in prisons, and it has been found that in New Zealand at least one in three in prison is likely to have had problems with gambling sometime in their life that have contributed to their imprisonment (Abbott, McKenna, & Giles,

2000). For women prisoners, predominately Maori, current prevalence of problem gambling is higher than for males, and approximately one in three female prisoners are in jail related to current gambling problems (Abbott & McKenna, 2000b). Despite government policies and interventions developed in order to try and reduce Maori imprisonment, at least one in two in prison self-identify as Maori.

This population is also likely to have other health problems, especially mental health and drug and alcohol addictions. The health needs of this population should be considered and included in any Maori health strategy. It is estimated that if there are 6,000 people in prison, at least 3,000 will be Maori; of that population at least 1,000 will have had or have problems with gambling, and they would have affected the lives of at least 5,000 other people.

Gambling is also rife in prison and so, although you may enter prison without a problem, you could leave with one. Maori imprisonment and government policies related to gambling are interrelated. Evidence from these studies show clearly the impact of gambling on an indigenous population of significant size and provides a warning for other indigenous populations of the risks associated with gambling.

A public health approach must recognise those populations at risk of gambling-related harm, especially indigenous populations, and ensure that appropriate policy, health, and related services are in place and funded.

Maori expenditures on gambling

Maori as gamblers at present provide considerable revenue to the government, even though tangata whenua have on average half the incomes of non-Maori and many are dependent upon government income support. In 2000, a study on New Zealanders' participation and attitudes on gambling was undertaken by the Department of Internal Affairs. From this study it was found that 87 percent of New Zealanders interviewed had gambled at least once in the past year. In contrast, Maori participation was 91 percent and, on average, Maori reported spending $534 a year on gambling, in comparison to non-Maori (excluding Pacific peoples) who spent $446 annually (Department of Internal Affairs, 2001b).

For Maori this figure equates to approximately $10 a week. This is more than Maori households report spending on education ($7.30), and is equivalent to 3.5 percent of Maori males' ($15,000) and 5.2 percent of Maori females' ($10,000) average incomes in the 2001 census (Te Puni Kokiri, 2000). Money spent on gambling by Maori and by other low income groups is regressive, as they

are likely to pay a greater share of their household income on gambling than other households (Korn, 2000).

Further, if money is spent on playing gambling machines or buying Lotto, gamblers are contributing to the government's income and are providing a greater share of tax revenue in proportion to their personal income. Gambling is a means of both exploitation and redistribution of income and wealth.

Maori presenting for help with problems with gambling report that the month prior to seeking help they were spending over $1115 on gambling (Paton Simpson, Gruys, & Hannifin, 2004). In relation to Maori incomes this level of funding is substantial. It is likely that funding for gambling has come from borrowing or stealing from whanau members, petty crime, not buying kai (food) for the whanau,or by taking out new mortgages or credit cards to keep gambling. Loan sharks are now increasingly visible in Maori and Pacific communities where gambling machines and other forms of gambling are concentrated (Ministry of Health, 2003).

To reduce gambling-related harm in New Zealand a public health approach must focus on the relationship between gambling and taxation and where gambling venues are sited.

Gambling and impact on children

Gambling now impacts considerably upon children in New Zealand, and one in three children live in households where incomes are below the relative poverty line. Many children in these households are Maori (Child Poverty Action Group Inc., 2001). Increasingly in Auckland there are concerns of growing crime, especially in South Auckland, but no one has linked household burglary with increased access to gambling and, in particular, to gambling machines (Rankine & Haigh, 2003).

A public health approach must focus on those who are affected by gambling and problem gambling. The effects of gambling on children and young people and their needs must be a high priority in a public health approach to reduce gambling-related harm.

Location of gambling machines

Gambling machines are not equitably distributed in all communities in New Zealand. They are strategically placed where there are: high levels of gambling; an acceptance that gambling is a normalised activity; concentrations of Maori, Pacific, and Asian populations; and where there is limited community and political resistance to the growth of gambling (Ministry of Health, 2003).

Problem gambling fragments the strength of whanau and communities as it increases the risk of crime, household debt, impacts on relationships, and health problems? both physical and mental.

The impact of gambling and problem gambling must be seen through a wide public health lens and must involve a broad range of public, private and community stakeholders, including diverse ethnic communities.

Gambling and community involvement

The Labour government proposal for communities to have a say in where new gambling machine venues will be allowed is laudable. However, how do communities really have a say to mobilise and, if appropriate, to veto new gambling sites when no community funding has been provided by the government for "David"to take on "Goliath,"or for the "tuna to take on the taniwha"? (For Maori, the taniwha is a fierce legendary reptile.) The responsibility to clean up the mess from gambling has been conveniently transferred from the government to local governments under proposals for responsible gambling and in local councils' new role of being accountable for the social, economic, and cultural environments in which people live.

Local governments will need to be careful in their new role, as they may be encouraged to become involved in the distribution of local funding which comes from gambling. Therefore, like the government they will become dependent upon this revenue to support local activities, rather than seeking funding from local rates to support essential social services. Local governments should demand that funding be made available by the government, possibly through freeing up site payments for gambling machines, to fund community action regarding gambling.

A public health approach in New Zealand to reduce gambling-related harm should support local governments' involvement, and ensure that communities have long-term funding available to support community action and involvement in gambling matters.

Gambling: A community health benefit

All forms of gambling with the exception of casinos are now promoted in New Zealand as a positive community health benefit, even though research is only now being funded to identify the positive and negative impacts gambling may have on communities and on distinct populations, such as Maori (Department of Internal Affairs, 2001a).

Such research should have been completed before major gambling developments were supported and local government legislation was passed enabling communities and Maori to have a greater say in shaping the social and economic environment people live in. Elected local governments can, with Maori participation, now have a major say in whether laws should be developed and enacted in relation to gambling to protect the public's health and safety, or to safeguard against activities that are a nuisance.

These powers have not yet been seriously considered by local governments in relation to gambling. However, there is no reason why such new powers cannot be used to address this issue, when some councils have considered them in relation to determining where prostitutes should be able to operate their business, controlling boy racers (car racing) and dogs, and limiting where alcohol may be drunk in public places.

A public health approach to reducing gambling-related harm must support new areas of research and enable local councils to use their new statutory role and authority.

Need for a comprehensive Maori public health strategy

A public health approach to addressing gambling and problem gambling is important for Maori as it offers a number of new opportunities. They include opportunities to see gambling and problem gambling in New Zealand as a public health issue; for tangata whenua to be a key stakeholder with the Crown in determining the role, size, and place legalised gambling should occupy in New Zealand society; and for Maori to be involved in all aspects of planning, delivering, and monitoring of any public health strategy to reduce gambling-related harm.

Drawing upon the government's health strategy for Maori in He Korowai Oranga, which focuses on the development of whanau (family networks), hapu (tribal communities), and iwi (tribal groups), there is a need now:

- to raise Maori awareness of the risks associated with gambling
- to provide government funding for essential Maori services
- to include the Treaty of Waitangi in new gambling legislation
- to have a specific Maori public health strategy developed that has clear goals, objectives, and targets to be achieved, so that the risk of Maori problem gambling is reduced at least to the same level of risk of problem gambling as with

Pakeha within two to three years (Ministry of Health, 2002; Ministry of Health, 2004).

To achieve the above, Maori health providers across all health, disability, social service, and justice sectors will need to be resourced to develop and deliver public health interventions in gambling, and for education and workforce development. A Maori research agenda will also need to be funded so that Maori are empowered and able to participate alongside the Crown, local government, and health care and other agencies in major decisions.

A Maori comprehensive public health strategy must be developed by Maori with key stakeholders as a fundamental part of a strategy to reduce gambling-related harm in New Zealand.

Conclusion

New Zealand 's future, if we look closely at the proposals in the Responsible Gambling Bill? now called the Gambling Bill? is dependent upon a nation of gamblers. Gambling is now a fundamental part of the government's tax revenue strategy. Problem gamblers now provide considerable income to the state, directly and indirectly, as a result of their gambling. Without income from gambling, the government would have to consider other options for taxation, such as increasing personal income tax, placing a tax on the sale of property or shares, imposing death duties, and so forth. Further, without gambling, the government would be unable to invest now to help offset the costs later for an aging New Zealand population, predominately Pakeha (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003).

These decisions are now being taken at the expense of Maori, even though it is known that tangata whenua die on average ten years earlier than non-Maori and could benefit from positive investment, such as access to tertiary free education, quality housing, and investment in Maori and tribal businesses.

The New Zealand government has all of the signs and symptoms of being a problem gambler. A public health approach to addressing gambling-related harm places the government in the spotlight, highlights areas of conflict of interest, raises the visibility of Treaty of Waitangi rights and obligations, challenges relationships and stakeholder interests, and requires new policies and interventions be put in place.

In conclusion, this conference is important in shaping a public health approach in New Zealand to reduce gambling-related harm. The Maori experience of gambling in New Zealand provides

a real warning of the risks and costs of gambling for indigenous populations. It also provides an opportunity to remind the government, both nationally and local councils, that in accordance with Te Tiriti o Waitangi, Maori have a right to have a say in all aspects of gambling policy in New Zealand and to financial benefits.

Real evidence is mounting of the need to support Maori development and for Maori to consider legal action for breaches of Treaty of Waitangi obligations in relation to gambling as part of a public health response to reduce gambling-related harm in New Zealand.

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1 The Gambling Act 2003 was passed in New Zealand during the course of the international conference "Gambling through a Public Health Lens,"held in Auckland, September 2003. Within the legislation is defined the formula required to be considered by gambling industries to provide funding for gambling-related services, and it was defined in policy that the Ministry of Health would become responsible for purchasing services to reduce gambling-related harm. The Ministry of Health took over this responsibility on 1 July 2004.

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Pokie gambling and Maori women: Friend or foe?

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Abstract

Gambling behaviours and health promotion strategies to address problem gambling are becoming increasingly important in Aotearoa-New Zealand, as in other parts of the world. Successful health promotion strategies are underpinned by contextual knowledge around the issue in question. This paper discusses some of the contextual factors that health promoters will need to consider when addressing strategies aimed at Maori women affected by problem gambling. The paper is a work in progress contributing to a doctoral thesis to explore Maori women's perceptions of new forms of gambling and the health implications on whanau (extended family) in Rotorua and Auckland.

Introduction

[1] The purpose of this study is to document the views on gambling of Maori women gamblers and their whanau (extended family) members, and to explore the impact of gambling on the health of Maori women and their whanau in Rotorua and Auckland.[2] In addition the views of problem gambling service providers will be explored.The study so far is comprised of interviews with Maori women and their whanau and Maori service providers. Participants were recruited from personal and whanau networks as well as through advertisements placed in Maori health service locations. Women who were interested in being part of the project contacted the researcher directly.

This paper focuses on the findings from interviews conducted with 12 Maori women, who identified that they have had or currently do have a problem with gambling, specifically on pokie machines (electronic gambling machines). This group of women is made up of solo mothers, community health workers, professionals, academics, and kuia (respected Maori elder women). Additional

interviews are still in progress. The paper presents some preliminary findings of content from the interviews so far. It aims to give an idea of some of the issues that Maori women face in their use of pokie machines. The descriptions attend not only to the negative effects, but also to what Maori women see as the apparent positive side of using pokie machines.

Despite the recent and past studies by gambling theorists that Maori involvement and new forms of gambling have increased in Aotearoa-New Zealand, there is little information about why this may be (Abbott & McKenna, 2000; Abbott, 1999; Abbott & Volberg, 1999; Abbott, 1998; Dyall, 1997, 2002). For example, there has been little research or theoretical development linking the effects of gambling issues for Maori women and their whanau (Dyall, 2002; Curtis, 2000). Of particular importance is the exclusion of Maori women from past and present studies undertaken by gambling theorists in Aotearoa-New Zealand. Moreover, most of the studies documented have focused more on problem or pathological gambling and relate to male samples. In order to address this imbalance the following will help provide some information to overcome the gap that currently exists in Aotearoa-New Zealand about Maori women and the impact of gambling on their whanau. It will show that if some of the issues identified below are not taken into consideration in the design of programmes then the seriousness of gambling for Maori women will continue to be neglected.

Overview of Maori women and gambling in Aotearoa - New Zealand

Maori women and gambling

Maori women's health status has been a concern to the government of Aotearoa-New Zealand for a number of years (Ministry of Health, 1998). The 1998 publication of data on the problem gambling help-line has also identified that Maori are more likely to be problem gamblers (Compulsive Gambling Society, 1998). Moreover, reported incidence of problem gambling for Maori is increasing in comparison to other ethnic groups. This suggests that Maori groups are more proportionally disadvantaged and their whanau are in crisis.

The 1991, 1992, and more recent 1999 survey (Abbott, 1991, 1992, 1999) carried out to identify the prevalence of gambling problems in the community found that rates of problem and pathological gambling were significantly higher for Maori women than for non-Maori women. The year following the last survey, a report from a survey of gambling and problem gambling among recently sentenced inmates in three New Zealand prisons for

women found that Maori women are 70 percent more likely to have a problem with gambling (Abbott & McKenna, 2000). According to the Problem Gambling Helpline Maori women are six times more likely than non-Maori women to experience gambling problems. Abbott suggests that the position is similar for most indigenous women worldwide, that gambling behaviours have increased rapidly over the past decade (Abbott, 1998). These recent findings suggest that gambling is problematic for Maori women.

Although these differences in prevalences exist and are known, what remains undocumented is the actual lived experiences of Maori women who are problem gamblers. Likewise, Maori women are increasingly seeking help with problem gambling related to pokie machines, and present for treatment at least 10 years earlier than non-Maori (Dyall, 2002). More Maori women have gambling problems than non-Maori women, leading to increasing concern (Abbott, 1998; Dyall, 1997, 1998; Morrison, 1999; Sullivan, 1997).

The increase in Maori women's gambling

According to a senior Maori counsellor working in the field of addictions and primarily in gambling, 40 to 55 percent of her clientele are Maori women (Dianne Richards, personal communication, April, 2000). This finding is consistent with a recent Auckland University study showing that Maori women were four times more likely to become problem gamblers in comparison to non-Maori women (Grant & Kim, 2002).

More recently, the "Brainstorm" facilitators reported a study which found that there was a high incidence of gambling among Maori and Pacific Island people, especially young Maori women (Laird, 2001). Further, some participants from the same study sought information to learn more about the links between Maori women and gambling and why Maori women featured so prominently in the current statistics. The same year the Group Te Kahui Trust and the Rotorua Addictions Centre (from Rotorua) in collaboration with the Problem Gambling Foundation piloted an information-based approach to determine the effectiveness of a harm reduction strategy amongst Maori women problem gamblers in the Bay of Plenty region (Grant, 2001). The primary objective was to determine the patterns of co-consumption and provide information to the women to perhaps provide some context for their gambling. Unfortunately this project did not eventuate due to preliminary difficulties. However, what is important to note is that Maori women in the Bay of Plenty region are experiencing problems with gambling.

A study by Abbott and Volberg (1999) on problem gambling

indicated that Maori women's gambling has increased following the introduction of casino and pokie machine gambling. Moreover, it seems that Maori women are likely to spend six times more per annum on gambling than non-Maori women (Dyall, 1998) and a high proportion of Maori women access the gambling helpline (Paton-Simpson, 2002, p. 244).

The effects of colonisation (where Maori went from a position of power to powerlessness following the introduction of the European settlers), ongoing legislative law reforms, and the social reforms over the past twenty years have had a profound effect on Maori social structures. As a consequence of these effects Maori women often are exposed to physical and emotional violence from their partners. Maori women suffer more health problems, including smoking, cancer, and alcohol- and drug-related problems per person compared with Pakeha (New Zealand-European origin) women (Durie, 2001). These socio- economic factors must be included to provide a context as to why Maori women favour gambling. It is also important to not generalise these findings to all Maori women.

Income

Poverty had been a feature in the lives of most of the women interviewed for this study. Gambling was often seen as a way to supplement income and improve their financial status.

Maori women who are unable to meet the basic needs of their whanau often use gambling as a rationale for this need. That is, low-income earners such as Maori women are unable to meet the costs associated with food, clothing, and rent (Ministry of Women's Affairs, 2002) and this results in financial anguish (Morrison, 1999). Market rentals have made it impossible for many women, especially solo mothers, to be able to provide decent non-crowded homes for their families. In Auckland rents rose from between 25 to 40 percent in the last two years (Ministry of Women's Affairs, 2002).

An examination of the international gambling literature draws the same conclusion (Hunter, 1988; Abbott, 1999). That is, low income (i.e., earning less than NZ$25,000 per year) was found to be a factor associated with lifetime problem gambling for both Aboriginal female and for non-Aboriginal female problem gamblers. Again, it is indigenous women who do not fair well in regards to income.

With reference to income and socio-economic status the women often talked about never being dependent on other people and being able to live a comfortable life. Gambling was often seen as

a way to supplement income and improve their financial status. Maori women said:

> I am going to win big …and never have to work again… never have to be on the benefit again.
>
> I will be able to send my kids to university.
>
> I will never be without ever again.

A study of Australian women found that "to win the jackpot to increase their wealth" was a significantly frequent response for most people who gamble on pokie machines (Brown & Coventry, 1997). A similar trend was noted for most of the women in this study. That is, the primary motive of overcoming their current lower socio-economic status was indeed their reason for playing on the pokie machines. They identify how the illuminated jackpot signs at pokie venues lure and insinuate easy access to instant wealth. Furthermore, vigorous advertising by casinos promising to eliminate the current lack of income or low income is indeed very appealing:

> I got hooked and then when I saw how big the jackpots were, well it just got more exciting and worthwhile. I kept thinking that I would win the jackpot and I would never have to work again.
>
> I could just see myself driving away on one of the Sky City BMW's it was so seductive…

Given the recent trend in the uptake of new forms of gambling activities for Maori, past and current studies suggest that Maori are more proportionally disadvantaged than non-Maori and their whanau are accordingly negatively affected.

Furthermore, Aotearoa-New Zealand studies of gambling problems for Maori have not focused on ethnicity as a variable and have insufficient Maori in their samples to give an accurate account of their gambling problems (Dyall, 1997). That these surveys have inadequate numbers of Maori participants to be accurate is particularly significant when viewed in the context of a 1991 report prepared by the Public Health commission on the health status of New Zealanders (cited in Durie, 1994). The study considered socio-economic status, food and nutrition, alcohol, tobacco, and pathological gambling to be particularly relevant in contributing to the poor health of Maori. The relevance of gambling and socio-economic status for Maori gamblers is that Maori spend almost twice as much on gambling as non-Maori, or NZ$686 per year compared to NZ$376 per year (Dyall, 2002).

However, the issue is that Maori households and personal incomes are significantly lower than non-Maori (Te Puni Kokiri, 2000). This reality needs to be examined in more detail.

Being a Maori woman in Aotearoa-New Zealand

Maori women make up a disproportionate share of social beneficiaries, are frequently from low socio-economic regions and often live away from their whanau and thus have limited support networks. Maori women are more likely to be poor than any other group in Aotearoa-New Zealand today, including the elderly. Poverty in Maori society greatly affects the rest of a person's life, so for best effect it has to be nipped in the bud; prevention is better than cure.

The impact of the current market on Maori women is that value is only placed on paid work. There is a view that the market is supposedly neutral and gender-free, but in fact the contribution of Maori women is currently only counted when they are leading lives similar to men's (Ministry of Women's Affairs, 2002). Over the past 10 or so years what women uniquely do? either because of biology or tradition? has been viewed as of less worth because it is unpaid and because women do not operate by the market's rules of maximising their own self-interest. As no income or profit is involved, it is not viewed as productive to give birth and raise children. The effect of this on women has been very detrimental.

Pay equity for Maori women has been a contentious issue for the last two decades (Durie, 2002). The recent study by the Ministry of Women's Affairs with the support of the Maori Women's Welfare League found that Maori women earn lower amounts. That is, for every dollar earned by non-Maori men, Pakeha women earn 86 cents whereas Maori women earn 74 cents. These findings fit well with those gambling theorists who propose that people gamble primarily for economic gain and to increase their wealth (Cornish, 1978; Dickerson, 1984; Halliday & Fuller, 1974).

Women's organisations have worked hard over many years to gain social support for women and recognition in social and economic policy of the different reality of women's lives. The Women's Health League and the Maori Women's Welfare League have made significant contributions toward these gains (Murchie, 1984; White, 1988; Durie, 1999). The social welfare state suited women because they are much more dependent on the social wage and the benefits of the welfare state than on wages earned in the labour market.

However, much of this has been swiftly eradicated in the past few years. Despite continuous rhetoric about traditional family values,

the family has been severely undermined by recent government policies. Solo mothers have suffered benefit cuts, and despite ratifying the UN Convention on the Elimination of All Forms of Discrimination against Women, New Zealand exempted itself from the requirement to provide paid parental leave. This means that many women with newborns are forced back to work earlier than they want. Low wages and job insecurity also force mothers back to work to hold onto jobs or keep their careers on stream. Alternatively, they delay their first child until their late thirties or early forties, when their fertility is reduced, thereby increasing the risk of breast cancer through late motherhood, and leading to exhaustion from trying to raise boisterous young children during mid-life. Low wages mean that both parents need to be in the paid workforce. The biggest change in women's workforce participation has been the entry of women from two-parent families into paid work. Twenty-seven percent of women with children under one year of age and 45 percent of those with children aged one to four years now work.

There is also a recognised lack of services available for Maori women. Gambling services are no different. A start would be to elicit the help of government agencies (such as the Ministry of Women's Affairs) to help ensure that gambling services for Maori women are given urgent attention. The Women's Health Strategy advocates for a gendered approach to health policy and has women working within the District Health Boards who work with these issues. However, for effective implementation of the identified issues consultation and collaboration must be first initiated with Maori communities working in the area of gambling addictions. To not include the expertise of these key informants has the potential to result in ineffective services that further disempower Maori women. The issue of equity for Maori women has important implications, for they require support to develop gendered and culturally appropriate programmes. Currently, only a limited number of evolving gambling services are available for Maori women in Aotearoa-New Zealand (Dyall, 2002). It is also fair to say that these evolving services need to be well-supported and resourced to ensure that gambling-specific training is ongoing and, more importantly, that the acceptance of Maori-specific skills and programmes are acknowledged.

Gambling motivations

Imagine what it would be like to live a day in the life of a movie star? this for most people living ordinary lives would be like entering another world; to always have a guaranteed high income and the recognition that goes with high socio-economic status. As well, there would be more positive social relationships and support networks. There is also a degree of glamour and the ability to access services that allows one to manage stress.

Wouldn't we all like to live this life? For Maori women this is the dream they are chasing or living when they play the pokies.

The following are some quotes from the study participants that fall under the categories of income, social status, positive social relationships, glamour, and stress management.

Income

It is clear from the information previously mentioned that Maori women spend more than non-Maori on gambling (Dyall, 1998, 2002). However, Maori incomes in comparison to non-Maori are substantially lower than even those for non-Maori women (Dyall, 1998, 2002). The implications for Maori overspending on gambling to try to increase their wealth have been a public concern from some Maori communities and active anti-gambling lobbyists, both Maori and non-Maori, in relation to the social, economic, and cultural determinants of gambling. Again, there is insufficient information about the financial losses incurred by Maori gamblers. The following quote best describes how Maori women use gambling to help overcome this dilemma.

> … it basically means that I could get out of what I would call a poverty trap…I want to make big money and I suppose you could say it is the lazy way, you know but I found that is why I gamble. I just want to be like the other people in there that are winning big money.

Social status

There is a belief that all Maori women have access or entry to special social status; this belief is a secondary obnoxious by-product of past and present government legislation, in my opinion. Maori have not benefited from legislative changes and particularly from changes in legislation that have greater negative impacts on the poor than on the wealthy (Dyall, 2002). For example, with the anti-smoking legislation it could be argued that one needs to be rich to smoke (due to the high price of cigarettes), but smoking remains a staple lower-socio-economic comfort (Glover, 2000).

It has been widely theorised that the measure of a people's success in any society is material wealth. Moreover, have not smoking, drinking, and gambling been perpetuated by advertisers as high social status indicators? Furthermore, the women could hope to experience a lifestyle that they had never known before. Material assets mark the quality of success in any society. This materialistic accumulation of commodities informs people of their success in society. Further, it provides a measurement of where

you are situated in society. Given that Maori women continue to dominate the low-income bracket it is reasonable to infer that for some of the women their hopes and aspirations may centre on what they believe they can attain by gambling.

One of the major issues highlighted from the interviews was the women's perception that using the pokie machines meant that they got to live life on the other side of the fence. For several women:

> When I get on that machine I get to star in my own movie, there is lots of attention; the stewards bring you complimentary food and drinks. You know why, I can be whomever I want to be, if I want to be in a jungle setting I play on the Triple Tigers and Jungle cash machines. I too, can be Jane and Tarzan. My favourite are the Multi Star machines, now that is where I get to be the best actress of all, and the attention when those bells start ringing it is almost orgasmic. Yes, that is what it is like for me I can get to star in my very own movies.
>
> Using the Pokies allows me to experience life on the other side...
>
> I don't have to worry about all the hassles of life while I am in the pokie venue.
>
> I get to close the door and leave everything behind.

Positive social companionship

An Australian study of gender differences in pathological gamblers seeking medication treatment with 78 women and 53 men found that women are more likely to become pathological gamblers sooner after starting to gamble than men (Grant & Kim, 2002). Similar results have come from Brazil (Tavares, Zilberman, & Gentil, 2001). Furthermore, women stated that avoiding loneliness was a significant factor in their gambling. To date, we know that for some Maori women gambling activities have made possible the process of whanaungatanga (the process by which whanau ties and responsibilities are strengthened) (Durie, 1994), and, as well, long-term friendships and whanau connectedness (Morrison, 2001). A gambling study in Rotorua (Morrison, 1999) supports the view that, for Maori women, social support systems are regularly maintained whilst playing in card schools and housie (bingo). The card schools serve to foster long-term friendships with whanau members. They provided an occasion for laughter, sharing of problems related to relationships or whanau, and more importantly

whanaungatanga (connectedness), i.e., the women were able to provide some context to their own gambling behaviour from information shared by older members of the card schools. Furthermore, gambling in card schools and housie halls provided safe environments for the women. Custer suggested, although in a different context, that society accepts men gambling, but disapproves of women gambling (Spanier, 1994).

Furthermore for most of the women in Rotorua and Auckland it was noted that they have adapted their regular gambling venues to suit their own needs. That is, using the pokie machines allows for increased positive social companionship that is not often available to Maori women. The turnaround in how pubs were made to be more female friendly is widely emphasised in pub and casino venues. The once male-dominated domain of male-only pubs has seen a significant change with an increasing number of women who feel comfortable walking into a pub. This is in contrast to negative views associated with women and gambling by some, particularly by men (Custer, cited inSpanier, 1994). The message that came through in the interviews was that the machine accepts the women for who they are in terms of gender, age, and culture. These messages came from different women:

> The machine becomes my companion; it doesn't ask anything of me.
>
> The machine doesn't kick me or put me down.
>
> It never answers me back.
>
> The machine accepts me for who I am.

These quotes further suggest that gambling on pokie machines is indeed appealing to some Maori women.

Glamour

Glamour was an issue highlighted by the Maori women as a major draw card for going to pokie venues and using the machines. The venues often provide services and commodities that are usually out of their reach. Some of the women reported that they did not have access to a television set, let alone to digital satellite television. It is sometimes assumed that in every New Zealand household a television is nestled comfortably in the living room. This chattel is considered important to people's daily enjoyment and access to information. However, this is not always the case for some of the women in this study. The women discussed how owning a television was secondary to providing for the basic needs required to maintain their households. Furthermore, the

opportunity provided by gambling venues to watch television without the constant demands of children or partners was also reported. This was evident in the following comment: "I can watch SKY TV [digital satellite TV] for as long as I want with no one wanting to change the channel." Comments like these indicate that, as is often the case, Maori women prioritise their own needs secondary to that of their whanau. There is a belief that women who put their own needs first over their families' are considered lacking in maternal ethics (Van Den Bergh, 1991).

For some of the women, the comfort and elegant surroundings of the gambling venues are also attractive. For example, some of the women alluded to the comfortable furnishings that enable them to relax and unwind on the machines. One of the women reported that for her it was about winding down before she went home to her less plush environment: "Look, I get to sink down in those lovely rich-coloured, plush sofas before I head home to my crusty, shabby, and soiled couch." For whatever reason, it is the plush environments and glamour that continue to attract Maori women who have little material wealth.

There was another view also that regardless of winning or losing money the women had the opportunity to self-indulge with the assistance of staff and available resources provided by the operators, such as:

> I don't have to worry about going hungry or thirsty, it is there for free and it just isn't crappy coffee it is the real coffee and it is unlimited free access to refreshments [food and drink].

Most of the pokie venues provide host responsibility that includes refreshments and food for their patrons. This is another attraction that helps to keep the women distracted. The rationale for this provision could also be seen as a way to ensure that gambling patrons do not have to leave their premises when they are hungry or thirsty. It would appear that some basic needs are being provided for by some of these operators. In casino environments, the women described having staff and casino assistants available to meet their every need—an otherwise unfamiliar experience. For example, some of the women who had husbands or partners spoke about having no support with childcare and household duties. Most of these responsibilities were met by the women as was the provision of meals. This comment is best described in the following paraphrase from three of the women: people at my beck and call, asking how they can help ME. What is important to note is that for some women who did not own a television set for economic or other reasons, this opportunity was indeed met by the pokie operators' venue.

Stress management opportunities

Gambling behaviour in people is often preceded by exposure to stress and personal adversity, notably, interpersonal losses and conflicts, commonly in relationship breakdowns, and disciplinary or legal crises. Such events may occur relatively commonly and may act as precipitating factors for high-frequency gambling (Chetwynd, 1997; Lesieur, Blume, & Zoppa, 1998). Furthermore, when such precipitating stressors arise, they may be exacerbated, as when a person experiences an increase in anxiety or depression because of the pre-existing stressors. Coman, Burrows, and Evans's (1997) study on why men and women gamble concluded that women gamble as a way of dealing with stress. Conversely, men in the study gambled more for financial reasons, and only to a lesser extent for stress reduction (p. 238).

The psychological problems of some Maori whanau members may arise from the stresses of gambling, although gambling alone may not be a sufficient reason to account for all the direct impacts associated with gambling (Morrison, 1999). In contemporary psychological literature, Lesieur et al.'s studies have been used extensively to study how gambling may affect health particularly in relation to stressful situations (Lesieur & Blume, 1987; Lesieur, Blume, & Zoppa, 1998). They also found that a number of cultural and psychological factors may mediate the relationship between gambling and stress. Gambling is strongly linked with psychologicaldistress, detachment from interpersonal interactions, isolation, and encapsulation in his/her own preoccupation with thoughts of the next session of betting/gaming and of the need to obtain funds to feed his or her habits (Sullivan, McCormick, & Sellman, 1997).

Low self-esteem has also been associated with high-frequency gambling behaviour (Volberg, Reitzes, & Boles, 1997; Blume, 1985; Coman, Burroughs, & Evans, 1997). One way to increase a person's esteem is through the short-term benefits of gambling and the illusion of control that many gambling activities offer (Volberg, Reitzes, & Boles, 1997). Most theorists recognise that people with emotional and behavioural difficulties feel badly about themselves (Sullivan, McCormick, & Sellman, 1997; Lesieur, Blume, & Zoppa, 1998) and demonstrate low self-esteem (Coman, Burroughs, & Evans, 1997). Research undertaken to ascertain the relationship between stigmatisation and hiding the compulsion to gamble has suggested that women favour gambling and drinking alone (Blume, 1985; Lesieur & Blume, 1991a). Additionally, there is a general tendency for women to not seek help for their addictions because of the stigma that may be attributed by family members and the shame that it will bring to their families (Van Den Bergh, 1991). Major problems facing Maori women are the effects of poverty and exclusion. Lack of

opportunities for partner support for parental time-out can have an impact on the number of problems encountered on a day-to-day basis. There is also little support for solving practical and psychological problems. This creates a cycle of despair when people are unable to meet their daily needs. The potential for high vulnerability to stress is further accentuated. Many of the women talked about the use of the pokie machines as a way to relieve and manage the stress associated with their lives and work. An example:

> You know, if you can imagine all this work that was hugely demanding of my time, often I had to work out of my ordinary work hours and it just all got on top of me. The only way that I could handle the work pressures was to go to the pokies. The machine didn't demand anything from me, it was non-threatening and all it asked was to be fed with coins.

However, most of the women reported that they started gambling relatively late in life and that they initially looked upon their gambling as a means of escape from overwhelming personal problems (Lesieur & Blume, 1991b). The following quote describes what some of the women experienced:

> I started gambling in my early 60s to get away from all of the constant demands of my family […] just recently I have had a lot of stress related to my oldest daughter, and her ex-partner violently abusing her. There was no support because I had no one to ask for help. The pokie machines helped me to forget about all my problems at home.

Solo parenting

Recent information indicates that many Maori women are parenting with little or no support from a spouse or whanau (Ministry of Women's Affairs, 2002). Te Awekotuku (1991) documents the complex issues related to rearing children without the support of a partner and extended whanau. A poorly paid Maori woman is often faced with a multitude of issues. She often has to meet the daily needs not only of her own whanau but of her extended whanau as well; more often than not she will have a large whanau; and rely heavily on government assistance for pre-school and after-school child care responsibilities. At the same time she will try her hardest to appease the many material demands that her children make as a result of peer pressure:

Look, the list goes on and on and I just can't cope. It has to be Nike's or nothing at all for my son. My daughter she won't wear

anything but Roxy [girls' clothing] I keep telling them that I can't afford these labels but they just won't listen, so I hope like crazy that I will get a windfall from the pokies …

Work related issues

Maori women are more likely to be working in services that have limited resources and little professional support, and they often work over and above the call of duty; therefore stress is an inherent part of their lives. There is often a huge expectation that Maori staff will go beyond their job description to assist Maori clients. The stress management opportunities that the pokie machines offer outweigh the negative. For example, women said:

> Using the pokies lessens the stress of my work and life.
>
> I don't have to make major decisions.
>
> I don't have to worry about things.
>
> I just have to think about me.

Other findings

Additional findings from the interviews were about the accessibility of childcare services at pokie machine venues and the location of pokie machines close to other services in restaurants and shopping malls. One of the women reported the following information about the invasion of pokies in her suburb:

> … like tomorrow when I wake up and go to school and there are three pokie machines all around me, it is a constant war. I have three pokie venues within walking distance; I don't need a car or a bus. You can't even walk a different way because you have got the top of town so that when you get into the town it is on the right. Even if you came in the other way there is one on your right so they are everywhere even right next to the library, very strategically placed. Now they have got them in one of the Valentines Family Restaurant.

To fuel the fire, pokie machines with Maori icons are now in venues popular among Maori women gamblers:

> My favourite machine is tikitiki [good luck symbol], he brings me good luck and when I lose my money he goes arohamai [sorry].

> I don't feel so bad losing my money on tiktiki because he is one of us.
>
> I don't have to go to the marae because my marae [Maori meetinghouse where traditional gatherings and meetings are held] has come to me.

These reinforcers from their culture only serve to increase the attractiveness of using pokie machines.

What does this mean for Maori women? As highlighted previously, there appear to be many positives associated with using pokie machines and for many Maori women these apparently outweigh the negative consequences including:

- financial mismanagement
- loss of home, relationships, whanau, and friends
- an overwhelming obsession and its associated behaviours, including lying, stealing, and deception.

Where to from here?

The most important message in this paper is that Maori women are experiencing significant negative effects from their increased participation in gambling. Due to their circumstances they find gambling to be a friend and a positive experience, and they either deny or ignore the negative aspects. More importantly, Maori women's perceptions of gambling need to be better understood in order to design suitable interventions. From the point of view of Maori women, they see far more positives associated with gambling than negatives and this perception needs to be accommodated within promotions and programmes. Employment and income opportunities, increases in positive social support, and affirmation of Maori women being valued for who they are, all need to be targeted in order for Maori as a culture and the people of Aotearoa-New Zealand as a nation to reduce the prevalence of harm from gambling. Yet Maori perceptions of gambling are infrequent in the literature (Bayly, 1999; Dyall, 1998; Morrison, 1999).

With the current absence of culturally-appropriate research health promotion campaigns and other intervention strategies, we are forced to rely primarily on wisdom from other sectors and anecdotal accounts. The interviews with Maori women in the current study provided some initial information on their perceptions and experiences of new forms of gambling. Despite the fact that there have been numerous studies in Aotearoa by non-Maori, Maori women have yet to be invited to discuss their

opinions and views. This descriptive information is a first step and should not be viewed as sufficient information upon which to base public health and treatment interventions. But it is still of critical importance to ask Maori women directly for their views and to discuss any issues that they think may have contributed to compromising their own health, their relationships, and the health of their whanau. As one of the Maori woman aptly reported:

> Every day is a war.
>
> No reira komutu to korero tena koutou katoa nga hui hui mai.

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Endnotes

1 The following paper details a presentation given on 13 September 2003 at the Third International Conference on Gambling held in Auckland. The introduction of the presentation provided an overview of the preliminary findings of the current Postgraduate Scholarship funded by the Health Research Council of New Zealand.

2 Both cities are in the northern part of New Zealand. Auckland is the larger city with over 1.2 million people, and Rotorua has about 67,000 people.

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Gambling issues for Tongan people in Auckland, Aotearoa-New Zealand

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Abstract

This paper focuses on a research project on gambling issues within the Tongan community in Auckland, New Zealand that was conducted by the Auckland Regional Public Health Service (ARPHS). It outlines the background and rationale for the research, progress as of the time of writing, preliminary findings, and future plans.

Introduction

In Aotearoa-New Zealand, problem gambling is more prevalent among people with lower socio-economic status and lower educational levels, within which the Tongan community in Auckland features significantly. The Problem Gambling Foundation of New Zealand identified that sixteen percent of the Pacific people who visited the Auckland Sky casino said they went there eleven times or more in one month. Thirty seven percent of Pacific people spent three hours or more at the Auckland Sky Casino during each visit and Pacific people are reported to have spent more money on gambling at the Auckland Casino than any other ethnic group. However, Pacific people involved in gambling are less likely to make contact by phone with treatment facilities, such as the Problem Gambling Foundation of New Zealand (The Study of the Social and Economic Impacts of New Zealand Casinos, 1998).

The project was managed by *Vaka Ola* (t he ARPHS Pacific Team) and was divided into two phases. The first phase was 18 months long, starting in December 2002, and included community consultation and the engagement of interested people from the

Auckland Tongan community. The New Zealand Health Research Council funded the first phase. The second phase has two parts. The first is data collection and analysis, and the second is the development of a health promotion plan to be implemented with other health providers in the Auckland Tongan community.

Research objectives

The overall objectives of the research project were:

- To explore the relevant issues for Tongan people in Auckland which contribute to the risk of developing addiction to gambling and problem gambling.
- To identify the effects of gambling on Tongan people in Auckland.
- To provide relevant information to health providers and planners in the planning and implementation of culturally appropriate strategies against problem gambling for Tongan people in New Zealand.

Pacific peoples

Comprised of seven major ethnic groups and numbering 231,801 (New Zealand Census, 2001), Pacific peoples are over-represented at the lower end of the socio-economic spectrum in New Zealand. The 40,716 Tongan people (New Zealand Census, 2001) stand in the lower hierarchy in most socio-economic categories.

Figures show that Pacific peoples are twice as likely to be unemployed, have less than 80 percent of the income of other New Zealanders, make up a third of those in overcrowded households and have higher hospitalisation and sickness rates than the rest of the population. These statistics have a cumulative effect on the health and well being of Pacific peoples. (Pacific Vision Conference Report, 1999)

Tongans in Aotearoa-New Zealand

The bulk of Tongan migration took place in the 1970s when there was a scheme between the two respective governments to allow Tongans into New Zealand on restricted working permits. They were to work in the then-booming economy as unskilled labourers. During this time Tongans also migrated to Australia and America and there are now significant pockets of Tongan communities throughout these countries.

Most Tongans in New Zealand still practise their own customs and traditions while adapting and living in New Zealand. They donate money to their churches and send money back to their home islands to fulfil family commitments and obligations. At the same time, they experience modern lifestyles, including gambling. These influences are factors in the conscious and subconscious changes made within the Tongan family structure.

The Tongan community was chosen for this research project because of the lack of information about gambling in this community, the opportunities for comparison with other Pacific groups, the problems already identified by *Vaka Ola*, and the previous involvement of the Tongan researchers with the Tongan community. The largest Pacific group, the Samoan community, had already been researched in a small pilot study. It was also discovered that a Samoan PhD student was investigating Samoan women and gambling. The ARPHS Pacific Team, Vaka Ola, felt that it would be beneficial to have two Pacific community studies in order to compare and identify similarities and differences in factors contributing to problem gambling. It would also be beneficial to compare findings with Maori research that was just completed.(Dyall & Hand, 2003). Anecdotal evidence suggested that many Tongans were deeply involved in gambling whether with casinos, local pokie machines, TABs (a betting facility for horse races and sports betting), or lottery products. The economic and cultural consequences of these gambling practices in the Tongan community had also been highlighted to the research team.

The ARPHS staff who identified gambling as a research topic were Tongans, and one team member was a Burmese physician who worked in Tonga for six years and had strong Tongan affiliations. Consequently, staff had a sense of cultural safety and confidence in working with the Tongan community.

Relevance to health: A public health response

After the July 2001 Problem Gambling Foundation of New Zealand National Conference, the government officially recognised problem gambling as a public health concern. Current restructuring within the Problem Gambling Foundation includes progressive strategic movements towards a ministerial public health portfolio.

The ARPHS has also identified the prevalence of problem gambling as an emerging concern within lower socio-economic communities. Anecdotal evidence collected through Pacific community fieldwork and networks indicates that problem gambling is increasingly identified as one of the factors leading to

family and/or partner abuse as well as financial stress and deficits. Pacific island staff working within their communities have identified and expressed concerns regarding the impact problem gambling is having within Pacific families.

Brief literature review of Pacific gambling]

The 1997 clinical report of the Compulsive Gambling Society of New Zealand (CGS) noted the significant increase in gaming facilities as well as the increase in numbers of problem gamblers. Gambling has grown considerably as a recreational and tourism industry since the late 1980s.

This growth resulted in an increase in the prevalence of gambling, problem gambling, and pathological gambling in Aotearoa-New Zealand. The prevalence of problem gamblers and pathological gamblers can be categorised into two groups:

	Pathological gambling	**Problem gambling**
(a) Lifetime prevalence rates:	4.25 % (+/- 0.6 %)	2.7 % (+/- 0.5 %)
(b) Current prevalence rates:	2.1 % (+/- 0.4 %)	1.2 % (+/- 0.3 %)

The prevalence for Maori was three times higher than for the European population. The prevalence for Pacific peoples was six times higher than for the European population and twice as high as for Maori. Problem gambling was more prevalent among people with lower socio-economic status and lower educational levels of all ethnicities (Abbott & Volberg, 1991).

Pacific peoples had high prevalences of both problem gambling and pathological gambling. Table 1 demonstrates the highest prevalence of problem gamblers and pathological gamblers with Pacific ethnicity compared with other ethnic groups in New Zealand.

Table 1: Ethnic-specific prevalences of problem gambling and pathological gambling. (Adapted from Australian Institute for Gambling Research, 1998)

Ethnicity:	Problem gamblers:	Pathological gamblers:
European	3 %	2 %
Maori	9 %	7 %
Pacific Islanders	16 %	15 %
Asian	10 %	1 %

Economic effects such as debt and bankruptcy are common among problem gamblers. In addition to the economic costs, problem gambling places enormous impacts on the families of problem gamblers through financial stress, loss of personal property such as TVs, motor vehicles, furnishings, and family homes and savings. Problem gambling is also associated with depression, denial, lying, crime, fraud, theft, violence, and partner and child abuse and neglect.

Existing gaming legislation is inconsistent and focuses on economic issues while ignoring socio-economic impacts. Brown (2001) suggests that governments review their gambling policies to include harm minimisation and harm reduction strategies. Brown states that a vision of responsible, sustainable gambling can be achieved through a balanced combination of treatment, harm minimisation, and health promotion strategies. However, current treatment facilities are limited to providing health care at a secondary level by focusing on interventions at the problem and pathological gambling stages.

Research

Progress in Phase One

At the time of writing, the research team has completed community engagement and interviewed 50 participants, including 20 religious ministers and 30 community leaders and professionals. This data is being analysed.

Some preliminary findings

Preliminary findings confirmed anecdotal evidence and the results of previous research on gambling among Pacific peoples. From the perspective of the participants, gambling is a major health issue that is emerging quickly and rising very steeply within the Tongan community. Its consequences are manifested in a number of ways such as financial difficulties (which results in properties such as vehicles and homes being re-possessed), broken families, neglected children, and an increasing number of people with substantial financial debts.

The factors contributing to why Tongans are involved in gambling are being analysed. These factors, together with themes and strategies suggested by participants to minimise and remedy problem gambling issues are detailed in the final report. It is available at http://www.arphs.govt.nz.

Where to from here?

An application for the funding of the second phase, July 2004-June 2006, is being prepared for the Health Research Council to enable us to explore themes that have already emerged, to interview more widely in the community, and to develop interventions that are culturally appropriate and effective for the Tongan community. Analysis of Tongan culture and language is central to this enterprise. One of the tools for this analysis is the engagement of authorities on Tongan culture and language in order to explore the emerging themes within the context of the research.

A recent study in Queensland, Australia, of problem gambling in four communities (not including Pacific peoples) identified the following as essential strategies:

- Community education
- Providing more culturally appropriate services
- Working in partnership with communities
- Implementing preventative services
- Instigating legislative change

These and other strategies, when based on an analysis of Tongan cultural concepts, are expected to be important guides to how best to plan and intervene in problems associated with gambling in the Tongan community.

The research team

Ms. Yvette Guttenbeil migrated to New Zealand with her family during the industrial boom of the 1970s. A daughter of working class Tongan parents, she has both insight and knowledge of the rapidly changing Tongan community in Auckland. She has worked with Pacific communities in developing and implementing health programmes for youth, women, and church congregations. She was the principal investigator for this research project.

Dr. Tin Htay is a physician with a postgraduate degree in public health. He has 17 years experience in public health research and intervention. In addition, he has working experience among Pacific communities in Auckland. He lived in Vava'u, Tonga, for six years and worked as the medical officer for the Vava'u Prince Wellington Ngu Hospital. Furthermore, he has strong affiliation with the Tongan community in New Zealand through his work as well as through his spouse, a Tongan nurse, and his children.

Mr. Sione Tu'itahi, Pacific service development manager,

Auckland Regional Public Health Services, is of Tongan ethnic background. A lecturer in Pacific studies and cross-cultural communications, he also works as Pacific development co-ordinator at Massey University, Auckland. He was the co-ordinator of the research project.

Dr. Jennifer Hand has long-term experience in research and in the evaluation of public services. She has worked cross-culturally and with multi-disciplinary teams and has particular interest in linking local communities and indigenous people with trained researchers and tertiary educational institutions. She is a senior lecturer in the social and community section of the school of population health of Auckland University and coordinates the research, evaluation, and advisory services for the Auckland Regional Public Health Service. She provided a link to the Centre for Gambling Studies and academic institutions. She collaborated with the other investigators throughout the project and provided research supervision. She was responsible principally for advising on the research methodology and for ensuring that all investigators received specific training as required.

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A public health approach for Asian people with problem gambling in foreign countries

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Abstract

There has been a rapid increase in Asian immigration to English-speaking countries such as New Zealand, Australia, Canada, and the United States. Anecdotal accounts and research suggest high levels of participation in gambling by people from Asian countries. Asian problem gambling is seen as being a social rather than an individual problem compounded by difficulties with post-migration adjustment. Contemporary public health perspectives are not limited to the biological and behavioural dimensions, but can also address socioeconomic determinants such as income, employment, poverty, and access to social and healthcare services related to gambling and health. This paper discusses how a public health viewpoint can lead to effective strategies against problem gambling. The five principles proposed in this paper are: (1) acknowledging similarities and differences within Asian populations, (2) ensuring that strategies are evidence-based, (3) treating Asian problem gambling in an acculturation framework, (4) addressing the issue of shame associated with problem gambling among Asian people, and (5) targeting at-risk sub-groups.

Introduction

Over the past two decades, gambling has expanded rapidly in New Zealand, as it has in other countries. For instance, New Zealand gross annual turnover has increased from NZ$1.5 billion in 1989 to over NZ$8 billion in 2001 (Adams, 2002). In the United States, between 1975 and 1999, adult gambling expenditure increased from 0.3 to 0.74 of personal income, and lower-income

Canadian households spent disproportionately more of their money on gambling than higher-income households (Shaffer & Korn, 2002). Macau is regarded as one of the busiest and highest revenue-generating casino operations in the South East Asian region. In 2004 Macau's casinos generated a new record of US$375 million in the single month of January, a 35 percent or more increase compared to the same time for the previous year, which included the Chinese New Year holidays (Ponto Final, 2004).

Asians make up the fastest-growing ethnic community in New Zealand today. Between 1991 and 2001, the number of people who self-identify as "Asian" grew by 140 percent to 238,180 people, or 6.7 percent of the New Zealand population (Statistics New Zealand, 2002a). Asians are now the third largest ethnic group in New Zealand, just after European and Maori. Chinese are the largest ethnic group within the Asian population (105,057), followed by Indians (62,190), and Koreans (19,023) (Statistics New Zealand, 2002b). The percentage increase in the Asian population has been mainly due to large gains in migration. Between 1990 and 2000, the United States population changed significantly as well and the Asian/Pacific Islander population increased from 2.8 percent to nearly 3.6 percent (US Census Bureau, 2000). According to the United States 2000 census, nearly 10 percent of the population was foreign born. It is estimated that the Asian population will increase to nearly 8.2 percent of the American population by 2050.

Around the world, anecdotal accounts, media reports, and recent research studies have made reference to the increasing level of participation in gambling by people from Asian countries and the high rates of problem gambling among Asian people (e.g., Bell & Lyall, 2002; Chinese Family Service of Greater Montreal, 1997; "The Stake," 2000; Victorian Casino and Gambling Authority, 1999). For instances in Australia, using the South Oaks Gambling Screen (SOGS) and a cut-off score of 10, it was found that members of Chinese community might be almost 50 percent more at risk of developing problem gambling compared with their Caucasian counterparts (Raylu & Oei, 2004). In Sydney, Australia, Blaszczynski and colleagues (1998) reported a prevalence estimate of 2.9 percent for problem gambling among Chinese participants compared to 1.2 percent for the Australian population (Dickerson, Baron, Hong, & Cottrell, 1996). (The issue of "Who are the Asians?" will be discussed in the later part of this paper.) This paper aims to propose five key strategies of how to implement an effective public health approach to address problem gambling among Asian people in foreign countries.

Terms and concepts

For the purpose of discussion, it is important to have a common language when exploring issues of public health approaches to Asian problem gambling. "Race" refers here to classification of people based on their looks and physical characteristics. The United States government uses the following racial categories: American Indian/Alaska Native, Asian American, African American or Black, and Native Hawaiian/ Pacific Islander. In New Zealand, on the other hand, people are asked which ethnic group or groups they belong to and they may specify as many as they wish. "Ethnicity" is understood in terms of self-perceptions and people can belong to more than one ethnic group. Ethnicity is a measure of cultural affiliation, as opposed to race, ancestry, birthplace description, nationality, or citizenship (Statistics New Zealand, 2002c). The four common ethnic groups referred to in New Zealand are: European/Pakeha[4], Maori, Pacific peoples, and Asian. Because ethnicity is self-perceived, people can identify with an Asian ethnicity even though they may not be descended from Asian ancestors. Conversely, people may choose to not identify with an Asian ethnicity even though they are descended from Asian ancestors. "Culture" is defined here as a shared system of values, beliefs, and learned patterns of behaviour. In this paper, culture includes racial and ethnic characteristics. Problem gambling among Asian people has to be seen as more than an individual problem and needs to be seen in its social context. A public health orientation to gambling broadens the focus to include culture and thereby enables the emergence of a set of useful strategies in dealing with Asian problem gambling. "Contemporary public health perspectives are not limited to the biological and behavioural dimensions related to gambling and health, but also can address socioeconomic determinants such as income, employment, and poverty" (Shaffer & Korn, 2002, p. 172).

These social issues in turn have links to the evolution of local and national public policy. What is needed to address these problems is a range of "healthy public policies"? policies that support the promotion of health and wellbeing (Korn & Shaffer, 1999). A public health orientation can lead to effective strategies for preventing, minimizing, and treating individuals affected by problem gambling (Volberg, 1994). Public health approaches to problem gambling help policy makers distinguish acceptable from unacceptable risks. They promote an epidemiological examination of gambling and gambling-related disorders to better understand the distribution and biopsychosocial determinants of gambling (Shaffer & Korn, 2002).

Public health approaches to Asian problem gambling

Based on a review of the literature and working experiences in the field of problem gambling, we propose five key principles that form

a basis for public health approaches.

Acknowledging the similarities and differences within Asian populations

In this paper "Asian" is discussed in terms of ethnicity. Asian people in foreign countries include immigrants, refugees and international students. In New Zealand, the term "Asian" usually refers to people coming from South-East Asian countries like China, Korea, Thailand, the Philippines, Japan, Malaysia, Cambodia, Vietnam, and people from the Indian subcontinent. Although the term is used to identify a collection of Asian ethnic groups, the authors are acutely aware of the cultural diversity within that collection, notwithstanding the fact that they do share many commonalities in terms of values and beliefs. In the context of discussing public health approaches for Asian people in foreign countries who are affected by problem gambling, the term "Asian" does have utility in that it refers to individuals who have strong, self-perceived cultural affiliations in terms of similar value systems, beliefs, cultural heritages and experiences of immigrating to a new host country. Some of these migrants are confronted by similar kinds of difficulties related to post-immigration adjustment, such as unemployment (or underemployment in some cases), language barriers, cultural differences, social isolation, and the lack of access to service information regarding settlement and employment (Ngai & Chu, 2001). Sometimes, they also refer to their immigration and post-immigration adjustment process as an "uprooting experience." Ho and associates (2000) identified four major forms of settlement assistance needed for Asian people in Aotearoa-New Zealand. They need assistance in learning to speak English, employment advice, job-finding skills, and supportive connections that assist in their acculturation. More importantly, evidence is emerging suggesting that, as a group, Asian people are disproportionately affected by problem gambling (e.g., Blaszczynski et al., 1998; Chinese Family Life Services of Metro Toronto, 1995; Cultural Partners Australia Consortium, 2000; Petry, Armentano, Kuoch, Norinth & Smith, 2003). On the other hand, there are significant variations across different groups of the Asian population in terms of their experience of legalized gambling prior to immigrating to their new host country. These variations included differences in the preferred mode of gambling, where they chose to gamble (home and private places for social gambling as opposed to public legalized gambling venues like casinos), with whom they gambled, and the size of the wagers. In a recent study on problem gambling among South East Asian refugees, it was found that the types of gambling in which individuals participate differed markedly across sub-groups within the South East Asian ethnic population. For example, 67 percent of Cambodians played slot machines compared to 17 percent of Laotians and 6 percent of

the Vietnamese (Petry et al., 2003). Asian clients attending Aotearoa-New Zealand counselling services indicated that casino table games were their primary gambling mode whilst a small proportion mentioned non-casino gaming machines and track betting (Paton-Simpson, Gruys & Hannifin, 2003). An effective public health approach to Asian problem gambling needs to strike the balance between using the label of "Asian" to create a population-based public policy to reduce gambling-related harm, while at the same time acknowledging the diversity of culture and gambling practices among Asian people.

Ensuring that approaches are evidence-based

A search of the literature indicates that there are many definitions of evidence-based practice. The term, evidence-based medicine, was coined by a group of clinical epidemiologists at McMaster University who worked together to produce a user's guide for critical appraisal of the medical literature (Oxman, Sackett, & Guyatt, 1993). One of the most common definitions from Sackett and colleagues defines evidence-based practice as:

> …the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71).

Since this beginning, definitions have expanded from individual treatment to evidence-based health care and on to evidence-based public policy. We propose the following set of five categories for identifying the types of evidence used in public health approaches to problem gambling:

Type I evidence: Effectiveness of public health action. In replicated studies, measures that diminish Asian population exposure to a set of identified risk factors are followed by a reduction of rates in problem gambling in the study population, relative to a comparison group;

Type II evidence: Differential incidence in population cohorts. Problem gambling incidence rates differ consistently between population cohorts, in accordance with known differences in levels of risk exposures;

Type III evidence: Association of onset of problem gambling with risk exposure. Onset of new cases of problem gambling in a population is consistently found to be associated with exposure to

a suspected risk factor;

Type IV evidence: Direct association between prevalence rates in problem gambling and level of risk exposure. Exposure to a suspected risk factor is consistently found to be higher among diagnosed problem gambling cases than among controls drawn from the same population;

Type V evidence: " *Ecological* " *association between prevalence rates in problem gambling and risk indicators*. Area rates of problem gambling are consistently found to vary with levels of risk exposure as shown by relevant administrative indices. (Modified from Cooper, 2003.)

To date, research on problem gambling involving Asian people in foreign countries is still in its infancy. What we have seen so far is an early but alarming indication of the degree of seriousness of gambling-related problems. There are virtually no empirical studies on the effectiveness of gambling treatment approaches specific to Asian peoples, so it is little wonder there is no evidence-based public health policies addressing Asian problem gambling.

We would argue that there are three major gaps in evidence-based research required to support public health approaches for Asian problem gambling. Firstly, we lack properly designed and statistically powered studies that investigate the extent (the incidence and prevalence rate) of problem gambling among Asian people in foreign countries. Secondly, we have very little knowledge of what is the most effective way to connect with Asian communities and of ways to raise Asian people's awareness of the potential harm caused by problem gambling. For example, should interventions target people who gamble, or concentrate more on their family and relatives? Thirdly, despite the likelihood of higher levels of gambling problems, research has indicated that Asian people may be less likely to seek help for their problems. I t is of critical importance to examine potential factors that provide barriers and incentives for Asian people seeking help (Bigby, 2003; Kung, 2004). In Aotearoa-New Zealand in 2002, Asian clients using face-to-face gambling services made up 3.6 percent of the total client population (Paton-Simpson et al., 2003). Asian clients are still grossly underrepresented in gambling counselling services when compared to the 6.1 percent in the whole Aotearoa-New Zealand population who are Asian adults (those aged 18 and above).

Treating Asian problem gambling in an acculturation framework

Acculturation is broadly defined as "those phenomena which result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups" (Slant & Lauderdale, 2003, p. 72). Acculturation and increased gambling among Asian people in host countries could be viewed in two ways (Raylu & Oei, 2004). Increased gambling is either related to a successful acculturation process (i.e., successfully adapting to a culture that has high acceptance of gambling) or related to difficulties in adapting to the mainstream culture.

Gambling often provides individuals with a certain amount of relief or escape from problems. Some describe it as offering them a temporary but effective reprieve from painful personal realities (Wong & Tse, 2003). In our clinical work, we often hear clients describing that when they are gambling they are either not thinking of anything or they are only thinking of the excitement and glamour of winning and being in a casino. Adjustment to living in a new country is not an easy process and may not work out for everyone. Asian immigrants may come across multiple difficulties. After dealing with the acute crises related to problem gambling, it is common to hear Asian clients describing a crisis as an "awakening" experience. They suddenly realize they have a need to integrate with their communities, improve their language skills, re-focus on their personal goals or aspirations, and find a new purpose and meaning to their life in the new country.

In accordance with the Ottawa Charter (1986), public health policy for Asian people affected by problem gambling in foreign countries needs to:

> i) build public policies that support and promote immigrants', refugees', and international students' integration into host communities;
>
> ii) create physical and social environments that support health and wellbeing (such as improving employment situations, providing recreational facilities); in other words, to go further than just stopping or reducing participation in gambling activities;
>
> iii) strengthen community action in the recognition that, with information, support and funding, the Asian communities can be empowered to work in the interests of their own needs;
>
> iv) develop Asian people's skills (such as developing Asian practitioners to work in the problem gambling area), and;

v) re-orientate treatment and educational services towards health promotion and effective intervention for problem gambling.

Addressing the issue of shame associated with problem gambling

Losing more money than what one can afford and thereby jeopardizing the future prospects of one's family in a new country leads a person to experience intense shame, devastating remorse, and the feeling of being a total failure. Shame is closely related to the pervasive influence of stigma and discrimination against people with problem gambling.

According to labelling theory, the degree of difficulties faced by individuals with problem gambling can be partly attributed to the stigma attached to having such addictive problems (Link & Cullen, 1990). Stigmatization can be defined as the process of linking the bearer of the labels "problem gambler" or "pathological gambler" to unwanted and usually undesirable attributes that discredit him or her in the eyes of others. As the stigmatizing attitudes of others are frequently internalized by those who encounter them, this can result for problem gamblers in weakened self-efficacy and negative outcome expectancies for recovery (Kaminski & Harty, 1999). Stigma produces discrimination. Discrimination is an act or attitude by a person or organization, which fosters unfair treatment of an individual because he/she is different. Discrimination develops from people's beliefs about problem gambling and the attitudes of others including family, friends, and the general community (Arthur, 2000). An individual's attempts to manage gambling behaviours could end up being viewed by family members and friends as yet "another rip off"? another set of lame excuses to borrow money. Problem gamblers are badly stigmatized and may find themselves labelled as irresponsible, as lacking any willingness to quit gambling, and, consequently, as a burden on the family responsible for the family continuing to "lose face." Such discrimination, combined with the effects of the problem gambling itself, can lead to feelings of disconnectedness and hopelessness, compounding what they have already suffered from the stress of the immigration process. An Asian person with problem gambling in a foreign country may suffer a double dose of stigma and discrimination by carrying both the labels of "problem gambler" and "Asian." This is especially the case in small communities (Tse, 2003). The attitudes and behaviour of fellow workers, friends from the same country of origin or village, people from same religious group and family members can be distressing and not helpful to recovery from problem gambling.

Maintenance of the good name ("keeping face") for an Asian family can often be affected by the behaviour of one member. The

desire to avoid shaming the family often discourages a problem gambler and his/her friends from seeking help (Tabora & Flaskerud, 1997). This can adversely affect the outcome of an intervention. Many clients only seek help from professionals as a last resort; they still seek to delay the humiliating effects on their family by seeking to hide their problems. Furthermore, the desire to avoid shame also tends to make the person unwilling to self-disclose his or her own needs, feelings, and thoughts; in turn weakening the formation of a trusting relationship.

To render an effective public health policy for Asian people in foreign countries, it is pivotal to address the issue of shame associated with problem gambling. This requires the systematic study of gambling in an Asian cultural context, along with its concomitant values and attitudes (Brown, 2002, The Wager, 1997). What are the help-seeking preferences and effective strategies to communicate with Asian communities through the media? Who holds and influences the knowledge of problem gambling in Asian communities?

Targeting at risk sub-groups

An effective public health policy must have a clear target population and identify a clear set of risk factors. In this instance, we need to identify who are the Asian people at risk of developing problem gambling. Risk for pathological gambling has been correlated with certain aspects of gambling activity, substance use, criminal offending, and socio-demographic features (Welte, Barnes, Wieczorek, Tidwell, & Parker, 2004). In our experience five at-risk groups warrant particular attention; these are people working in the food industry, tourist operators, international Asian students, South East Asian refugees, and members of "astronaut" families (i.e., those in which the mothers stays behind in a foreign country to look after their children while the husband returns to the home country to work).

Those disproportionately affected by problem gambling include Asian immigrants who are employed in shift work (e.g., restaurants, factories, takeaway food spots) and newly arrived young Asian adults studying English (P. Au, executive director of Chinese Family Services of Ontario, Canada, personal communications, February 4, 2003 and April 23, 2003; T. Cho, chairman of Auckland Chinese Food and Beverage Business Association, Aotearoa-New Zealand, personal communication, February 5, 2003). A survey carried out by the Chinese Family Service for Greater Montreal in 1997 found that up to 19 percent of Chinese restaurant workers were pathological gamblers (Scalia, 2003), and a survey conducted by Asian Services based in Christchurch, Aotearoa-New Zealand, found a similar trend (Tan & Tam, 2003). Tourist operators form another at-risk

occupational group that was recently identified by Aotearoa-New Zealand treatment services (Tse, Wong, Kwok & Li, 2004). Tourist operators will commonly bring overseas Asian visitors to casinos for a memorable experience. Unfortunately, a number of individual operators become addicted to gambling themselves. However, there is no published empirical data to date regarding this observation. A recent study on Asian young people gambling in Aotearoa-New Zealand involved a lifestyle survey of 246 international Asian students recruited from three English language schools in a metropolitan city. It was found that 9.1 percent of students admitted feeling unhappy or worried after a gambling session and 6.5 percent wanted assistance to deal with their gambling problems (Goodyear-Smith, Arroll, & Tse, 2004). Petry and colleagues (2003) also recently found that the lifetime prevalence of pathological gambling among South East Asian refugees to the United States was up to 59 percent. In the same study, 27 percent of problem gamblers and 42 percent of pathological gamblers were interested in learning about ways to reduce or stop their gambling. In Aotearoa-New Zealand there has been an increase in the number of Asian women clients seen by problem gambling counsellors in the year 2003 compared to the previous year. Upon closer examination, a general trend can be seen of more mothers with young children seeking help for their gambling problems. This observation is consistent with mothers feeling isolated and unsupported in their host country, having access to large amounts of disposable money, and facing the stresses associated with raising children in a new cultural environment. This makes solo mothers from astronaut families particularly vulnerable to develop gambling problems.

Conclusion

With the global proliferation of gambling, policy makers and service providers around the world face challenges in understanding Asian problem gambling. In this paper, we have discussed five important principles in developing effective public health approaches to problem gambling among Asian people. Effective public health policy does not rely solely on research information. It uses available information to underpin decisions for population groups within their particular social context. Treating problem gambling as an individual issue that ignores Asian values, traditions, and community connections tends to obscure the potential for change; while a contextual approach, on the other hand, encourages a greater utilization of Asian community resources and wisdom.

Although the focus of this paper has been on a public health approach, there are implications for those who work as case practitioners with Asian clients. Public health approaches that view problem gamblers in their social context need to become a

part of how counsellors and therapists work with their clients. From this perspective therapeutic interventions can be conceptualised not so much in terms of resolving problems or reducing or stopping gambling, but as a means of unleashing the potential of people, their families, and their communities to achieve change, thereby promoting the wellbeing of the Asian community as a whole.

Lastly, the conversion of public health rhetoric into action necessitates the identification of clear processes and ways in which progress can be measured. This paper is only the beginning of this important process. The challenge lies with the will and determination of policy makers, members of Asian communities, researchers, and problem gambling service providers to translate existing knowledge and policy into effective and culturally responsive action.

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4 Commonly used term to refer to European New Zealanders

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Where are the "Community Benefit" funds from pokie machine trusts distributed?

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Abstract

The key purpose of this research was to investigate where the community benefit funds from the six national pokie (electronic gambling) machine trusts (i.e., New Zealand Community Trust, Pub Charity, Lion Foundation, Southern Trust, Scottwood Trust, and Community Grants Foundation) are distributed. These trusts account for approximately 60 percent of all expenditure on gambling and 50 percent of all non-casino pokie machine sites in Aotearoa-New Zealand.

Introduction

Tables 1a and 1b (below) summarise the distribution of funding by region and sector; it shows that between 48 percent and 62 percent of all funding available to each region went to the sport/ physical activities sector. This confirms anecdotal evidence of disproportionate funding received by sporting groups. While the majority of respondents to the survey conducted as part of the second half of this research reported a positive experience, there were a number of issues raised about the application process.

Based on the analysis of this report, it is recommended that the following actions be adopted:

1) The standardisation of reporting procedures and formats by the six national trusts, including across regions and sectors, to facilitate comparison of information between trusts. The use of Territorial Local Authority boundaries is recommended.

2) Increase accountability for trusts to comply with funding criteria. For example, criteria such as "no more than 20 percent of an individual hotel site's total funding shall be made available to any one organisation", or "only one application per organisation per funding round", do not appear to be met.

3) Clarification of the funding available for greyhound and horse racing activities.

4) Greater public access to information and transparency of the processes of operation of the six national trusts. This applies to both personnel and procedures within the national trusts. For example, make public details of the experience and backgrounds of those who are involved with making funding decisions and provide public access to annual reports.

5) The 33 percent of funds allocated to administrative expenses for each trust should be investigated further. For example, this level of expenditure should be compared with the budgets of other philanthropic organisations.

6) A more balanced distribution of funding across all sectors.

7) Ongoing analysis of the distribution for a further four years to allow for greater comparison and a more in-depth analysis of distribution trends.

Table 1a: Distribution of funds by region and by sector (continued in Table 1b, below) A larger version is available here.

Region	Sport/ physical activities	Horse & greyhound racing	Arts & culture	Heritage/ Conservation/ Environment	Education	Youth	Welfare & support	Health	Emergency services
Auckland		196,102	1,019,416	206,784	6,448,628	1,359,417	1,160,856	2,569,874	1,639,003
	51%	1%	3%	1%	17%	4%	3%	7%	4%
Bay of Plenty	5,336,958	146,902	350,736	51,389	2,477,954	203,507	501,389	440,899	521,850
	48%	1%	3%	0%	22%	2%	4%	4%	5%
Canterbury	10,970,442	524,380	618,565	209,718	2,449,582	336,327	657360	651,034	910,244
	55%	3%	3%	1%	12%	2%	3%	3%	5%
Gisborne	1,157,202	7,777	34,988	14,789	473,520	25,904	65,458	49,339	159,196
	53%	0%	2%	1%	22%	1%	3%	2%	7%
Hawkes Bay	2,154,100	71,424	155,094	82,751	624,110	54,661	111,736	141,398	151,335
	55%	2%	4%	2%	16%	1%	3%	4%	4%
Manawatu Wanganui	3,703,216	129,819	108,766	123,128	1,044,410	102,772	123,673	142,219	162,295
	58%	2%	2%	2%	16%	2%	2%	2%	3%
Marlborough	464,286	4,500	10,942	0	68,198	8,212	24,560	15,330	14,029
	62%	1%	1%	0%	9%	1%	3%	2%	2%
Nelson / Tasman	2,651,917	11,380	182,179	13,884	388,770	22,921	88,287	229,655	194,287
	61%	0%	4%	0%	9%	1%	2%	5%	4%
Northland	2,973,123	110,728	131,638	54,010	1,267,933	177,849	156,133	214,070	289,319
	48%	2%	2%	1%	20%	3%	2%	3%	5%
Otago	3,393,793	110,119	163,366	78,199	608,780	93,088	103,597	109,444	258,791
	61%	2%	3%	1%	11%	2%	2%	2%	5%
Southland	1,434,274	16,000	68,379	28,120	344,361	78,430	79,889	162,707	109,430
	53%	1%	3%	1%	13%	3%	3%	6%	4%
Taranaki	2,081,887	60,117	89,979	24,632	476,774	27,454	87,672	45,137	99,209
	61%	2%	3%	1%	14%	1%	3%	1%	3%
Waikato	6,678,731	333,477	415,834	128,925	2,458,036	312,441	548,993	305,725	410,409
	52%	3%	3%	1%	19%	2%	4%	2%	3%
Wellington	13,005,106	270,257	2,163,782	129,465	2,130,943	287,560	672,004	891,049	1,362,226
	55%	1%	9%	1%	9%	1%	3%	4%	6%
West Coast	818,759	58,055	33,333	45,362	165,132	16,998	61,703	25,555	62,659
	57%	4%	2%	3%	11%	1%	4%	2%	4%
Unknown	3,121,801	1,591,846	214,597	38,723	913,631	195,755	214,680	245,991	85,130
		21%	3%	1%	12%	3%	3%	3%	1%

Table 1b: Distribution of funds by region and by sector (continued from Table 1a, above) A larger version is available here.

Region	Service clubs	Foundations & charitable trusts	Religious organisations	Marae & Maori organisations	Student associa-tions	Economic development	Leisure/ interest/ hobby	Row totals for Tables 1a and 1b
Auckland	366,796	2,082,811	289,944	204,020	50,352	238,555	1,070,549	38,314,675
	1%	5%	1%	1%	0%	1%	3%	---
Bay of Plenty	47,778	125,297	222,222	364,789	0	74,084	316,805	11,182,558
	0%	1%	2%	3%	0%	1%	3%	---
Canterbury	179,028	856,810	346,085	32,715	28,220	84,173	1,048,770	19,903,451
	1%	4%	2%	0%	0%	0%	5%	---
Gisborne	15,957	32,586	7,477	87,673	0	10,000	42,997	2,178,863
	1%	1%	0%	4%	0%	0%	2%	---
Hawkes Bay	21,088	33,920	21,000	48,030	5,000	90,446	155,025	3,921,118
	1%	1%	1%	1%	0%	2%	4%	---
Manawatu Wanganui	46,776	82,444	49,533	98,808	92,920	100,810	244,607	6,356,197
	1%	1%	1%	2%	1%	2%	4%	---
Marlborough	13,500	29,500	0	2,890	0	13,367	77,459	746,773
	2%	4%	0%	0%	0%	2%	10%	---
Nelson / Tasman	10,193	79,363	35,452	39,453	0	58,311	359,032	4,365,084
	0%	2%	1%	1%	0%	1%	8%	---
Northland	66,802	139,177	29,096	270,971	0	85,135	288,553	6,254,537
	1%	2%	0%	4%	0%	1%	5%	---
Otago	22,453	146,702	34,312	3,199	41,434	256,047	177,181	5,600,507
	0%	3%	1%	0%	1%	5%	3%	---
Southland	37,411	88,410	14,535	600	0	39,819	183,514	2,685,878
	1%	3%	1%	0%	0%	1%	7%	---
Taranaki	4,338	172,029	16,089	29,789	0	29,110	180,129	3,424,344
	0%	5%	0%	1%	0%	1%	5%	---
Waikato	74,351	232,860	44,534	373,528	5,000	63,712	551,313	12,937,869
	1%	2%	0%	3%	0%	0%	4%	---
Wellington	84,231	1,104,767	253,131	114,500	5,480	63,940	1,317,139	23,855,580
	0%	5%	1%	0%	0%	0%	6%	---
West Coast	8,999	21,648	20,998	11,803	0	11,769	81,526	1,444,300
	1%	1%	1%	1%	0%	1%	6%	---
Unknown	36,800	521,648	76,930	190,360	4,300	12,277	267,247	7,731,716
	0%	7%	1%	2%	0%	0%	3%	---

The distribution of funding

In the year ended December 2002, the six national pokie machine trusts accounted for approximately 50 percent of all non-casino pokie machine sites and about 60 percent of all expenditure on non-casino pokie machines (DIA website: http://www.dia.govt.nz). Ownership of the remaining sites is spread between single- and multiple-site hotel trusts and clubs (e.g., chartered, sports, Returned Services Associations, i.e.,veterans groups) who may operate pokie machines for their own purposes.

A condition of the licence granted to pokie machine operators is that they report annually on the minimum 33 percent of revenue required by government regulation to be distributed to community groups. These reports must be available to the public, and also lodged with the Department of Internal Affairs. Typically the report tends to be a newspaper-type publication. However, there appears to be little regulation in place to ensure standardisation of reporting. Frequently trusts operate on different financial years, and all vary in the manner in which details of the funding allocations are presented. There may also be variation within the same trust. For example, allocations for the first six months may be listed alphabetically while the second six months are presented by region. The introduction of standardised reporting formats and procedures would facilitate the ongoing analysis of information.

Working from the publications each trust is required to produce, funding grants made by these six trusts were analysed to identify how the funding was distributed in terms of region and/or sectors of the community. In each case the most recent 12 months of data was used, with the exception of Southern Trust for whom information on only nine months of funding grants was available. Grants totalling $237,769,648 were made by the six Trusts during the periods analysed, with 30,574 separate funding grants being made.

How has the information been analysed?

Sports/physical activities: The Hillary Commission definition was used as a guide for allocations to this sector. This definition included those sports that have a physical activity component. Rugby, rugby league, touch rugby, soccer, and netball are the predominant entries. Separate sports clubs set up by schools, as was previously encouraged by the Hillary Commission, also feature in the category.

Horse and greyhound racing: Although these categories could be classified as sport, this separate sector was added to identify the funds that appear to be being channelled back into gambling-oriented activities.

Arts and culture: This sector includes events as well as organisations with an arts and/or cultural perspective: for example, choral groups, young designer awards, arts societies, dancing and music groups such as pipe bands, and Irish dancing.

Heritage/conservation/environment: Historical and preservation societies were the main entry in this sector, but environmental research and recovery work is also featured.

Education: As well as including schools, kura kaupapa [Maori immersion schools] and related school groups, this sector also covers pre-schools, kindergartens, childcare centres, kohanga reo (Maori language nests/total immersion), and OSCAR (out of school care) organisations.

Youth: Guiding and scouting groups dominate the entries in this sector, although there are also instances of youth groups and youth-oriented projects: for example, youth suicide awareness trusts, and police-youth blue-light social events.

Welfare and support: Organisations in this sector are quite diverse, but are typically community aid organisations: for example, Habitat for Humanity, community houses, Birthright, SPCA, social services, missions, and budgeting services.

Health: This sector incorporates all organisations associated with disabilities and illness: for example, IHC, Arthritis Foundation, kidney transplant funds, and hospices. Although youth-specific, Canteen and Camp Quality have been included in this category given their health focus. Ronald McDonald House is also included as a health-based organisation.

Emergency services: In addition to volunteer fire brigades, St. John Ambulance and rescue helicopters, this category also includes surf lifesaving and coast guard activities.

Service clubs: This sector includes Masonic Lodges, Lions clubs, and Rotary clubs.

Foundations and charitable trusts: This category was included to provide a separate category for formalised foundations/trusts that had a clear purpose, but do not necessarily fit distinctly into one of the other categories. Large well-known trusts such as Outward Bound and Spirit of Adventure feature regularly, as do less well-known and more localised trusts, such as Landmarks Trust and Woodlands Centre Trust.

Religious organisations: This sector identifies funding for churches, such as the Salvation Army and Catholic orders, which were not obviously targeting welfare and support activities.

Marae and other Maori organisations: Although kohanga reo and kura kaupapa were coded as education, all other Maori organisations were coded to this classification. With coding decisions being based purely on the name of an organisation or group, it is possible that organisations with a Maori name, but which do not have a specific Maori focus, may have inadvertently been included in this category.

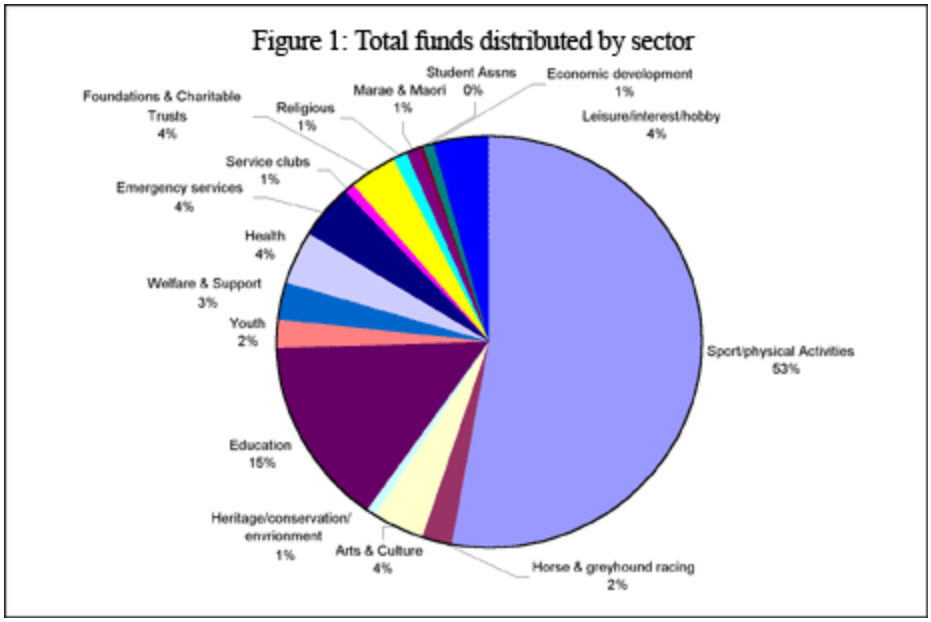
Student associations: Featuring predominately in Otago, these are associations of student groups such as medical students and dental students.

Economic development: Groups such as retailers' associations and tourism groups promoting a region fall into this sector.

Other leisure/interest/hobby groups: Car clubs and darts associations are groups in this category that could perhaps be considered sports-oriented, but which have been included here, given the informal "Hillary Commission" definition applied in the sports sector. It is possible that this sector also includes a number of sports teams, for if the name did not distinctly relate to a particular sport (e.g., "ultimate club") it was placed in this category. In addition, there are diverse groups such as sheep dog

trials and battalion groups.

See Figure 1 for a graphical breakdown of the funds across these 16 recipient types. A larger version is available here.



Analysis

Grants to individual organisations range from large (for example, $56,467.77 to the Hamilton Marist Rugby Football Club) to reasonably small (for example, $150 to the Porirua Canoe Kayak Club). Nationwide grants, such as the $175,000 donation to the NZ Olympic Committee by Scottwood Trust also feature. Large grants are also made by trusts to individual organisations/projects. For example, Community Grants Foundation made grants of $500,000 to Kelston Boys High School, $150,000 to Waitaki Developments Board, $200,000 to Harcourt Park Sound Stage Upper Hutt, and $100,000 to both Porirua City Council IT Education Trust and Porirua Park.

This preliminary investigation has identified several issues that could be considered more thoroughly. For example, the amount of money being channelled back into greyhound and horse racing activities must be questioned. Likewise, records that indicate that organisations outside a trust's "local" area are receiving grants appear to contradict the local distribution of funds criteria set by most of the national trusts. The lack of any requirement for standardised reporting means a degree of caution should be included in any comparisons made between trusts. Frequently trusts operate on different financial years and all vary in the manner in which details of funding allocations are presented.

Note: This material is an excerpt from the report of research conducted by Social Services Waikato for GamblingWatch in the first half of 2003. Copies of the full report are available on the GamblingWatch website (www.gamblingwatch.org.nz) and the report and full Access database are available on CD from GamblingWatch (order from gamblingwatch@xtra.co.nz).

Competing interests: None declared.

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Where are the "Community Benefit" funds from pokie machine trusts distributed?

Hope Simonsen, Social Services Waikato, Hamilton , Aotearoa-New Zealand

Suzanne Grant, University of Waikato, Hamilton, Aotearoa-New Zealand

Table 1a: Distribution of funds by region and by sector (continued in Table 1b, below)

Region	Sport/ physical activities	Horse & greyhound racing	Arts & culture	Heritage/ Conservation/ Environment	Education	Youth	Welfare & support	Health	Emergency services
Auckland		196,102	1,019,416	206,784	6,448,628	1,359,417	1,160,856	2,569,874	1,639,003
	51%	1%	3%	1%	17%	4%	3%	7%	4%
Bay of Plenty	5,336,958	146,902	350,736	51,389	2,477,954	203,507	501,389	440,899	521,850
	48%	1%	3%	0%	22%	2%	4%	4%	5%
Canterbury	10,970,442	524,380	618,565	209,718	2,449,582	336,327	657360	651,034	910,244
	55%	3%	3%	1%	12%	2%	3%	3%	5%
Gisborne	1,157,202	7,777	34,988	14,789	473,520	25,904	65,458	49,339	159,196
	53%	0%	2%	1%	22%	1%	3%	2%	7%
Hawkes Bay	2,154,100	71,424	155,094	82,751	624,110	54,661	111,736	141,398	151,335
	55%	2%	4%	2%	16%	1%	3%	4%	4%
Manawatu Wanganui	3,703,216	129,819	108,766	123,128	1,044,410	102,772	123,673	142,219	162,295
	58%	2%	2%	2%	16%	2%	2%	2%	3%
Marlborough	464,286	4,500	10,942	0	68,198	8,212	24,560	15,330	14,029
	62%	1%	1%	0%	9%	1%	3%	2%	2%
Nelson / Tasman	2,651,917	11,380	182,179	13,884	388,770	22,921	88,287	229,655	194,287

	61%	0%	4%	0%	9%	1%	2%	5%	4%
Northland	2,973,123	110,728	131,638	54,010	1,267,933	177,849	156,133	214,070	289,319
	48%	2%	2%	1%	20%	3%	2%	3%	5%
Otago	3,393,793	110,119	163,366	78,199	608,780	93,088	103,597	109,444	258,791
	61%	2%	3%	1%	11%	2%	2%	2%	5%
Southland	1,434,274	16,000	68,379	28,120	344,361	78,430	79,889	162,707	109,430
	53%	1%	3%	1%	13%	3%	3%	6%	4%
Taranaki	2,081,887	60,117	89,979	24,632	476,774	27,454	87,672	45,137	99,209
	61%	2%	3%	1%	14%	1%	3%	1%	3%
Waikato	6,678,731	333,477	415,834	128,925	2,458,036	312,441	548,993	305,725	410,409
	52%	3%	3%	1%	19%	2%	4%	2%	3%
Wellington	13,005,106	270,257	2,163,782	129,465	2,130,943	287,560	672,004	891,049	1,362,226
	55%	1%	9%	1%	9%	1%	3%	4%	6%
West Coast	818,759	58,055	33,333	45,362	165,132	16,998	61,703	25,555	62,659
	57%	4%	2%	3%	11%	1%	4%	2%	4%
Unknown	3,121,801	1,591,846	214,597	38,723	913,631	195,755	214,680	245,991	85,130
		21%	3%	1%	12%	3%	3%	3%	1%

Table 1b: Distribution of funds by region and by sector (continued from Table 1a, above)

Region	Service clubs	Foundations & charitable trusts	Religious organisations	Marae & Maori organisations	Student associa-tions	Economic development	Leisure/ interest/ hobby	Row totals for Tables 1a and 1b
Auckland	366,796	2,082,811	289,944	204,020	50,352	238,555	1,070,549	38,314,675
	1%	5%	1%	1%	0%	1%	3%	---
Bay of Plenty	47,778	125,297	222,222	364,789	0	74,084	316,805	11,182,558
	0%	1%	2%	3%	0%	1%	3%	---
Canterbury	179,028	856,810	346,085	32,715	28,220	84,173	1,048,770	19,903,451
	1%	4%	2%	0%	0%	0%	5%	---
Gisborne	15,957	32,586	7,477	87,673	0	10,000	42,997	2,178,863
	1%	1%	0%	4%	0%	0%	2%	---
Hawkes Bay	21,088	33,920	21,000	48,030	5,000	90,446	155,025	3,921,118
	1%	1%	1%	1%	0%	2%	4%	---
Manawatu Wanganui	46,776	82,444	49,533	98,808	92,920	100,810	244,607	6,356,197
	1%	1%	1%	2%	1%	2%	4%	---
Marlborough	13,500	29,500	0	2,890	0	13,367	77,459	746,773
	2%	4%	0%	0%	0%	2%	10%	---
Nelson / Tasman	10,193	79,363	35,452	39,453	0	58,311	359,032	4,365,084
	0%	2%	1%	1%	0%	1%	8%	---
Northland	66,802	139,177	29,096	270,971	0	85,135	288,553	6,254,537
	1%	2%	0%	4%	0%	1%	5%	---
Otago	22,453	146,702	34,312	3,199	41,434	256,047	177,181	5,600,507
	0%	3%	1%	0%	1%	5%	3%	---

Southland	37,411	88,410	14,535	600	0	39,819	183,514	2,685,878
	1%	3%	1%	0%	0%	1%	7%	---
Taranaki	4,338	172,029	16,089	29,789	0	29,110	180,129	3,424,344
	0%	5%	0%	1%	0%	1%	5%	---
Waikato	74,351	232,860	44,534	373,528	5,000	63,712	551,313	12,937,869
	1%	2%	0%	3%	0%	0%	4%	---
Wellington	84,231	1,104,767	253,131	114,500	5,480	63,940	1,317,139	23,855,580
	0%	5%	1%	0%	0%	0%	6%	---
West Coast	8,999	21,648	20,998	11,803	0	11,769	81,526	1,444,300
	1%	1%	1%	1%	0%	1%	6%	---
Unknown	36,800	521,648	76,930	190,360	4,300	12,277	267,247	7,731,716
	0%	7%	1%	2%	0%	0%	3%	---

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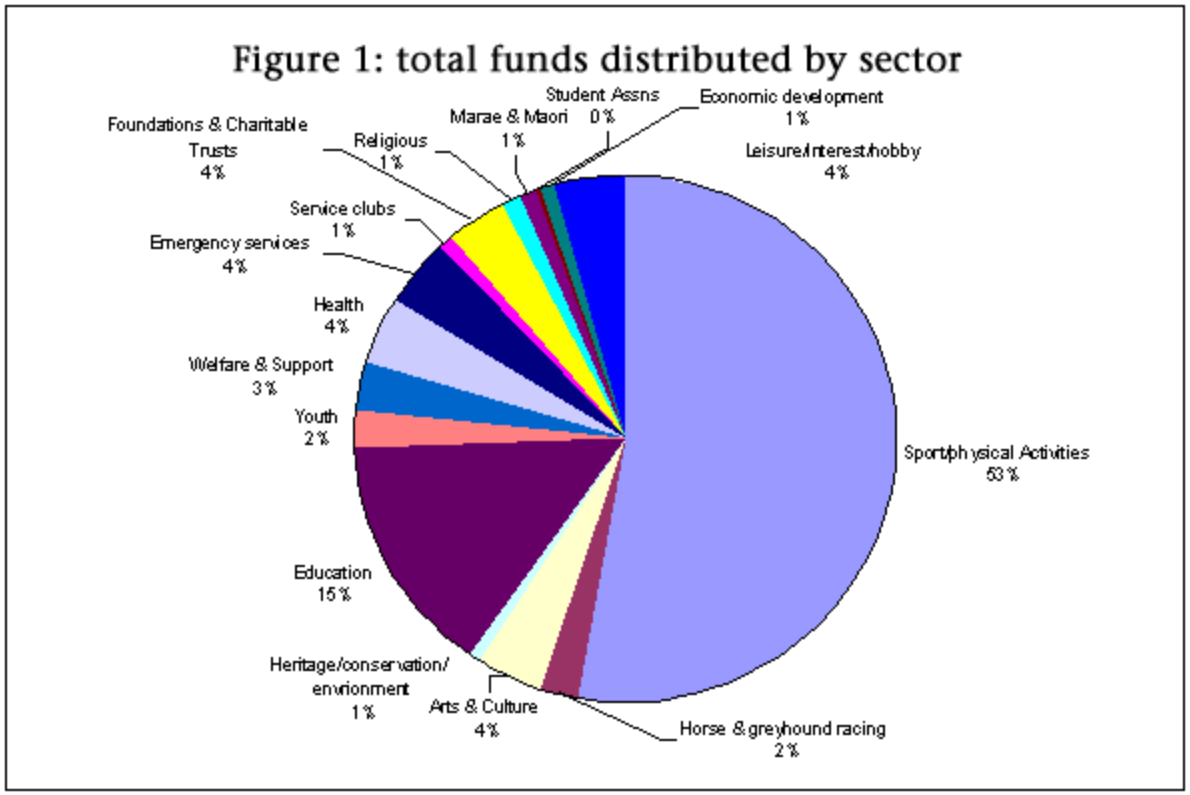

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[This article prints out to aprroximately 9 pages]

An International Charter for Gambling: The Auckland Conference and beyond

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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—

THE AUCKLAND INTERNATIONAL GAMBLING CHARTER
TUTOHINGA TUPONO NOA MO
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—portion was not edited due to its status as a charter document.

Competing interests: None declared.

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