Whānau Āwhina Plunket's Submission on the Draft Strategy to Prevent and Minimise Gambling Harm

October 2021

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Whānau Āwhina Plunket

1. Whānau Āwhina Plunket is the largest Well Child Tamariki Ora provider delivering health and wellbeing support services to tamariki and their whānau across Aotearoa, with a vision to make a difference of a lifetime in the first 1000 days. Getting things right during this period of a child's life sets them up for better outcomes later in life. We see over 89% of all newborn pēpi, including 62% of Māori pēpī in Aotearoa and have been supporting whānau for the last 114 years.

2. The range of support services we offer include Well Child Tamariki Ora health checks, parent education and support including play groups, car seat installations and safety checks, injury prevention, water safety, as well as the Before School developmental assessments.

3. Colonisation has taken a sobering toll on pēpi Māori and we know whānau Māori have inequitable health outcomes – meaning that before they are even born, many pēpi are so far behind the start line that they may not be able to catch up. Whānau Āwhina Plunket is committed to upholding the principles of Te Tiriti o Waitangi and provisions of the United Nations Convention on the Rights of the Child (Children's Convention). We have a stated equity goal that "By 2025 all Whānau Āwhina Plunket services will be delivered equitably".

4. In 2020, Whānau Āwhina Plunket released our *Te Rautaki Māori – Ngā Pae o te Harakeke*, founded on Te Tiriti o Waitangi principles. Te Rautaki Māori sets out the equity roadmap for Whānau Āwhina Plunket.

5. Gambling related harm affects problem gamblers and their whānau - an estimated 5 – 17 people are affected for every 1 problem gambler and the harm is felt by whānau and the community[1]. If the problem gambler is a parent[2], their tamariki are exposed to social, cultural, and economic gambling-related harm at various levels (individual, familial and community). For example, living in poverty, experiencing mental health problems, neglecting children, family violence etc.

6. Whānau Āwhina Plunket acknowledges that we receive funding gained from community gambling venues. We would prefer to be financially sustainable from other sources, however, this is not a reality for many in the community sector.

7. Whānau Āwhina Plunket supports the prevention and minimisation of gambling harm in Aotearoa. We strongly advocate for the protection of all tamariki and their whānau from gambling harm.

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[1] *Māori Problem Gambling: Too many chances*. (2021). Ngā Pae o Te Māramatanga. http://www.maramatanga.co.nz/project/m-ori-problem-gambling-too-many-chances

[2] Walker, S. E., Abbott, M. W., & Gray, R. J. (2012). Knowledge, views and experiences of gambling and gambling-related harms in different ethnic and socio-economic groups in New Zealand. *Australian and New Zealand Journal of Public Health, 36*(2), 153–159. https://doi.org/10.1111/j.1753-6405.2012.00847.x

Whānau Āwhina Plunket submission

8. This submission is informed by Whānau Āwhina Plunket's unique position of working in partnership with whānau, and our relentless commitment to the health and wellbeing of tamariki 0 -5 years old and their whānau across Aotearoa, New Zealand.

9. This submission will predominantly focus on the draft strategic plan and priorities for research and evaluation from the draft service plan 2022/23 to 2024/25 with a particular focus on issues pertinent to tamariki 0 – 5 years old, and those that directly impact on the health and wellbeing outcomes of tamariki and their whānau.

10. Tamariki are healthy and well when their whānau are healthy and well. All whānau deserve to be supported in building healthy relationships with their tamariki. Whānau Āwhina Plunket advocates that all tamariki should be safe and protected from all forms of harm, always.

General

11. Overall Whānau Āwhina Plunket agrees with the general direction of the draft strategy, but would like the Ministry to seriously consider the recommendations we have made.

12. There appears to be minimal differences between the current Strategy (2019/20 to 2021/22) and the proposed draft Strategy (2022/23 to 2024/25). The Needs Assessment[3] concluded the progress of the current Strategy was limited. We cannot see how the draft strategy will achieve different outcomes from the current strategy, given the minimal difference between them and the limited progress achieved so far in the current strategy.

13. We acknowledge that COVID-19 has been a factor in slowing down progress, however the prevalence of gambling harm remains the same[4]. The Government is responsible for leading and guiding the gambling harm prevention and minimisation sector – there needs to be greater public accountability and consequences for the lack of progress made. It is likely that COVID-19 may have accentuated the potential harm caused and there is no room for complacency. We are particularly concerned for the impact on priority population groups, and the ongoing detrimental effects on those most impacted by gambling harm. The draft strategy needs to be more ambitous and monitoring more rigorous if it is to reduce risks at an equitable level.

14. We are pleased to see the recommendations that have been taken on board in the priority action areas from the Needs Assessment. However, we believe that some of the recommendations need to be made more explicit in the service plan.
    a. For example, the recommendation to 'develop multi-sectoral approaches and responses' is not evident in the strategy. Whilst the strategy states it takes account of the recent strategic environment changes and recommendations from the Needs Assessment, it is unclear how this recommendation has been embedded in the draft strategy and draft service plan.

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[3] Malatest International. (2021). *Final report: Gambling harm needs assessment 2021.* Malatest International.
[4] Malatest International. (2021). *Final report: Gambling harm needs assessment 2021.* Malatest International.

15. Overall, the service plan appears to focus predominantly on the minimisation of gambling harm (this is also where the majority of the funding is focused), and much less on prevention. We would like to see a balanced approach between prevention through to treatment interventions. Breaking the intergenerational cycle is a key part in preventing and minimising the impacts of gambling harm, and to effectively break the cycle, prevention and intervention measures need to be targeted[5].

16. Whānau Āwhina Plunket is concerned with the lack of consideration and inclusion of tamariki as a vulnerable population group. The draft strategy and draft service plan must acknowledge the vulnerability of tamariki from gambling harm, with particular focus on the following considerations, to put an end to intergenerational harm.
    a. The voices of tamariki are often not heard and rely on adults to advocate for them. Some adults have shared their stories and recall their experience as a child in the Consultation Hui. It is acknowledged whilst there is a significant impact of gambling harm on them as a tamariki, they are not able to articulate or seek help .

    b. The impact of gambling harm on tamariki are long lasting. Child poverty, child neglect, and health risks[6,7], these are some of the gambling harm experienced by tamariki.

    c. Health risks for children of problem gambling parents are even greater when it exists along other risky behaviours, increasing the risk of poor outcomes. It is also known; children of problem gamblers are at increased risk to have alcohol disorders (31% vs 4%), major depression (19% vs 7%), any psychiatric disorder (60% vs 11%)[8].

    d. In addition, tamariki exposed to problem gambling behavior are 2-10 times more likely to become problem gamblers themselves later in life. They are even more likely (10-15 times) if children's father is the problem gambler[9].

    e. The role of mother (as predominant primary care giver) is crucial in minimising gambling harm for tamariki, both as a problem gambler and as Concerned Significant Others (CSO). Everyday stress can affect parenting[10], and for mothers, gambling can be seen as a socially acceptable coping strategy (compared to smoking or drinking)[11]. Easy access to gambling venues only exacerbates addictive behavior.

    f. It will take a multi-pronged approach to support mothers. Providing resilience education, tightening Host Responsibility monitoring, reducing number of community pokies, and developing effective interventions specifically targeting mothers. These are some of the

[5] Dowling, N. A., Shandley, K., Oldenhof, E., Youssef, G. J., Thomas, S. A., Frydenberg, E., & Jackson, A. C. (2016). The intergenerational transmission of problem gambling: The mediating role of parental psychopathology. Addictive behaviors, 59, 12-17.
[6] Downs, C & Woolrych, R. (2010). Gambling and debt: the hidden impacts on family and work life. https://doi.org/10.1080/13668803.2010.488096
[7] Downing, N. (2014). The impact of gambling on families. Australian Gambling Research Centre.
[8] PGF. 2019. Gambling harm and children – fact sheet 7. Retrieved from https://www.pgf.nz/downloads/assets/13509/1/fs_11%20gambling%20harm%20and%20children%20sep%202019.pdf
[9] PGF. 2019. Gambling harm and children – fact sheet 7. Retrieved from https://www.pgf.nz/downloads/assets/13509/1/fs_11%20gambling%20harm%20and%20children%20sep%202019.pdf
[10] Crnic, K., & Low, C. (2002). Everyday stresses and parenting. In M. H. Bornstein (Ed.), *Handbook of parenting: Practical issues in parenting* (pp. 243–267). Lawrence Erlbaum Associates Publishers.
[11] Palmer du Preez, K., Mauchline, L., Paavonen, A., Thurlow, R., Garrett, N., Bellringer, M.E., Landon, J., & Abbott, M. 2019. A mixed methods analysis of gambling harm for women in New Zealand. Auckland: Auckland University of Technology, Gambling and Addictions Research Centre.

actions that agencies can co-design with service providers and those with lived experience.

g. For mothers as a CSO (Concerned Significant Others), we believe the de-stigmatisation programme proposed is essential to support mothers to seek help early. A meta-analysis study showed partners of problem gamblers are impacted significantly both physically and psychologically, it recommends services need to respond to the needs of CSO[12].

h. Impact of gambling harm is significant, research shows that children suffer silently and worry about problem gambling behavior of their parents[13], we only need to look at the news[14],[15] about how problem gambling behavior can be fatal to children. The consideration of the role of parents and mothers need to be magnified in the strategy if we want to eliminate inter-generation gambling harm as this is a key area of prevention of gambling harm.

17. Responses to gambling harm needs to be co-ordinated across Government particularly across the mental health and addiction sector, child and youth wellbeing sector, and family violence sector etc, while retaining its unique approaches. The approach and funding often get 'drowned out'. Addressing the social determinants of health is a key part of preventing and minimising gambling harm[16]. Currently, multi-sectoral actions are either missing or not clear how this is embedded in the draft strategy.

18. We are concerned with the lack of consideration of intersectionality if equity is a key goal for this strategy. Clear acknowledgement and description of such complexities needs explicit mention and consideration. We know that problem gambling is often present alongside mental health problems, alcohol and drug abuse[17] and/or family violence, and Māori are disproportionately affected[18].

19. Gambling harm affects Māori, Pacific, Asian and young people more significantly than other population groups. Whilst the draft Strategy prioritises these communities, there needs to be more consideration of the complexities of how diverse Pacific peoples and Asian people are within their groups and the societal norms for these group. The strategy should explicitly acknowledge this.

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[12] Riley, B. J., Harvey, P., Crisp, B. R., Battersby, M., & Lawn, S. (2018). Gambling-related harm as reported by concerned significant others: a systematic review and meta-synthesis of empirical studies. *Journal of Family Studies*.

[13] Riley, B. J., Harvey, P., Crisp, B. R., Battersby, M., & Lawn, S. (2018). Gambling-related harm as reported by concerned significant others: a systematic review and meta-synthesis of empirical studies. *Journal of Family Studies*.

[14] https://www.nzherald.co.nz/nz/kids-left-in-casino-car-park-mum-walks-free/Y37WRI7EJM7FIXR7NVNLPUMRUE/

[15] http://stoppredatorygambling.org/wp-content/uploads/2012/12/Examples-of-Children-Left-in-Cars-at-Casinos.pdf

[16] Malatest International. (2021). *Final report: Gambling harm needs assessment 2021.* Malatest International.

[17] Grant, J. E., & Chamberlain, S. R. (2020). Gambling and substance use: Comorbidity and treatment implications. *Progress in Neuro-Psychopharmacology & Biological Psychiatry,* 99, 109852–. https://doi.org/10.1016/j.pnpbp.2019.109852

[18] Bellringer, M., Palmer du Preez, K., Pearson, J., Garrett, N., Koziol-McLain, J., Wilson, D., & Abbott, M. (2016). Problem gambling and family violence in help-seeking populations: Co-occurrence, impact and coping. Auckland University of Technology, Gambling and Addictions Research Centre and Centre for Interdisciplinary Trauma Research.

Feedback on the draft strategic plan

The proposed strategic goal

20. Whānau Āwhina Plunket agrees that problem gambling is a public health and equity issue[19]. It is known, gambling-related harm impacts individuals as well as their whānau and community[20] and that it impacts some population groups more than others[21].

21. Whānau Āwhina Plunket supports the proposed strategic goal, especially as the goal supports pae ora by adopting the Whakamaua: Māori Health Action Plan objectives[22].

Objectives and respective Priority Action Areas

Objective 1: Create a full spectrum of services and supports

22. Whānau Āwhina Plunket agrees with this objective to create a full spectrum of services and supports. However, we are concerned with the lack of consideration of the impacts of gambling harm on tamariki. Services and supports for tamariki must be explicitly stated.

23. The funding boost focusing on supports and services needs to consider and address whānau impacted by problem gamblers, not just the gamblers themselves. An individual gambler affects between 5-17 people. The need to look at the significant others can start from their help-seeking behaviour[23] to treatment options[24].

Objective 2: Shift cultural and social norms

24. Whānau Āwhina Plunket agrees with this objective to shift cultural and social norms. Significant emphasis on shifting cultural and social norms is necessary to change perceptions and behaviours. We recommend that the priority action areas be explicit in demonstrating how this will be done for the priority population groups from prevention through to treatment of problem gambling harm. The priority action areas and draft service plan needs to also explicitly state how the gaps identified in the Needs Assessment will be mitigated or minimised.

25. As mentioned earlier, de-stigmatisation needs to consider the role of mothers both as a problem gambler who need to find a way to cope with daily stress (resilience and healthy choices), but also as a mother who seeks help as a CSO (seeking help can be affected by their partner being a problem gambler).

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[19] Walker, S. E., Abbott, M. W., & Gray, R. J. (2012). Knowledge, views and experiences of gambling and gambling-related harms in different ethnic and socio-economic groups in New Zealand. *Australian and New Zealand Journal of Public Health, 36*(2), 153–159. https://doi.org/10.1111/j.1753-6405.2012.00847.x

[20] Browne, M. et al (2017). Measuring the gambling harm in New Zealand. Queensland University and Auckland University of Technology.

[21] Browne, M. et al (2017). Measuring the gambling harm in New Zealand. Queensland University and Auckland University of Technology.

[22] Ministry of Health. (2020). *Whakamaua: Māori Health Action Plan 2020–2025*. Wellington: Ministry of Health.

[23] Hing, N., Tiyce, M., Holdsworth, L. *et al.* All in the Family: Help-Seeking by Significant Others of Problem Gamblers. *Int J Ment Health Addiction* **11,** 396–408 (2013). https://doi.org/10.1007/s11469-012-9423-0

[24] Makarchuk, K et al. (2002). Makarchuk, Karyn MSc; Hodgins, David C. PhD; Peden, Nicole BSc Development of a Brief Intervention for Concerned Significant Others of Problem Gamblers, Addictive Disorders & Their Treatment: December 2002 - Volume 1 - Issue 4 - p 126-134.

26. We would recommend that 'awareness and education programmes' 'de-stigmatisation initiative' be developed specifically for target population groups. Simply translating a general campaign to different cultural groups and languages simply do not work[25].

27. In addition, shifting cultural and social norms requires a cross-sectional approach. Co-design with population groups need to start from prevention[26] through to treatment to ensure it is the same messaging that extends across the full spectrum of services.

28. The impact of gambling harm on tamariki is detrimental and long lasting. Whānau Āwhina Plunket strongly support a co-design approach and inclusion of voices of lived experience (as a problem gambler and as a CSO). Their experience will be valuable to develop effective prevention interventions that are tailored to the priority population groups and in particular for tamariki.

Objective 3: Strengthen leadership and accountability to achieve equity

29. Whānau Āwhina Plunket agrees with this objective to strengthen leadership and accountaility to achieve equity. However, the last two priority actions areas (identify improvements to legislative and regulatory framework, and ensure gambling operators are meeting their obligations) under objective three are not clearly translated in the draft service plan activities.

30. Without clear translation of action areas from objectives to activities in the service plan, there is increased risk of not acheiving the outcomes. .

31. We are supportive of the service plan proposal (and it's relevant action areas) to collaborate and co-design with priority population groups and people with lived experience of gambling harm, and supporting healthy policies (at national to local levels). However we urge there to be explicit consideration of them in a whānau context, including the involvement of tamariki.

32. Regulation of host responsibility needs strengthening. There needs to also be more accountability and consequences for failing to actively minimise gambling harm where possible.
    a. Hosts from the gambling industry should be considered as part of the 'building workforce capability' action area. They are common referrers and should have transparency and communication with the services they refer clients to and are a part of the client's referral pathway into primary and tertiary care.
    b. Of particular concern are parents who are problem gamblers accessing gambling at Class 4 venues[27], and their tamariki.

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[25] Wallia, S., Bhopal, R. S., Douglas, A., Bhopal, R., Sharma, A., Hutchison, A., ... & Sheikh, A. (2014). Culturally adapting the prevention of diabetes and obesity in South Asians (PODOSA) trial. *Health promotion international, 29*(4), 768-779.

[26] Adams, P. J., & Rossen, F. (2012). A tale of missed opportunities: pursuit of a public health approach to gambling in New Zealand. Addiction, 107(6), 1051-1056.

[27] PGF Group. (2019). Gambling harm and children – fact sheet 7. Retrieved from https://www.pgf.nz/downloads/assets/13509/1/fs_11%20gambling%20harm%20and%20children%20sep%202019.pdf
Palmer du Preez, K., Mauchline, L., Paavonen, A., Thurlow, R., Garrett, N., Bellringer, M.E., Landon, J., & Abbott, M. 2019. A mixed methods analysis of gambling harm for women in New Zealand. Auckland: Auckland University of Technology, Gambling and Addictions Research Centre.

33. We would like to encourage the Government to provide secure funding to community grants and sports clubs, who are currently funded by monies from pokie machines in clubs and pubs ($241 million).

    a. A robust review of distribution of pokies to ensure stronger regulations to limit the number of Class 4 venues, especially in high deprivation neighborhoods is necessary.

    b. Eliminating pokies in high deprivation areas can minimise gambling harm[28], and community groups and sports clubs will no longer be dependent on funding from money lost to pokies by the most vulnerable communities.

34. Regulations needs to future-proof and consider the impact of COVID-19. Online gambling has dramatically increased during the pandemic[29]. The ease of access of online gambling not only exposes gambling behaviour to tamariki at home but increases risk of child neglect[30]. Currently, there are no regulations on online gambling and off-shore gambling.

    a. We would like the Government to explore ways of regulating online gambling to reduce gambling harm impact during the vulnerable hours of the day and night. For example, new parents are likely to be more vulnerable to gamble during the nights when newborn babies tend to wake up for feeds or due to sleep problems.

    b. The increased ease of access means more frequent gambling. For parents and caregivers, being able to gamble in the home may interfere with the bonding and attachment process with infants and children[31].

Objective 4: Strengthen the health and health equity of Māori, Pacific peoples, Asian peoples and young people/ Rangatahi

35. Whānau Āwhina Plunket agrees with this objective. We support collaborating and co-designing with the priority populations; and accelerate and spread kaupapa Māori services and Pacific values-based services. However, we caution that in order for this objective to be successful, the work needs to be well supported by workforce capabilities and funding.

Priority Populations

36. Whānau Āwhina Plunket agrees the priority populations for this strategy should be Māori, Pacific peoples, Asian people and young people / ranagatahi. Priority populations need to be considered not only as individuals but in the context of their tamariki, family and community and for Māori, their whānau, hapū and iwi.

37. Despite Māori being prioritised in the current strategy there has been no significant change in terms of prevention and minimisation of gambling harm outcomes. We can see recommendations

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[28] PGF Group. (2020). White paper – Ending community sector dependence on pokie funding.
[29] Ministry of Health. 2021. *Strategy to Prevent and Minimise Gambling Harm 2022/23 to 2024/25: Consultation* document. Wellington: Ministry of Health
[30] PGF Group. (2019). Gambling harm and children – fact sheet 7. Retrieved from https://www.pgf.nz/downloads/assets/13509/1/fs_11%20gambling%20harm%20and%20children%20sep%202019.pdf
[31] Christensen, M., Patsdaughter, C., & St. Germain, M. (2000). Mother-Bingo Bonding: Screening for Gambling Addiction in the Neonatal Intensive Care Unit. *Neonatal Network, 19*(7), 7–11. https://doi.org/10.1891/0730-0832.19.7.7

from the Needs Assessment have been embedded in the action areas. The challenge will be doing it well, by ensuring the right amount of funding and support is in place to achieve improved outcomes for Māori. For Māori, interventions will need strong consideration of whānau, when an individual is affected by gambling harm the whānau as a whole is also affected, including their community.

38. We are pleased with the aim to collaborate and co-design with prioritised population groups to prevent and minimise gambling harm. However, the priority populations section fails to consider the complexities of the groups within Pacific and Asian ethnicities. Access barriers to supports and services, such as language and cultural barriers are unique to these groups and continue to be a problem. The draft strategy does not address the complexities of such barriers.

39. The top three ways Asian people generally seek support for gambling problems are turning to their family and friends, self-help strategies and support groups (face to face)[32].

40. We agree with the focus on de-stigmatisation. Stigma related barriers are the biggest barriers for Asian people in seeking gambling support. However, other forms of barriers exist which need to be further understood in the New Zealand context[33].

41. We are pleased to see the addition of young people / rangatahi to the priority population groups and this is aligned with the Child & Youth Wellbeing Strategy. Also, because the Strategy considers the disproportionate higher number of Māori and Pacific youth affected by gambling harm.

42. The consideration of people with disabilities and therefore their increased vulnerability to gambling related harm is not explicit enough in the strategy. The consideration is also missing from the draft service plan.

43. If this strategy truly wants to address inequities experienced by these priority populations, it needs to be more ambitious and consider the above points.

Research and Evaluation

44. Whānau Āwhina Plunket agrees with the continued focus on research and evaluation. However, we are concerned with the reduction in funds in this area – we do not understand why the underspend cannot simply be boosted into funding for this financial year.

45. The proposed reduction in research and evaluation funding and previous underspend indicates there needs to be a clearer direction of research areas. As shifting cultural and social norms is a key priority, it is logical to focus research in these areas, as well as the needs of children and their families.
    a. We recommend not reducing the research and evaluation funding, and instead to contribute towards addressing existing research gaps and building a strong evidence base underpinning activities of gambling harm prevention and minimisation.

[32] Asian Family Services. (2021). New Zealand Asian Responsible Gambling Report 2021
[33] Asian Family Services. (2021). New Zealand Asian Responsible Gambling Report 2021

46. Cultural norms that target the identified priority population groups (Māori, Pacific peoples, Asian people and young people/Rangatahi) needs to be strengthened. Most research on these groups focuses on only on access barriers, little is known about effective prevention strategies or factors that facilitate successful health promotional programmes and interventions.

47. Similarly, targeted research can focus on specific social norms or roles. There is limited research on mothers or caregivers who are problem gamblers and the impact this has on tamariki. Evaluation studies on effectiveness of Host Responsibility would also be helpful, especially to understand how this cohort continue to be able to access Class 4 venue despite host responsibility regulations in place. Research of this kind would help to understand and develop support that can be given to mothers or caregivers who are problem gamblers.

48. Whānau Āwhina Plunket is concerned research into impact of gambling on children in the NZ context is limited. There are visible harmful effects such as poverty, but there are also psychological aspects that are long lasting.

49. Babies bond at an early age, the first 1000 days are critical for parents and caregivers to establish attachment and bonding with their baby. Child neglect can have long term consequences on their health and developmental functions[34]. Research needs to look into the impact of gambling on younger children (0-5 years old), especially to explore effective strategies and interventions to end intergenerational harm.

[34] Avdibegoviü, E. et al. (2020). Child neglect – causes and consequence. Psychiatria Danubina, 2020; Vol. 32, Suppl. 3, pp 337-342.