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SUBMISSIONS TO THE PRODUCTIVITY COMMISSION INQUIRY INTO AUSTRALIA'S GAMBLING INDUSTRIES.

A NEW ZEALAND PERSPECTIVE

Presented by the Committee on Problem Gambling Management (Inc.)
At Melbourne, Australia on Tuesday the 24th November 1998

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ABOUT THIS SUBMISSION

The Committee on Problem Gambling Management (COPGM) is a registered charitable trust formed to fulfil the functions described in Statute by the Minister of Internal Affairs pursuant to the problem gambling management functions as set out in the Lotteries & Gaming Act No 2 Amendment 1996. In short, this Committee has the responsibility currently, exclusively so, to resource remedial services coping with New Zealand's presenting serious problem gambling population. The Committee is obliged to fund a range of education, research and counselling interventions via the collection amongst the gambling industry sectors of a voluntary contribution for the setting of an annual budget.

The gambling industries makes a voluntary contribution as follows:

The Lottery Grants Board representing the Lotteries Commission.

The Racing Industry Board, representing the various forms of track racing, racing clubs and TAB off course betting.

The Casino sector.

The gaming machine operators.

The industries agree amongst themselves for an annual contribution to the Trust for the purchase of an appropriate levy range of services. COPGM advises the Minister on an appropriate levy for the gaming machine sector, as the collection from 2400 sites on a voluntary basis is unworkable. The Minister gazettes the amount of the levy which is then collected as a separate Problem Gambling Levy at the same time as the annual gaming machine site licence. This money is collected by the Department of Internal Affairs and then passed to COPGM.

COPGM is obliged to report to the Minister annually on it's activities and that report is tabled in Parliament.

In addition to the Gambling Industry representatives of whom there are five, a further five representatives on the Trust is made up of treatment provider representatives, includes cultural and ethnic representation on behalf of tangata whenua (NZ Maori) and Pacific Island nations peoples. The Trust is chaired by a mutually agreed neutral chairman, currently a barrister.

THE TREATMENT SERVICES

COPGM currently engages services of a specialist purchasing agency, The Problem Gambling Purchasing Agency of NZ Ltd, to act on it's behalf for the independent selection of appropriately priced contracts, fulfilling the objects of the statute and conforming to comparable market price costings and with Best Practice Guidelines on the treatment and support of persons with serious gambling disorders as prescribed by the Ministry of Health. To date, funding has been predominantly focused on a range of first access and crisis intervention telephone counselling now being provided by the Problem Gambling Helpline, a subsidiary of Lifeline Auckland, offering a seven day a week toll free, referral and motivation counselling service, outpatient brief care facilities operated by the Salvation Army and a stepped care, nation wide assessment and brief intervention programme provided by the Compulsive Gambling Society of NZ (CGS). Approximately twenty percent of the funds are allocated to education, health promotion and research. This includes work in progress by the Auckland University Medical School, the Christchurch School of Medicine, Massey University and the development and production of a range of health promotion and generic awareness raising education materials.

In the current financial year, COPGM contracted services will provide for assessment and treatment of fifteen hundred new clients nation wide, thirty to thirty-five thousand Helpline calls, attracting approximately three thousand first time callers and access for help spread through twenty eight venues throughout the North and South Island. By years end all major centres and secondary cities will have face to face counselling facilities with distance counselling, coordinated by the Helpline for people in isolated or more sparsely populated districts. Without the work of this Trust, it is submitted that no services would be in place for persons suffering from problem gambling and its related effects. The Government provides no Vote Health support and excludes implicitly the treatment of persons with pathological gambling disorder from publicly funded mental health and addiction services unless clinicians can

categorically establish that the gambling disorder is secondary to the funded help available in substance abuse programmes, (drug and/or alcohol), or a co-morbid diagnosis to some other funded mental health problem.

PATHOLOGICAL AND PROBLEM GAMBLING IN NEW ZEALAND

In New Zealand and in some other countries, public awareness of pathological gambling and concern about inadequate treatment provision has increased in association with the legalisation of new forms of gambling. This concern was reflected in submissions to the Committee of Inquiry into the Establishment of Casinos in New Zealand (Department of Internal Affairs, 1989) and Review of Gambling in New Zealand (Department of Internal Affairs, 1990). Both reviews concluded that problem gambling exists in this country but noted that there was a lack of objective information concerning it's scale. Public opinion polls conducted in 1985 and 1990, cited in the 1990 Review report as well as in Christoffel (1992), indicate that during this period the majority of New Zealanders were of the view that there was a problem with people who gamble excessively and that those who want to give up excessive gambling should be given special help to do so. These polls also showed that support for both viewpoints increased from 1985 to 1990. By 1990, 71 percent of adults believed that there was a problem in New Zealand with people gambling too much and 91 percent said there should be special help provided for such people. All of these trends were confirmed in the 1995 polls.

The need and potential demand for counselling and therapy services was highlighted by recent Department of Internal Affairs reports on the prevalence of pathological gambling in New Zealand (Abbott & Volberg, 1991; 1992). The research summarised in these reports was based on telephone interviews with a representative national sample of 4,053 adults, followed by further in-depth, fact-to-face interviews with a smaller group. Over half of the 217 people re-interviewed face-to-face had been identified, using a validated diagnostic screen, as probable pathological gamblers or problem gamblers. The remainder were regular gamblers who did not report any significant problems in association with their gambling.

From the Department of Internal Affairs research it was concluded that in 1991 approximately 1.2 percent of adults were currently pathological gamblers and that a further 2.1 percent suffered from gambling-related problems of lesser severity. Research in other countries has shown that for every pathological gambler, typically between five to ten other people in their family or wider social network are adversely affected. The number can be much greater, for example, when pathological gamblers are lawyers, accountants or treasurers who steal client funds or misappropriate trust monies to sustain their gambling 'addiction'.

Although an estimated 3.3 percent of adults were considered to have some problems associated with their gambling, less than one percent acknowledged that they had a problem. However, two percent of people surveyed said that at some time in their lives they had had a problem with gambling and four percent indicated that one or both of their parents had a problem with gambling. Over half (59 percent) of the people interviewed in depth said they knew other people who have a gambling problem. From the foregoing, while acknowledging that it is difficult to give precise estimates of the number of people living in the community who are pathological or problem gamblers, serious gambling problems are becoming more evident. Furthermore, it would seem that people are much more likely to recognise these problems in other people than they are to acknowledge when they personally are a problem or pathological gambler.

Pathological and problem gamblers were found to come from all walks of life. However, some groups were heavily over-represented. High risk groups included Pacific Islanders and Maori, the unemployed, young adults, men, single people, those with a parent who had a problem with gambling and people with a history of heavy involvement in continuous forms of gambling, especially horse or dog racing and gambling machines.

Of the pathological gamblers interviewed face-to-face, while nearly half felt that they personally had a gambling problem at some time, none reported having ever sought or received professional counselling or therapy for their gambling. This was not because they were not suffering. Pathological gambling is a serious psychiatric disorder and, of those interviewed, 45 percent were found to be experiencing significant levels of psychological distress and 43 percent were clinically depressed.

The authors of the Internal Affairs survey concluded that further research is required to determine why pathological gamblers do not seek or receive professional help. Lack of knowledge on the part of the wider community and health professionals may provide a partial explanation. However, the most likely explanation is that at the time the national survey was conducted, there were virtually no specialist services available. In 1992 Christoffel (undated), on behalf of the Department of Internal Affairs, surveyed treatment services. He found that only one institution, the Springhill Centre in Hawkes Bay, specifically catered for the treatment of pathological gamblers, taking approximately six to eight people per annum into its general addictions treatment programme. A further 20 pathological gamblers from prisons or on community corrections sentences were estimated to be referred to the Department of Justice psychological services each year. A few psychologists in private practice also took an unknown but probably modest number of clients. As far as ’specialist’ professional treatment services were concerned, this completed Christoffel’s list. With respect to self help groups, at the time of this survey, there were six active Gamblers Anonymous (GA) Groups operating with an estimated weekly attendance (nation-wide) of 100 people (Abbott, 1993; Christoffel, undated).

In early 1998, the New Zealand Government agreed to a second prevalence study with the original authors contracted in association with the Department of Statistics to revisit the 1990/91 sample and determine changes to prevalence rate and also include longitudinal aspects within the second review. We believe that this study will have important implications for the Productivity Commission’s Inquiry as it will for our domestic public policy considerations. Approximately one-million New Zealand dollars has b been allocated for this work with the majority of funds coming from the Lotteries Grants Board and one-hundred thousand dollars contributed from this years COPGM budget.

Since 1991, and the release of the Abbott/Volberg study (phases 1 & 2), much has happened in the provision of gambling for New Zealanders. Two Casinos have opened, Auckland and Christchurch. Dunedin has been granted a provisional licence with Queenstown and Hamilton under consideration for further licence approvals by the Casino Control Authority. From 1991 through to 1997, gambling turnover has moved from one-billion dollars to almost six and a half billion dollars per annum. Although the average gambling spend per capita is approximately half that of Australian citizens, the growth and expenditure in New Zealand by comparison in the period mentioned above has moved ahead at almost twice the rate. Increased access to gamble and a greater variety of gambling opportunities has generally been accepted as a contributing factor in

the number of persons now presenting for help with serious gambling related problems across the country.

A closer examination of the 1997 Problem Gambling Counselling in New Zealand - National Data Set, illustrates a clear correlation between the opportunity to gamble and an increase in problem gambler presentations. Similar findings are shown in the 1996 and 1997 CGS Clinical Services Reports. Notwithstanding an almost three-fold increase in the contribution to remedial services between 1995 and 1998, direct Government contributions have remained at zero. During this period of time the government collected nearly $800 million by way of Gaming Duty and GST. None of this money has been directed towards the treatment of problem gambling or the moderation of gambling consumption. Further, no adjustment has been made to public health policy and inter-sectorial targeting of resources to identify and assist persons affected by gambling problems.

The lack of government funding towards this matter is in contradiction to the stated purpose to the introduction of the Gaming Duty in 1991. During the Parliamentary debate it was reported in Hansard that the introduction of the Gaming Duty was "to meet the social costs of gaming". The funds obtained from the Gaming Duty have not been focused in this area.

WHAT SHOULD WE DO NOW?

In April of this year, COPGM having committed itself to continue to provide funding for a specialist range of services to persons suffering from pathological gambling disorder or the effects of serious gambling problems, recognised the need to review the sustainability in the long term of this position. What we believe to be an absolutely unique development began to emerge. Treatment and social service providers, along with gambling industry representatives on COPGM, developed a joint rationale for the continued targeted assistance for problem gamblers and their families. This review is appended as the COPGM Draft Policy for Promoting Responsibility in Gambling.

The position quickly reached by the service providers and funder representatives on the Trust was that a comprehensive public policy appraisal for the broader ownership of problem gambling related matters, including the evolution of a harm minimisation strategy for consumption, promotion and levels of accessibility ought to be reflected in a total health response. The ongoing funding of specialist services without the contextualising of help within a continuum of care and support makes little sense. Clearly, problem gambling must be seen in the context of offering treatment as a health issue. Of material relevance to this Inquiry is the opting out by successive Governments throughout Australia and New Zealand of public funded support and provision within core health services for problem gamblers.

For whatever reason the issue of managing problem gambling in this part of the world has been seen as the responsibility of the gambling industry. Our experience shows in New Zealand that the lack of allocation of monies from Vote Health, Vote Social Welfare and the Criminal Justice System is now contradicting and constraining the small range of remedial services supported by additional funding from the Industry.

Serious questions now arise in all of our respective jurisdictions about the purpose of our gambling taxes. It is our contention that unless Governments are willing to redirect a proportion of gambling tax revenue into remedial strategies including a well defined and integrated harm minimisation public health policy, that hazardous consumption will emerge as a lasting consequence.

We support the need for urgent consultation about the adjustment of public policy to reflect a cohesive attempt to ameliorate harm occasioned from the growth in gambling. Community education, consumer information, early intervention and detection strategies, encouragement for early help seeking behaviours amongst those persons experiencing problems with their gambling, are functions best performed by the State. While accepting standards as responsible hosts, the gambling industry cannot be expected to take over the responsibility of their customers. Choice around safe levels of consumption must stem from neutral and public reference points in broad brush interventions by governments to reduce the prevalence of pathological gambling disorder.

To exclude by policy decisions this addiction from Vote Health expenditure is not only harsh but self defeating. We take the view that people can participate in gambling responsibly and in an enjoyable manner as in the case of alcohol consumption. Independent assistance is required to promote customer responsibility. The public policy blue print document appended illustrates a construct within which fresh perspective's can be developed with a number of objectives highlighted in an inclusive high level of social debate from which agreements and accords may be realised.

We would be happy now to explore some of these points in more detail. We thank you for giving us this opportunity to present these submissions to you and look forward to collaborating with the Productivity Commission in information exchange and the development of trans-Tasman dialogue as the proposition to revisit Australia's regulatory regimes, social costs and impacts will have some influence on our own domestic policy considerations.

We now ask you to turn to the summarised attachment headed COPGM Draft Public Policy on Gambling and associated recommendations.

For and on behalf of the Committee on Problem Gambling Management (Inc.)

.....
Ralph Gerdelan
(TREATMENT SERVICES PROVIDER TRUSTEE REPRESENTATIVE).

.....
Roger Parton
(GAMING INDUSTRY AND FUNDER TRUSTEE REPRESENTATIVE).

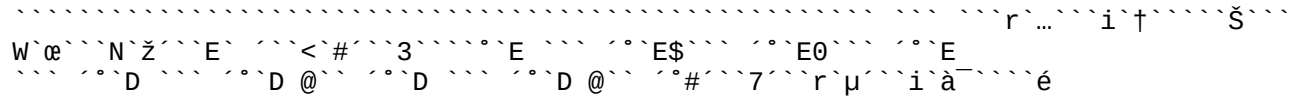
Attachments:

COPGM Harm Minimisation on Gambling and Related Public Policies.

Problem Gambling Counselling in New Zealand - 1997 National Data Set (COPGM).

Guidelines for the Assessment and Treatment of Pathological Gambling. Ministry of Health, NZ. 1996.

Public Health Association of Australia - Position on Gambling and Public Health, 1997.



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SUMMARY DOCUMENT

The following points reflect the thrust of the submission with the focus on solutions and the processing of public positions reached to date by the COPGM in New Zealand. These submissions encourage the development of a comprehensive public policy review to determine an equitable social formula within which gambling can be provided, sustained and enjoyed in a less harmful way than the current ad hoc arrangements have delivered.

Particular emphasis is drawn to the following:

- The regulatory and licensing regimes need to be reviewed in association with appropriate adjustments in public policy.

- Government should accept the lead role in the moderation of consumption, equitable regulation and appropriate provision for public access remedial services.

- Broad-brush interventions by the State to provide community education and awareness of the risks associated with hazardous levels of consumption and high at-risk circumstances.

- Consumer information aimed at clear choices and self-monitoring by gamblers ought to be provided by the State as a reciprocal obligation in the regulation and permissibility of a behaviour/product known to have harmful possibilities or consequences.

- The submitters concur strongly that problem gambling is in the first instance a matter best directed to publicly funded health services.

- Remedial strategies ought to be driven by a public policy response. This should reflect inter-sectorial commitment from government services and agencies involved in intervention with problem gamblers.

- The state should provide a wide range of information from independent research to assist and effect planning regulation. Long term health consequences of problem gamblers need to be understood and provided for.

- Consumption of gambling should be reflected within a public health construct delineating a continuum of social and enjoyable participation through to harmful and hazardous use.

- Parallels are drawn to international charters on alcohol and addictive substances underpinning government health policy responses.

- Health responses to the consumption of alcohol have now been in place for over twenty-five years. Gambling requires to be included in public health considerations in a similar way.

- We strongly urge the Commission to encourage the development of a health and public policy charter on gambling as we are doing in New Zealand.

- Public policy responses in Australia do have an influence and an impact on the respective regulatory and policy frameworks in New Zealand.

- A public policy and health charter on gambling, in our view, should reflect the principles of the Ottawa Charter and should be a companion to the conventions applied in the control and regulation of alcohol and other addictive substances.

- Problem gambling must be absorbed within Vote Health as a part of mental health and addiction services. Member States should develop treatment guidelines and Best Practice Standards to ensure ease of access, integrated and co-ordinated care for the co-morbid health issues invariably detected in the presentation of pathological gamblers.

- Currently, in Australia and New Zealand, access to treatment, support and care for serious problem and pathological gambling populations is supplied by a range of industry funded initiatives. We believe that whilst these have been well intentioned, they have now reached a point where a full and comprehensive range of care is required.

- The level of expenditure on gambling in Australia and New Zealand, now warrants special attention if we are to avoid unwanted long-term health and cost implications for our societies.

COMMITTEE ON PROBLEM GAMBLING MANAGEMENT (COPGM)

Draft Policy for Reducing the Prevalence of Problem Gambling and Minimising Harm

Prepared as an Attachment to the Principal Submission for the Australian Federal Government's Inquiry into Gambling

Productivity Commission Melbourne Hearing
Tuesday, 24th November 1998

Table of Contents

1. Introduction

Gaming has become a major area of economic and social activity in New Zealand. In recent years it has become the subject of considerable moral, financial and emotional debate with the capacity to polarise factions of society.

Existing public policy surrounding gaming in New Zealand is fragmented and lacks coherence. Indeed the existing legislative framework reflects the application of different policies to different forms of gaming over time, or as particular issues have arisen. There does not appear to be any overarching set of principles responsible for shaping the development of gaming in this country.

While the gaming industry makes a considerable economic contribution to the community, there are also considerable negative impacts in the form of problems arising from problem gambling. If New Zealand is to retain a viable and flourishing gaming industry it is essential that there is developed and implemented a comprehensive national policy to address problem gambling[1].

As its contribution to the development of a national policy to address problem gambling, the Committee on Problem Gambling Management (COPGM) has consulted widely[2] and developed a draft policy, outlined in this paper. The policy is designed to achieve a reduction in the prevalence of problem gambling, a minimisation of associated harm and to initiate a nation-wide response to problem gambling.[3]

2. COPGM's role

COPGM was established by its constituent members as an independent charitable trust. It is not a Government organisation but is recognised by Government under the Gaming and Lotteries Act. Its role is to purchase services to address problems associated with problem gambling. COPGM's membership comprises representatives of the gaming industry and representatives of community organisations providing services to problem gamblers. It has an independent chairman.

The composition of COPGM, with industry, providers of treatment service providers and tangata whenua sitting around the table together, makes it internationally unique. The wide-ranging co-operation and synergy built around a commitment to common social objectives and the recognition of business objectives and prerogatives between these potentially adversarial parties is of great significance. Every effort should be taken to maintain this unique and powerful union.

COPGM receives funding for problem gambling treatment services from the gaming businesses represented on COPGM, who together have contributed:

$2 million 1996/97
$2.2 million 1997/98

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[1] Problem gambling is defined as occasional or regular gambling to excess to the extent that it leads to problems in other areas of life, particularly with personal functioning, finances and inter-personal relationships. Throughout this document problem gambling should be read as including pathological gambling unless otherwise specified.

[2] Consultation findings are summarised in Appendix 2

[3] A research review is presented in Appendix 1

$2.75 million 1998/99

COPGM has concentrated on ensuring essential help is available to the people with the most serious gambling problems. These services, as valuable as they are, address only the 'tip of the iceberg' of gambling problems. (See Fig 2 page 12.)

It is of concern to COPGM that prevention and early intervention in gambling problems are not being addressed other than through occasional, local and limited activities by voluntary organisations, which are poorly resourced to do this.

3. Rationale for COPGM's policy for minimising harm associated with gambling

COPGM's policy is based upon a number of factors derived through review of pertinent research and consultation with sixty key people in gaming businesses, government and regulatory bodies and treatment provider organisations. The factors are:

- The accessibility and variety of gambling available to New Zealanders has increased markedly in the past decade.
- Widespread participation (by 90% of adults) and a fourfold increase in national expenditure indicate that gambling, in one form or another, provides a positive social experience for many New Zealanders.
- Indications are that accessibility, variety and participation will continue to increase, particularly with the advent of home Internet and interactive television gambling.
- There is clear evidence that gambling can result in harm for a minority of individuals who engage in excessive gambling or who gamble irresponsibly.
- There exists a gambling-problem continuum along which such individuals can move, to the extent they become problem gamblers, or reduce their problem.
- Increasing the opportunities for gambling will increase further the number of problem gamblers in the community but it is unclear if a levelling off will occur.

4. The policy

The policy objectives are harm minimisation and the reduction of the prevalence of problem gambling. These goals will be achieved through encouraging New Zealanders to develop responsibility in gambling.

Core elements in COPGM's policy are:

- Sound research and evaluation processes
- Availability of balanced and valid information
- Individual gambler responsibility
- A code or codes of practice for gaming providers
- Comprehensive, culturally appropriate nation-wide treatment services

- A coherent national gambling policy.

COPGM's policy

COPGM is committed to the reduction of the prevalence of problem gambling and to the minimisation of associated harm to the individual, their family/whanau, tangata whenua and the community.

The principles of the Treaty of Waitangi are accepted and honoured.

COPGM is clear that it cannot achieve its overall goals through its own actions alone. COPGM is actively committed to providing certain services within its mandate and resources and to supporting and facilitating the provision of other services.

COPGM believes that the best outcomes will be accomplished through a combination of:

Rigorous research, that:

- Defines clearly the prevalence and trends occurring in problem gambling
- Clarifies the relationship between forms and accessibility of gambling and trends in problem gambling
- Evaluates the effectiveness of intervention at each of the problem and pre-problem stages of the gambling continuum.

Balanced information initiatives, that:

- Provide the gambling public and at-risk groups with balanced, valid information about the potential risks and adverse effects associated with gambling
- Educate young people
- Encourage and assist gamblers and at-risk individuals to adopt **more responsible** gambling practices, thereby reducing the risk of their suffering harm through gambling.

Responsible gambling operators, who:

- Develop and adhere to industry codes of practice aimed at reducing the risk of excessive or irresponsible gambling among customers and encouraging responsible gambling
- Protect gamblers and potential gamblers from unethical or misleading advertising
- Adopt responsible gambling measures that facilitate early identification and appropriate response to problem gamblers and at risk populations in the community including denial of access to those who should not gamble

- Support through COPGM, the research, education, detection and treatment interventions that contribute to the reduction in incidence of problem gambling and the minimisation of harm associated with gambling, as embodied in the national strategy.

Comprehensive nationwide treatment services, that:

- Ensure effective treatment and rehabilitation for all those experiencing gambling problems or harm associated with gambling
- Accord with best practice
- Are accessible nation-wide and matched to individual treatment needs
- Are culturally appropriate
- Are provided by agencies and individuals committed to development and implementation of the national strategy to minimise harm from gambling
- Maximise the benefits that come from co-operation among the various service providers and others interested in this field.

Government support and actions, that:

- Produce a coherent national gambling policy, which addresses the future development of gambling and takes account of the "safety" of gamblers
- Protect New Zealand "social capital" by encouraging gamblers and gambling providers to co-operate in developing responsible gambling practices
- Ensure support and co-operation of government agencies in development and implementation of the national strategy to minimise harm from gambling.

Multi-party co-operation, that:

- Addresses the adverse effects of gambling by involving all interested parties together in a co-ordinated nation-wide approach
- Is based on an agreed strategic plan developed in consultation with all parties concerned that maps a medium to long-term approach to addressing the elements contained in this policy.

5. Problem gambling – The international context

Several countries have recently initiated gambling reviews or begun publishing policy recommendations, for example:

Canada seeks to minimise the harm associated with problem gambling through a focus on shared responsibility among gaming industry, regulatory agencies, service providers and government, community based service delivery systems sensitive to

community needs and values and a focus on evidenced-based programmes that demonstrate effectiveness and efficiency.

Australia has initiated a Federal inquiry into gambling industries and their economic and social impact, with a view to determining the size and costs of associated problems, links between problem gambling and criminal activity, alcoholism, and depressive disorders, the effectiveness of rehabilitation and the impact of industry codes of practice.

Britain has adopted a gambler protection model in regulating the establishment and operation of casinos. This provides regulation designed to protect the customer as part of Britain's public policy toward gambling.[4]

Holland has undertaken the most direct action aimed at reducing problem gambling and minimising harm, by placing restrictions on the number of machines per site and size of payouts.[5] In the first year following introduction of these restrictions, problem gambler presentations to mental health agencies in Holland halved.

Some individual states in **America and Canada** have moved to limit the expansion of casinos and gaming machines. Particular concern is being directed at the latest VLTs (video lottery terminals) which are considered to be more potentially "addictive", and therefore place gamblers at more risk of developing into problem gamblers.

While countries such as Holland have instigated some harm minimisation strategies, most countries are still at an early and very reactive stage in addressing the problem.

6. New Zealand in context

New Zealand, by contrast, is well placed to move toward a co-ordinated, comprehensive, nation-wide strategy to combat problem gambling and its negative accompaniments, at both the preventive and rehabilitative level. If endorsed and adopted by government, industry and treatment providers, this COPGM initiative will provide an opportunity for New Zealand to lead the way in addressing both the precursors of problem gambling and the harm arising from it.

7. Problem gambling and New Zealand mental health

[4] In this model casinos cannot advertise to stimulate demand, cannot offer complimentary services, provide entertainment, or use any other methods to promote the casino or gambling

[5] This Dutch policy recently resulted in removal of gambling machines from cafes to reduce underage access. Licensed bars are now restricted to a maximum of two gaming machines, with low payouts and no linked jackpots. Additional measures to prevent the development of problem gambling are that machines accept discrete bets only, are programmed to provide compulsory periodic shutdowns to interrupt play, and display warnings discouraging continuous play.

Pathological gambling is a recognised mental health disorder both in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) and in the International Classification of Diseases (ICD-10). However the treatment of pathological gambling in New Zealand is not funded as part of core health funding. The Government expects treatment for pathological gambling to be funded by the gambling industry, i.e. via COPGM. Government agencies typically adopt a policy to only treat problem gambling when the gambling problem is secondary to an existing problem already being treated.

The result of this is a limited approach to the treatment of problem gambling which does not extend to education, information and other forms of intervention, which are beyond the mandate and resources of COPGM.

COPGM's proposed national policy to address problem gambling, set out in this document, is consistent with the Government's goals for mental health:

- To decrease the prevalence of mental illness and mental health problems within the community.
- To increase the health status of and reduce the impact of mental disorders on consumers, their families, caregivers, and the general community.

COPGM believes that Government mental health agencies dealing with people whose disorders include problem gambling, should co-operate with COPGM funded treatment organisations. This will require an ownership by the mental health system of their contribution to the treatment of pathological gambling.

8. Benefits and costs of gambling

Gambling, in its many forms, is a popular leisure-time pursuit that many New Zealanders find entertaining and enjoyable. Of those who gamble, most spend amounts that are not out of keeping with expenditure on other forms of entertainment. The Government and communities benefit from gambling through social and recreational opportunity, creation of jobs, income derived from taxes on gaming and the distribution of proceeds to charitable causes.

However, there is a down-side to those benefits where gambling is excessive and becomes a problem:

- *Personal consequences* - for example, debts, work absences, family and relationship problems, mental problems such as anxiety, mood swings and suicide, and crime to finance gambling habits.
- *Community consequences* - for example, employers who suffer loss, businesses which pay for treatment services, and taxpayers who finance the costs of health and other social services and the justice system.

9. The nature and prevalence of the problem

Currently the extent of problem gambling is poorly defined, such that it requires better definition through research.

A 1991 study[6] of the prevalence of problem gamblers in New Zealand found current prevalence rates of 1.2% or 18-32,000 pathological gamblers and an additional 2.1% or 40,000 people who are problem gamblers. A further study in 1994[7] estimated that there were between 12,000 and 68,000 pathological gamblers in New Zealand at the time of the 1991 survey.

Problem gamblers come from all walks of life, all socio-economic groupings, and all levels of society. Some characteristics of problem gambling are:

- A proportion of problem gamblers will be unable to control their gambling and will need to be supported to stop gambling with long term assistance needed in order to avoid relapsing
- Other less severely addicted gamblers will successfully learn to modify their problem gambling and be able to gamble in a controlled and non-harmful
- Some problem gamblers "grow out' of the problem without any formal assistance
- It is often hidden within individual problem gamblers and their families, so that by time of discovery significant damage has already occurred
- It is frequently accompanied by other psychological disturbances, like depression or anxiety states, and may be co-existent with alcohol abuse. In many cases it is unclear which is the primary disorder
- It is linked to crime, with as many as 70 - 80% of problem gamblers committing offences to fund gambling.

Clinical trends in New Zealand indicate that increasing numbers of women and young people are becoming problem gamblers. The apparent speed of onset and severity for youth appears due, in part, to the similarity between video games and electronic gaming machines gambling (Fisher, 1995). The availability of the Internet and interactive television gambling may affect this trend.

COPGM is beginning to gather reliable national statistics that increase the understanding of who problem gamblers are:

- 952 (98%) of the people to whom counselling was offered during 1997 were completely new clients of treatment services funded though COPGM[8]. This indicates that the services are attracting those who need help, but concurrently there is a concern about the increasing numbers presenting
- Electronic gaming machines (EGMs) were identified by 67.8% of those receiving counselling as their main mode of problem gambling
- Three quarters of the people presenting for treatment were males. The mean age of those presenting was 36 years
- There appears to be increasingly rapid onset of problem gambling among those who adopt EGMs as their main mode of gambling.

[6] Abbott and Volberg
[7] Manly, Gonzalez, and Sullivan
[8] Hannifin J and Gruys M, *Problem Gambling Counselling In New Zealand 1997 National Statistics*, COPGM, June 1998

10. Research direction and co-ordination

COPGM is actively supporting a programme of research and data gathering. Accurate data and balanced information about the risks associated with gambling, problem gambling and its adverse effects are required. There is a serious shortage of sound data about problem gambling. A lack of co-ordinated national policy has resulted in available data not being brought together in a systematic repository of information; nor are regular studies carried out. COPGM is supporting a second national prevalence survey that will build on the results of the 1991 survey. This is timely and will clarify current prevalence rates and trends.

Whether problem gambling is an increasing public problem that will compare with alcohol and drug addiction in its future seriousness, or whether it constitutes more of a trend that may prove to be self-limiting, possibly replaced by some other behavioural problem within a generation is not known.

11. The scope of existing services to address problem gambling and its adverse effects

The majority of the effort to address gambling-related problems is clustered at the treatment end of the continuum, carried out once a problem has emerged. Services to problem gamblers and their families are primarily provided by community agencies, many of which rely on COPGM for funding. Included in the services supported by COPGM are: a national telephone hotline, personal counselling services in centres throughout the country, and a range of research and education projects aiming to enhance treatment services.

Other (non-quantified) treatment services for problem gambling are known to operate through privately and publicly owned health services responding to a wider variety of personal problems.

Few organisations work at the prevention end of the continuum. Information packs and publicity materials are made available by some treatment and gaming providers. These are however limited, as is the level of service aimed at educating and informing the public about the potential risks and adverse effects of gambling.

(See Figs 1 & 2 on pages 12-13 for a diagrammatic representation of the range of service providers.)

12. Culturally specific services

Initiatives dealing with problem gambling need to be responsive to different cultural settings in order to avoid the dissatisfaction and apprehension by groups in society that do not ‘fit’ monocultural approaches. The absence of such groups’ involvement in and ownership of initiatives to deal with the adverse effects of problem gambling means that the relevance and outcomes of those initiatives will be dubious. This is

the more important because of the higher prevalence rates of problem gambling among several of these groups.

The principles of the Treaty of Waitangi - the principles of partnership, reciprocal obligations and equality - are a point of reference for responsiveness to Maori needs for services. The interpretation of the Treaty by the Courts has focused on the relationships between Maori and the Crown. COPGM is not part of the Crown, but will be guided by these principles in leading this process for enhancing services for problem gambling in New Zealand in the public interest.

13. A national policy for gambling – Government's future role

Central to COPGM's policy to address the harm associated with problem gambling is the necessity for the development of a comprehensive overarching 'national policy' on gambling. There is widespread support among service providing agencies for such a policy. The national policy for gambling would determine future direction and growth of gambling in New Zealand. It would make explicit gambling's role in the nation's economic and social development, while recognising the impact that problem gambling can have.

Such a policy is the prerogative of the Government. COPGM's analysis from its involvement with problem gambling and from the feedback received from the people consulted, is that the scope of a national policy should include:

1. Legislation governing gambling, having regard to:

   (a) the complexity, accessibility and effects of different forms of gambling

   (b) retaining, or integrating, the different philosophies behind the Gaming and Lotteries, Racing and Casino Control Acts

   (c) powers to deal with problem gamblers
   (d) protection of family property
   (e) limits on pay-outs.

2. Socio-economic effects, addressing for example:

   (a) the place of gambling in the economy

   (b) gambling across international boundaries
   (c) the use of taxation from gambling
   (d) relationships to other State objectives for employment, tourism, recreation, savings/superannuation, benefit payments, crime prevention.
   (e) the 'victim' effect on families, businesses, other peoples' property.

3. Matching the willingness to allow industry growth with effort to inform and equip the public to handle the effect.

4. Establishing codes of practice, standards and accountability for gambling activities and interventions.

5. Engendering an educational and social environment wherein children and adults are encouraged to develop individual responsibility in gambling.

6. Undertaking overall responsibility for promoting and monitoring national plans, services and outcomes by independent bodies.

7. Providing a mechanism for the co-ordination and integration of efforts to address gambling problems.

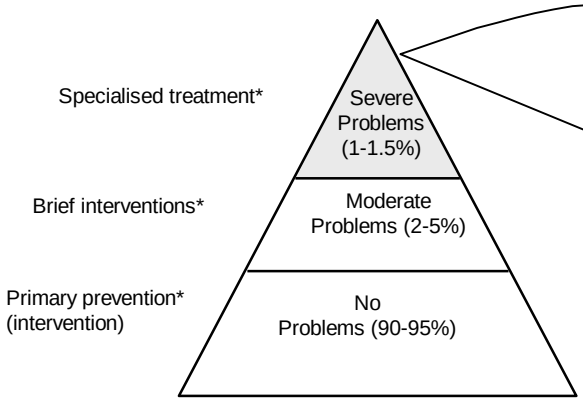
8. Monitoring the pre-cursors of problem gambling and harm arising from this.

	Occasional Investigation, Research and Data Collection	Policy and Legislation	Education and Training	Gaming Environment and Detection	Treatment Services	Culturally Targeted Services	Services to 'at-risk' Populations	Co-ordination
Government departments: Internal Affairs Health Education Courts Police Corrections Children & Young Persons Service	✓	✓						
Gaming providers			✓	✓				
Consumer associations			✓					
Personal help societies: Compulsive Gambling Society Lifeline	✓		✓		✓ ✓			
Church organisations; Salvation Army Joint Anglican and Catholic	✓		✓		✓			
Iwi and other associated culturally specific groups	✓							
Voluntary welfare organisations								
National youth organisations								
Private Clinicians					✓			
Universities: Auckland Massey Otago	✓ ✓ ✓		✓					
COPGM	✓				✓			✓

Fig 1 Table of Service Providers by Activity[9]

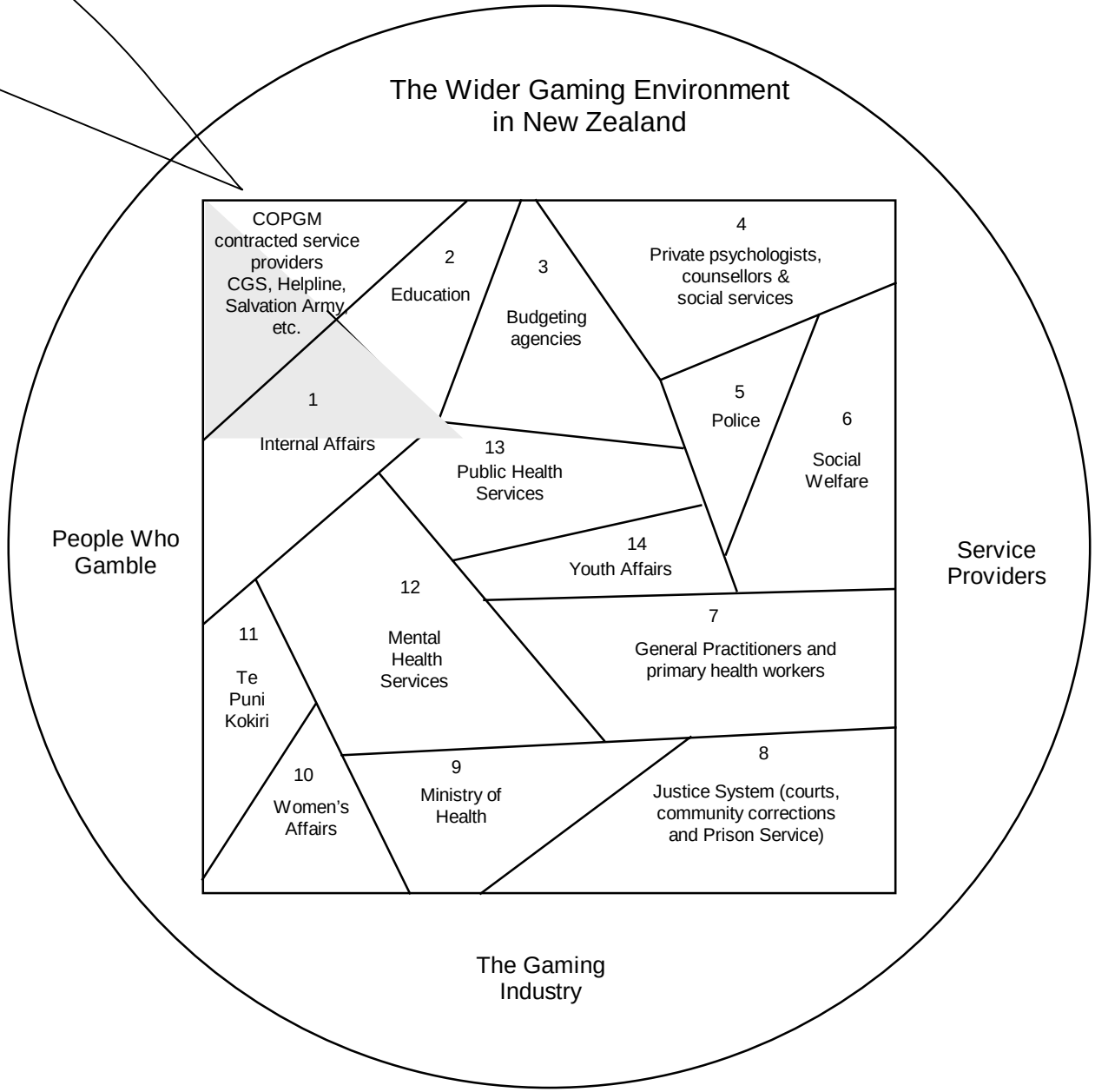
[9] Represents only the information currently available to COPGM

Estimate of the Number of People with Gambling Problems in the New Zealand Population



Gambling Problems

Triangle is adapted from: Broadening the Base of Treatment for Alcohol Problems; National Academy Press, Washington DC 1990



Services Provided: (**from jig saw)**

1. policy development oversight and coordination
2. including information regarding gambling and risk taking in the curriculum and training health and the professionals to deal with gambling issues in their work
3. financial counselling for those who get into difficulty through gambling
4. Relationship counselling, Iwi services, social services and others
5. incorporating gambling in dealing with white-collar crime, family violence and similar
6. including children & young persons service (people whose financial & family circumstances are adversely affected by gambling)
7. screening, assessing and offering brief interventions and referral to those who attend
8. providing early intervention, education & referral
9. co-ordination and oversight of health policy
10. incorporating gambling in dealing with issues of women
11. incorporating gambling in dealing with issues of Maori
12. screening, assessing & treating people with gambling problems who turn up at their services with other mental health problems
13. including gambling in their prevention activities
14. incorporating gambling in dealing with issues of youth

* see next page for a more detailed explanation

Fig 2 Services to People Experiencing Adverse Effects of Problem Gambling

Additional information for Fig 2:

Primary intervention activities are directed toward the population of individuals without gambling problems but also have important effects on individuals who have already developed problems – these programmes operate generally throughout society.

Brief intervention is used to reduce or eliminate the individual's gambling problems in a timely and efficient manner with the goal of preventing consequences of those problems. While targeted towards people with mild or moderate problems these 'brief interventions' also have some significance for those with more serious problems – most of whom will never seek nor receive formal treatment. (This applies both in the alcohol problem population and also the wider population of people with serious mental health problems.) However those with serious problems seek assistance for other problems of various kinds and will come into contact with a variety of health, social service and other agencies – providing brief intervention in these sectors can only be positive.

The summary comment in the Institute of Medicine report (page 215) is:
" … if the alcohol problems experienced by the population are to be reduced significantly, the distribution of these problems in the population suggests that a principal focus of intervention should be on persons with mild or moderate alcohol problems" – this is referred to as 'the prevention paradox'.

COPGM deals with the more troubled population of those with serious or pathological gambling problems (these are immediately hazardous and social mores require that we attend to their suffering). The other health and social service agencies thus need to address the gambling problems across the remainder of the triangle to ensure effective results and a reduction of overall of gambling problems.

APPENDIX 1

SIZE AND SCOPE OF THE PROBLEM

The de-regulated environment and expansion of gambling

During the past decade, concurrent with de-regulation in many other areas, New Zealand experienced significant growth in legalised gambling opportunities. Lotto was introduced in 1987 and licensed electronic gaming machines became available in pubs and clubs in 1988. Instant Kiwi scratch tickets appeared in 1989. In 1993 the TAB established a television channel dedicated to racing and introduced sports betting in 1996. New Zealand's first casino opened in Christchurch in 1994, followed by a larger one in Auckland in early 1996.

Turnover on all forms of legalised gambling grew from $1.07 billion in 1987 to nearly 6.5b in 1997. The net amount expended on gambling in 1997 was $966 million – an increase of 388% on the $249m net spent in 1987. Growth in gambling can be attributed, in part, to the introduction of new products such as Lotto, Instant Kiwi, and Keno and sports betting, a huge increase in the number of electronic gaming machines in bars, and the introduction of casinos (Ninness, 1998). Each of the four gaming segments, Lotteries, TAB, casinos and gambling machines now accounts for over $200 million of the annual gambling spend. While there has been levelling off in turnover for Lotteries Commission games and race betting since 1990, this has been more than offset by increases in gaming machine and casino turnovers (The Social Impact of Gaming in New Zealand, 1995, p 21).

Entertaining and enjoyable

A majority of adult New Zealanders taking part in legalised gambling find such activities entertaining and enjoyable. Most spend amounts that are not out of keeping with expenditure on other forms of entertainment. The New Zealand Lotteries Commission observes that despite more than half the population gambling weekly, "*the overwhelming majority of New Zealanders who gamble do not suffer serious negative consequences from this activity*" (Responsible Gaming, 1995, p 28). Government and communities benefit through taxes, and through distribution of proceeds to charitable causes.

However, as Abbott and Volberg (1992) point out, there are significant costs associated with increased gambling by New Zealanders. These costs relate to the financial, personal, and health problems experienced by individual New Zealanders who develop gambling problems. There are negative consequences experienced by families and loved ones of those described as "*problem gamblers*".

Problem gambling

A 1995 DIA report (Social Impact of Gaming in New Zealand) describes problem gambling as, "*occasional or regular gambling to excess to the extent that it leads to problems in other areas of life, particularly with finances and inter-personal relationships*."

These "*problems*" range from family arguments over gambling to major financial and interpersonal difficulties. Pathological gambling, as diagnosed in the 1994 edition of DSM-IV, is identified as the most serious form of problem gambling. The report notes that neither problem gamblers nor pathological gamblers constitute a distinct group. The accepted view is that there is a continuum ranging from non-gamblers to occasional gamblers, to moderate to heavy gamblers, to problem and potential pathological gamblers, through to individuals who meet the clinical criteria for the DSM-IV diagnosis.

Evidence for a relationship between problem gambling and availability of gambling

The 1995 DIA report on social impact of gaming in New Zealand notes that, "*increasing the opportunities for gambling tends to increase the number of problem gamblers in the community*", but acknowledges more research is needed in this area (p 129 and p 8)

Several overseas researchers are convinced already that increased gambling opportunities not only create more gamblers, but also lead to a rise in the amount of problem gambling a community experiences (e.g. Volberg, 1994; Goodman, 1996). Volberg (1994) compared prevalence rates in five American states in tightly controlled studies employing the South Oaks Gambling Screen (SOGS). She found a clear positive relationship between availability and prevalence of problem gambling. In Iowa, where gambling had been legal less than 10 years, fewer than 0.5% of adults were pathological gamblers, and a further 1.0% were problem gamblers.[10] Where gambling had been legal for more than 20 years, as many as 1.5% of adults were pathological gamblers, and a further 2.8% scored enough on the SOGS to be problem gamblers.

Other relevant American research includes, for example, that undertaken by the Capitol Gaming Taskforce in Louisiana. The Taskforce reported a 500% increase in problem gamblers seeking help between 1991 and 1994, the years when riverboat and electronic machine gambling expanded rapidly in the state (Laborde, 15 July 1994). In New Jersey, it was noted that compulsive gambling helpline calls jumped from 1,200 a year to 32,000 after casinos were introduced (McGettigan, 1995).

An increase in numbers of problem gamblers receiving treatment has been noticeable in Germany since 1984. Meyer (1992) in reviewing the German literature on gambling, concluded that there had been an increase in the prevalence of problem

[10] Pathological gamblers are those who score 5 or more on the SOGS and could be expected to meet the diagnostic criteria of DSM IV. These are considered to be the extreme "*tip of the iceberg*" of problem gamblers. The Volberg (1994) survey indicated that while 0.5% of the adult population of Iowa were pathological gamblers, these were included within the1.5% scoring 3 or more on the SOGS and classifiable as problem gamblers. Unless otherwise indicated in this paper, problem gambling includes pathological gambling.

gamblers as a consequence of increased availability of legalised opportunities for gambling.

Remmers (1995) suggests the increase in compulsive gambling in Holland occurred as a result of increased numbers of electronic gaming machines (EGMs) and the introduction of casinos. The Jellinek Addiction Center reported 400 visitors in 1986 – the year EGMs were introduced. Six years later this had risen to 6,000 per year. Over ninety percent of Dutch compulsive gamblers were found to be EGM players. Indeed gambling on machines became such a problem that in 1994 the Dutch government decided to remove all 64,000 machines from local stores (CSM editorial, Jan 19, 1994).

These findings accord with Rosecrance's (1988) observation of a general consensus among researchers that, "*increasing the availability of gambling opportunities will... eventually lead to an increase in problem gambling*."

Other researchers have argued that a linkage exists between even the "*less addictive forms of gambling*" and the prevalence of problem gambling. Thus, Clotfelter and Cook (1989) analysed data from what they describe as "*the most complete survey of gambling participation ever conducted*." They concluded that creation of lotteries by US State governments encouraged people into participating in other forms of gambling. Controlling for a large variety of variables, including sex, race, religion, household income, age and education, they reported, "*the likelihood of participation in commercial gambling was heavily influenced by whether or not the respondent lived in a lottery state. [We conclude that] the lottery is a powerful recruiting device, responsible for inducing about one quarter of the adult population who would not otherwise have done so, to participate in commercial gambling*" (Clotfelter and Cook, 1989, p 89)

In similar context, Lorenz (1992) noted a significant increase in problem gambling following establishment of state lotteries in the United States. Likewise, Hraba et al (1990) concluded that lottery play could engender problem gambling if associated with other predictor variables for problem gambling, such as impulsive personality or alcohol consumption in gamblers.

In Canada, the CCSA National Working Group notes how problem gambling prevalence rates can be seen to increase as new forms of gambling are introduced, with recent surveys indicating prevalence rates (including pathological gamblers) of 3% to 5%. CCSA defines problem gambling as, "*a progressive disorder characterised by loss of control over gambling, a preoccupation with gambling and with obtaining money to gamble, irrational thinking, and a continuation of the behaviour despite adverse consequences*" (1998, p 2). They note the social costs include uncontrolled spending, significant debts affecting the individual and family, marital conflict, child neglect, impaired work performance, and frequently co-morbid disorders.

The CCSA has become concerned enough to draft a policy statement to address problem gambling in Canada. While not adopting any moral position on gambling *per se*, the CCSA proposes policy measures aimed at reducing, and where possible preventing the harm associated with excessive gambling.

The Victorian experience: Arthur Andersen in Australia

Closer to home, Arthur Andersen (1997), summarising research findings for the Victorian Casino and Gaming Authority, noted economic benefits associated with the expansion of gambling opportunities in Victoria, together with adverse social impacts. Chief among these had been the effect on problem gamblers and other high use groups.

Growth in gambling expenditure rose from 1.3% to 3.3% of household income following the introduction of EGMs. [11] This increased spending on gambling was funded through reduction in household savings levels from 7.9% in 1991-2 to 3.5% in 1995-96. This is consistent with the experience of other Australian states.

The increase in problem gambling was assessed through increased gambling expenditure and numbers of problem gamblers seeking help through Breakeven and G-Line.[12] There was a positive association between accessibility of EGMs in different regions of the state and numbers of new clients presenting to “Break Even Centres" in those regions.

Overall, the Victorian research found that increased gambling was accompanied by an increase in problem gambling. There were associated financial problems – in the form of gambling debts, vocational problems – in terms of lost work and lost productivity, family and relationship problems, affective disorders – such as anxiety and mood swings, and, legal problems – with 25% to 30% of clients engaging in illegal acts to finance their gambling.

In summary, there is a considerable body of research suggesting that the rate of problem gambling in a community tends to go up *the more gambling is available* in that community and *the longer it is available* (City of Vancouver Review, August, 1994). Iowa, for example, legalised gambling only gradually from the mid-1980s on, with a lottery in 1985, then later added racetracks and riverboat casinos. This state has the lowest incidence of pathological and problem gambling in the United States, at 1.5% of adult population in a 1993 survey. In contrast, Connecticut, with a plethora of legalised gambling operations, started with a lottery in the early 1970s, and followed by jai alai, simulcast racing, and casino gambling, had by 1993 the country’s highest rate of pathological and problem gambling at over 6% of adult population (Christiansen Cummins).
Applying these overseas findings to New Zealand, which has experienced a substantial increase in both the availability and the variety of legalised gambling during the past decade, would lead to an expectation of increased prevalence in pathological and problem gambling since the first national survey was undertaken in 1991.

Extent of problem gambling-prevalence in New Zealand

[11] Arthur Andersen (1997) found low-income earners spent proportionately more of their income on gambling activities.

[12] Recent community surveys indicate over 34,000 Victorians, or approximately 1% of the adult population, are currently problem gamblers. In this series of studies, Arthur Andersen (1997) found problem gambling affected women as often as men.

The benchmark problem gambling prevalence study was undertaken by Abbott and Volberg in New Zealand in 1991. Using a version of the SOGS[13] that had been adapted for New Zealand conditions, Abbot and Volberg found current prevalence rates of 1.17% for (probable) pathological gamblers and an additional 2.1% for problem gamblers.

This Abbott and Volberg work has been accepted as the definitive prevalence study (Sullivan, 1993; de Joux, 1995). Statistical issues in determining the actual numbers of current pathological gamblers in the community are complex and should not be underestimated. Manly, Gonzalez, and Sullivan (1994) used the Abbot and Volberg findings to estimate that there were between 12,000 and 68,000 current pathological gamblers in New Zealand at the time of the survey in 1991.

The 1995 submission of the New Zealand Lotteries Commission to the inter-departmental review of gaming (p 93) states that the "*accepted estimate is that at least 10,000 of New Zealand's approximately 2.3 million adult population may be pathological gamblers.*" This estimate in turn appears to be based upon a letter from Max Abbott to the Gaming Industry Advisory Committee on Problem Gambling of 3 May 1994. This figure of 10,000 pathological gamblers represents just 0.38% of the adult population.

A survey undertaken by NRB on behalf of North Health in 1996 suggested a current pathological gambling prevalence rate of 0.44%. In reviewing this survey, Brown (1996) noted a series of methodological errors that could have contributed to the survey under-estimating the true prevalence of pathological gamblers. While this study probably under reported both pathological and problem gambling, its findings did further confirm that there are at least 12,000 current pathological gamblers in New Zealand. According to de Joux (1995, p 107) it seems safe to assume that at an absolute minimum there are 12,000 adults in New Zealand who can be classified as current pathological gamblers. Given the relationship between pathological and problem gambling found here in New Zealand and overseas, it would seem reasonable to assume that there are, in addition, at least 20,000 individuals who are currently problem gamblers (Brown, 1996, p 17). In all, even as a best case scenario, it would seem reasonable to assume that there are a minimum of 32,000 gamblers currently experiencing problems associated with their gambling.[14]

[13] Hannifin and Gruys (1998, p 12) comment that the SOGS is the most established tool for gauging the severity of gambling problems. People who score three or more can be considered problem gamblers. People who score five or more are likely to also meet the DSM III criteria for pathological gambling.

[14] At the other extreme, based upon the Manly, Gonzalez and Sullivan (1994) work on the Abbott and Volberg survey, there may be as many as 68,000 current pathological gamblers. Applying the same ratio of pathological to problem gamblers, there may be in addition, as many as 112,000 problem gamblers. In this worst case scenario there may be as many as 180,000 gamblers currently experiencing problems.

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APPENDIX 2

THE CONSULTATIONS

Sixty people from gaming businesses, from government and regulatory bodies and from treatment providers were interviewed. The interviewers used a standardised interview format for each interview. Each person was asked for their views about the nature and dimensions of the problem. There was a lack of knowledge of the existence of the problem in some quarters, in the main, however, there was consensus about:

Multi-dimensional effects
There are negative effects on the individual, with adverse flow-on effects on the family and society. Many of these relate to conflict around the problem gambler's preoccupation and need for money to continue gambling. In addition, there are adverse cultural and economic effects at the national level.

A continuum
Problem gambling extends along a continuum, from non-gambler to occasional gambler, to regular gambler, to excessive gambler, to pre-problem gambler to problem gambler, to pathological gambler.

Individuals can move along the continuum from non-gambler through to pathological gambler. It seems unlikely that problem gamblers can revert to non-problem gambling.

A form of addiction
Problem gambling has many of the qualities of an addiction, without substance involvement. The problem gambler continues to engage in gambling despite it causing serious harm, much as the addict continues "using" the addictive drug.

As with addiction, it appears that the problem gambler may never be "cured", but remains "at-risk" of problem gambling should s/he gamble again.

It is often hidden within individual or family, so that by time of discovery significant damage has already occurred to the gambler and family.

Association with other problems
Problem gambling is frequently found to be co-existent with other psychological disturbance, specifically depression or anxiety states. In many cases it is unclear which is the primary disorder. Some problem gamblers consider suicide.

Problem gambling is frequently found to be associated with alcohol problems. In some instances problem gamblers engage in alcohol abuse when gambling. In other cases alcoholics engage in problem gambling.

Problem gambling has links to crime, with some problem gamblers committing offences to fund gambling

High prevalence groups

The highest prevalence of problem gambling occurs among males under 30 years in lower socioeconomic groups.

There are disproportionately high prevalence rates among Maori, Pacific Island, and Asian males. These are traditionally considered to be “at-risk” groups.

There appears to be increasing prevalence among women and younger people. Increasing numbers of these problem gamblers identify EGMs as their primary mode of gambling.

There appears to be increasing rapid onset experienced, particularly among those who adopt EGMs as their mode of gambling.

Definition
There is general acceptance of the SOGS and DSM-lll definition of problem gambler and pathological gambler. Individuals who score 3 or above on the SOGS are classified as problem gamblers. Those scoring 5 or above are classified as probable pathological gamblers.

Current prevalence
There is uncertainty about the true number of individuals classifiable as problem gamblers and pathological gamblers currently. Several respondents questioned the accuracy of the 1991 national survey which indicated a minimum of 12,000 pathological gamblers and 20,000 problem gamblers.

Trends
There is uncertainty about whether the numbers of problem and pathological gamblers have increased since 1991. However many respondents believed that increased problem gambling is a likely outcome of continuing increases in availability and variety of gambling. The national survey now underway is considered to be timely in that it will clarify current prevalence rates and trends.

Cost
No respondent could place an accurate cost on problem gambling, either for the individual or the nation.

Pro-active approach
A majority believe the problem needs to be addressed through a pro-active approach. A few considered it will resolve itself and that there are other more pressing issues to be addressed within the public health arena.