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Maori and Gambling: Why a Comprehensive Maori Public-health Response is Required in New Zealand

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Abstract

This paper presents findings from a study which has investigated whether gambling is an emerging health for Maori, its effects on Maori and proposes recommendations which need to be implemented from a public health perspective to address Maori gambling-related harm in New Zealand.

Keywords: Gambling; Public health; Indigenous health; New Zealand; Maori.

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Background

New Zealand has a unique history of gambling. The place it occupies in New Zealand society and in the lives of many Maori needs to be understood and analysed from a cultural context (Mcmillen, 1996). Prior to contact with tauiwi (new settlers) in the early 18th century, Maori the indigenous population of New Zealand, had no real history of gambling, drinking alcohol or smoking tobacco. All three products have been introduced to Maori or the indigenous population of Aotearoa/New Zealand. They are now considered cultural baggage and widely available in different settings with the health effects of each product alone or in association with each other now affecting Maori health status. Gambling should now be seen like alcohol and tobacco as health hazards, which have and continues to limit the development of tangata whenua in Aotearoa/ New Zealand (Durie, 2001; Hutt, 1999; Reid & Pouwhare, 1992).

This paper will present findings of a doctorial study that has reviewed gambling research literature from a Maori perspective and has investigated whether gambling is an emerging public health issue for Maori by interviewing Maori problem gamblers and interviewing key informants involved in the development of gambling policy or are associated in some way with gambling. The term public health is defined broadly to encompass development and implementation of interventions, which aim to improve the health and wellbeing of communities as well as protect people from ill-health and minimize the risk of disease(Public Health Commission, 1995).

In addition, the following will be reported:

- the size of the problem gambling for Maori by reviewing gambling prevalence data,
- the effects of gambling on Maori development,
- implications of Maori gambling for other indigenous populations and
- solutions that are now required in New Zealand to address Maori gambling-related

harm.

The term *gambling-related harm* is defined broadly to cover all the effects that may arise at individual, family, and community levels as result of gambling.

The study has been undertaken in New Zealand from February 1999 to February 2003, with the aim to provide a Maori face to gambling in New Zealand so the effects of gambling and problem gambling could be made visible. Secondly, to provide information to support Maori involvement as an equal partner with the Crown or its agencies in determing the role and place of gambling should play in New Zealand.[1]

During the course of this study, there has been concern from community leaders and political parties on the growth and expenditure on gambling in New Zealand, the effects of casinos and gambling machines on communities and the increasing number of people, especially Maori seeking help with problems from gambling. In 2001/2002 New Zealanders, a population of just under 4 million, turned over $11.6 billion on gambling and lost $1.6 billion of which almost half was due to gambling machines[2] (Department of Internal Affairs, 2003). As a result of community and political concerns about gambling, there have been three reviews of gambling legislation since 1996 resulting in legislative proposals to implement measures that are considered to promote responsible gambling (Department of Internal Affairs, 1996; Department of Internal Affairs, 2001a; Select Committee on Internal Affairs and Local Government Committee, 1998).

New legislation is currently waiting to be approved by parliament which defines areas where different forms of gambling can occur; licensing requirements for different classes of gambling; specific requirement for local government involvement in the siting of outlets for gambling machines; a restriction of nine gambling machines on new gambling machine sites; provision for a community to veto new gambling machine sites; a requirement for the development of harm minimisation regulations, including electronic monitoring of gambling machines, a requirement for gambling operators to pay a compulsory levy to cover the costs of services for problem gambling; and the establishment of a

Gambling Commission to oversee ongoing casino licences and to consider appeals where applications for gambling machines licences have been declined (Select Committee on Government Administration, 2002).

There is also government recognition that problem gambling should now be considered a public health issue especially for Maori with the Ministry of Health having policy responsibility to purchase services with gambling money to prevent and treat problems associated with gambling. The Department of Internal Affairs has the responsibility to develop harm minimisation regulations and monitor overall gambling developments in New Zealand (Department of Internal Affairs, 2001a; Ministry of Health, 2002). This proposed legislation complements the new Local Government Act 2002, which became enforceable on July 1, 2003, giving local authorities specific statutory responsibilities to recognise the Treaty of Waitangi in their work and the power to develop bylaws to protect the public health and safety of people (Department of Internal Affairs, 2001c). These new powers are now only being considered in relation to addressing gambling by local governments (Rankine & Haigh, 2003). Overall a broad harm minimisation framework as outlined above has been proposed in New Zealand and it effectiveness to reduce gambling related harm is only now being considered from a public health perspective.

Maori Centered Research: Methodology

A Maori centered research approach was taken by reviewing New Zealand and international literature to identify the prevalence of Maori problem gambling, its impact on Maori development and implications of gambling for Maori and other indigenous populations.

Maori supported the study with an interest in gambling as it was considered there was a need to provide Maori face to gambling to support the development of solutions which endorsed Maori and tribal aspirations and resulted in wide ranging interventions which reduced Maori gambling-related harm (Compulsive Gambling Society of New Zealand, 1998).

Alongside reviewing gambling research, fifteen problem gamblers who self identified as Maori and had sought help regarding problems with gambling in

Auckland were interviewed using a semi-structured qualitative questionnaire to ascertain their views on gambling and problem gambling; experience of gambling; impact of gambling on their culture, health and significant others; views of whether Maori should be involved in all forms of legalised gambling in New Zealand; and whether the Treaty of Waitangi should be recognised in the development of gambling policy in Aotearoa/New Zealand.

Similar interviews covering the same areas were conducted with 30 key informants both Maori and non Maori who were involved in the provision of health services to Maori, the provision of gambling policy advice to Government or were associated with gambling in some way, such as distribution of funds from gambling or were reliant on gambling funding for social service provision.

All interviews were conducted through an informed consent process, where agreed taped, transcribed, and interviews from each of the two groups were analysed separately and then as an overall group to identify key themes. All themes emerged were analysed from a Maori centered perspective to provide a Maori perspective on gambling (Cunningham & Durie, 1988).

Information from this study has been used to inform Maori of the risks associated with gambling, has assisted with Maori input into Government reviews on gambling, has supported the establishment of a national Maori organisation on gambling and has supported the need for a Maori specific gambling research program and a public health program which focuses on both reducing Maori gambling-related harm and assisting Maori and tribal development (Dyall, 2002).

Treaty of Waitangi and Gambling

The Treaty of Waitangi is New Zealand's founding constitutional document. It is recognised as an ongoing social contract which provides the basis for a democratic elected Government to be established on certain conditions. They are that Maori through tribal arrangements are able to maintain control over their own land, forests and others properties so long as they so wish and for Maori to be accorded the same rights as British subjects (Durie, 1998a). The role and place of the Treaty of Waitangi is constantly debated in New Zealand in

all policy areas and until recently its place in relation to gambling has received little attention (Department of Internal Affairs, 1996; Dyall & Morrison, 2002). The Ministry of Health, however, has recognised the role and place of the Treaty of Waitangi in the development of its harm minimisation approach to reduce gambling related harm, which validates recognition (Department of Internal Affairs, 1996; Dyall & Morrison, 2002; Ministry of Health, 2002).

Since the 1990s opportunities to gamble in New Zealand have increased resulting in greater public awareness of the harm gambling creates. Maori have requested a greater role in licensing and regulation of gambling, the opportunity to co-own and operate casinos and to receive greater economic benefits from gambling. Successive Governments in New Zealand however, have largely ignored Maori and tribal aspirations to be involved in all forms of legalised gambling with the outcome that Maori have had to consider other areas for development such as resolving grievances which have occurred by the Crown breaching Treaty of Waitangi obligations. This is in contrast with other first nations in America and Canada which have used gambling to exert their "dependent sovereignty", to be able to establish their own casinos or other forms of gambling to provide economic wealth as a means to fund their own development programs (Abbott & Volberg, 1999; Duffie, 1988; Dyall, 2002).

Interviewing Maori problem gamblers and key informants has revealed strong support for recognition of the Treaty of Waitangi in gambling policy and legislation. Both groups considered that:

- the Treaty of Waitangi should provide the foundation for legalised gambling in New Zealand,
- Maori and the Government should be required to work in partnership so that gambling creates minimal harm, and
- both Maori and the Crown should positively benefit from gambling.

This finding supports Maori views that new gambling legislation should include provision for recognition of the Treaty of Waitangi and a requirement for Maori to participate in all levels of decision making consistent with new local government statutory requirements.

Prevalence of Maori Problem and Pathological Gambling

In 1991 the first New Zealand national gambling prevalence study was conducted which involved interviewing just over 4,000 New Zealanders by way of landline telephone interviews using the Southern Oaks Gambling Screen (amended) as a tool to asses problem gambling.[3] From this study it was found that 16% of the Maori adult population had a problem with gambling sometime in their life and were two to three times at risk to either problem or pathological gambling than non-Maori (European). Further, 3.2% of the New Zealand population would have had problems within the last six months, defined as current prevalence.[4] These results were found prior to the establishment of casinos and wide spread availability of gambling machines in New Zealand study (Abbott & Volberg, 1991).

This study was replicated again in 1999, and just over 6,400 people were interviewed. Despite the low number of Maori interviewed due to limitations of the survey design and overall population surveyed by way of telephone landline, it was found again that Maori were two to three times at risk to problem or pathological gambling. Overall it was calculated that 7% of Maori would have had problems with gambling sometime in their life compared to 2% of non Maori (European) population. The current prevalence of problem and pathological gambling for this study was calculated at 1.3% for the total New Zealand population (Abbott & Volberg, 2000). Taking account of limitations of both studies it is considered that the 1991 Maori lifetime and New Zealand current prevalence estimates are more appropriate for Maori due to number of Maori surveyed in this study (Smith & Barnfield, 2001).

Applying the 1991 lifetime prevalence figure to the 2001 Maori census adult population (299,000) it is estimated that just over 47,000 Maori would have had problems with gambling sometime in their life and at just under 9,000 Maori adults would have had gambling problems in the past six months (Abbott & Volberg, 2000).[5]

Research suggests that each problem gambler conservatively affects the lives of at least five people usually family members and significant others and this population is larger than those who are assessed as having a gambling problem (Abbott, 2001; Productivity Commission Report, 1999; Sullivan & Arroll, 2000).

To estimate the number of people indirectly or passively affected by problem gambling using the above 1991 lifetime and current prevalence figures for Maori and multiplying by five it is projected that at least 239,000 people would have been affected by lifetime prevalence, and 45,000 people would have been affected by current prevalence.

These figures do not include Maori problem gamblers. To calculate the size and total impact of problem gambling on Maori and on others, it is concluded that lifetime prevalence would have affected over 287,000 people and approximately 54,000 people by current prevalence. The latter figure is recommended as the basis for planing gambling treatment services for Maori even though all of this population will not likely identify, as Maori but their lives are closely associated with Maori such as non Maori partners.

Recognising the number of people, predominately Maori, affected in some way by problems with gambling there is sufficient evidence to recognise problem gambling as a serious health issue for Maori. Using the 1991 Maori lifetime gambling and current New Zealand prevalence data and including those affected, it is estimated that least half the Maori population would be affected with problem gambling sometime in their life and at least 10% of the Maori population on a daily basis.

Maori Problem Gambling and Imprisonment

At least 50% of prisoners in New Zealand self identify as Maori. The number of Maori in prison is constant despite Government led interventions to reduce Maori criminal offending (Department of Corrections, 1999). Two prison studies to estimate the degree of problem gambling amongst prisoners have recently been undertaken using the same questionnaire and problem gambling screen as the community study undertaken in 1999 (Abbott & McKenna, 2000a; Abbott & McKenna, 2000b).

Results from both studies are alarming for Maori. It is estimated that one in three prisoners in jail have experienced problems with gambling sometime in their life and that gambling is a major factor that has led to their imprisonment. From a prison population of approximately 6000, it is estimated that at least 1000 Maori prisoners are in prison related to problems with gambling.

Calculating the passive effects, these prisoners with gambling problems would have also likely affected the lives of at least 5,000 people and thus overall a further 6,000 people, predominately Maori are affected by problem gambling.[6]

For female prisoners the lifetime and current prevalence rate of problem gambling was higher than for males where at least a third surveyed had current problems with gambling. Of this population (94) two thirds identified as Maori, and overall it was found that this prison population had the highest prevalence of problems with gambling found in any other previous gambling survey reported, apart from surveys of people seeking treatment for pathological gambling, or a report of study of male prisoners in Australia which had not yet been published (Abbott & McKenna, 2000b).

Results from this study of female prisoners are a major concern. It highlights the increasing effects of women and in particular Maori women developing problems with gambling which can lead them to neglect their families, commit crime and use valuable household income for gambling (Paton-Simpson & Gruys, 2002). Women prisoners reported that they often used gambling as a means to win money, for excitement, to socialise, to support worthy causes, to relieve boredom and as a coping strategy to avoid committing crime. This indicates in the development of treatment options for problem gambling they need to be gender focused and personalised to meet the needs of individuals and family members (Bero, 1989; Lesieur & Blume, 1991).

Maori male and female prisoners were found more likely to have a history of hazardous drinking, problems with behaviour and in prison for violent offending than non-Maori. At least 85% of people in New Zealand prisons are likely to have an alcohol abuse problem (Department of Corrections and Ministry of Health, 1999). In the development of public policies relating to

alcohol, gambling, funding, purchasing and provision of health and related programs to reduce the effects of alcohol and gambling-related harm, the interrelationships of the causal effects of alcohol abuse, problem gambling, mental ill health and criminal offending is complex and requires special recognition for Maori (Durie, 2001; Fazel & Danesh, 2002). A single focused approach in addressing gambling-related harm will achieve little for Maori as the effects of gambling-related harm are generally invisible but require recognition in all areas of the health, disability, accident, justice and social service sectors in New Zealand (Ministry of Health, 2002).

Recognising the multiple health needs of Maori in prison due to past and current barriers to health care there is also a need to develop an integrated and co-ordinated public health strategy for this population addressing all of their health needs (Ministry of Health, 2000; Ministry of Health, 2002). Overall information from the prison studies provides evidence of the adverse effects of gambling and alcohol on an indigenous population.

Sub Maori Populations At Risk to Problem Gambling

Results from the two community prevalence studies in New Zealand discussed previously, identify that within the Maori population there are sub populations at risk to problem gambling. They are Maori youth, Maori women, older Maori, Maori with mental illnesses, and Maori who co addictions problems (Abbott & McKenna, 2000a; Abbott & McKenna, 2000b; Abbott & Volberg, 1991; Abbott & Volberg, 2000; Lejoyeux & Ades, 2000).

Abbott also found in following up gamblers from the 1991 study and interviewing them again in 1999, including Maori participants, that problem gambling did not have to be a lifetime chronic health problem. Changes in lifestyle, income, employment and establishment of significant relationships, can influence whether individuals continue to gamble or change their behaviour (Abbott & Williams, 1999).

Positive changes, such as, improved employment, income or children can

reduce interest in gambling. These factors are important for Maori and indicate that any public health gambling strategy developed should focus on the development of Maori, such as education, employment and whanau development to reduce gambling related harm in New Zealand.

Maori Expenditure and Utilisation of Gambling Treatment and Support Services

Maori have a different pattern of gambling than non-Maori. A study in 2000 identified that of those Maori interviewed only 9% had not gambled in the past year and they reported that they spent approximately $538 per year on gambling a reduction on previous expenditure, which was ($912) in 1990 (Department of Internal Affairs, 2001d). The amount spent by Maori was more than spent by Europeans ($446) even though Maori median incomes are half that of non Maori (Department of Internal Affairs, 2001b) and in the 2001 census the average income of Maori males was $15,000 and for Maori females $10,000 (Statistics New Zealand, 2002).

Reported expenditure on gambling by Maori equates to approximately $10 per week and is similar to the amount Maori report spending on health, goods and services and tobacco ($9.00 and $11.00) but is more than Maori report spending on education expenses on a weekly basis ($7.30) (Te Puni Kokiri, 2000). There are real opportunity costs for Maori in expenditure on gambling, as resources spent here cannot be used to support the development of children or families generally.

Maori are both continuous and non continuous gambler and like to play games of chance which they consider they have a fair chance of winning such as products offered by the New Zealand Lotteries Commission which is owned by the Government such as Lotto (weekly national lottery), daily keno, horse and sports betting and gambling machines. Maori surveyed were supportive of interventions that raised awareness of the risks of gambling but were not supportive of the Government using gambling as a form of tax revenue, which is a current reality in New Zealand (Department of Internal Affairs, 2001b).

Although Maori expenditure on gambling may have decreased since 1990, Maori with gambling problems are generally spending more, contributing to the growing expenditure on gambling in New Zealand. At least a third of all people in New Zealand with gambling problems identify as Maori (Department of Internal Affairs, 2001b).

One in four people presenting for help through gambling treatment or helpline services self identify as Maori and this population is increasing. More Maori women than Maori men are now presenting for counselling help (Paton-Simpson & Gruys, 2001). Despite expansion of gambling out reach services, Maori with gambling problems are not presenting for help in relation to need indicating that there are barriers in accessing treatment services such as being in prison or feeling whakama (embarrassed) in having a problem.

Both Maori males and females presenting for help report that gambling machines create the most problems for them along with other forms of gambling. Following up Maori who have sought help with counselling the majority after five months reported a reduction in gambling but were still assessed as having gambling problems indicating their gambling was still compulsive. This finding is consistent with research, which has found that it is difficult to treat and address problem gambling (Paton-Simpson & Gruys, 2002; Paton-Simpson & Gruys, 2003).

Maori and Indigenous Gambling

There has been limited gambling research, which has involved or reported the effects of gambling on indigenous populations (Abbott & Volberg, 1999; National Research Council, 1999). Maori prevalence of problem gambling is estimated to be similar to other first nation American populations which do not live on reservations and have similar socio economic status (Abbott & Volberg, 1999). Prevalence of problem gambling populations may vary within and across indigenous populations depending upon their history and involvement with gambling. Where casinos are located there is an increased risk of problem gambling which provides a warning for indigenous populations living beside a casino or interested in establishing one (Australian Institute for Gambling

Research, 1998; Cozzetto & Larocque, 1996).

Indigenous populations generally have increased risks related to problem gambling but also have aspirations for economic independence and self-determination. Information on the costs and benefits of being involved in gambling should be fully available to indigenous populations so that they can make informed decisions knowing the risks involved. Alternatively, they should be able to use existing knowledge if so desired to negotiate a fair share of revenue from gambling or compensation for gambling related harm in situations where Governments and gambling providers promote gambling as a reasonably harmless activity similar to legal actions, which have been taken in relation to tobacco (Jacobson & Warner, 1999).

Governments should now consider indigenous populations views, aspirations and treaty status and involve them when developing, implementing and reviewing gambling policy and developing public health interventions to reduce gambling related harm (Dyall & Morrison, 2002; Korn & Shaffer, 2000; Volberg & Abbott, 1997).

The effects of problem gambling on indigenous populations are generally invisible and often masked by other problems such as alcohol and substance abuse or mental health problems. To make problem gambling visible screening is important. As a public health tool it can also be used to raise awareness of the risks associated with gambling, provide information on the signs and symptoms of problem gambling and problem gambling, provide opportunities for early intervention and treatment and can assist in reframing gambling and problem gambling to be seen and recognised as a public health issue (Shaffer & Korn, 2002).

Maori Problem Gamblers Views on Gambling

Cultural identity was identified as an important factor that influenced Maori problem gamblers to seek help and be involved in research. Participants were aware of the effects problem gambling had had on their lives and people who were important to them. This reality motivated them to participate in treatment to help rebuild their lives and whanau (family) relationships.

Problem gambling affected all four cornerstones of wellbeing considered important for Maori. They are spiritual wellbeing, mental wellbeing, family wellbeing and physical wellbeing and as a model of health is broader than a medical or World Health Organisation perspective (Durie, 1998b). Gambling for Maori problem gamblers was not a fun wagering activity but a painful addiction that damaged their family and wider relationships and led to almost all to commit criminal offences to be able to continue gambling. For participants gambling was not about winning money but a means to create excitement in their lives, to escape from boredom and to cope with trauma in their lives, such as loneliness, other addiction problems, relationship problems and physical or sexual abuse (Dyall, 2002). Problem gambling therefore was a symptom of other needs or distress.

Participants were supportive of Maori involvement in the development of gambling policies. They were concerned that gambling had eroded Maori culture and were not supportive of gambling machines on marae, a focal meeting place in Maori communities where many cultural and tribal activities take place. Concern was also expressed that tribal groups should not be interested in the operation of casinos, as this would create more problems for Maori.

Key Informants Views on Maori and Gambling

All key informant groups: Maori health workers, government policy advisers and those involved in some way with gambling, such as involved in operating a casino or being a recipient of gambling funding, recognised that wagering created harm for Maori. Participants working with Maori whanau (family) saw that gambling eroded social capital, such as it weakened family relationships, affected Maori cultural and family values and took valuable resources (time and money) from families. Children and young people were identified as most at risk from problem gambling.

Those providing policy advice considered that gambling created harm for Maori but they were reluctant to challenge current Government policy that gambling was a positive community activity and provided community benefit. There was

agreement that a wide range of interventions should be in place to minimise gambling related harm, such as community education and host responsibility programmes in gambling outlets as well as treatment and other support services in place.

Key informants associated with gambling also recognised that gaming created harm for Maori. To justify their involvement in gambling they emphasised the range of harm minimisation interventions they had put in place to reduce harm, such as host responsibility training for staff, allowing problem gamblers to self ban themselves from casinos and encouraging bars and clubs which have gambling machines to have host responsibility programs in place.

Maori interested in the operation of gambling such as casinos, considered that gambling created harm but local Maori with tribal support were the most appropriate to manage Maori at risk, such as Maori wardens which have statutory authority to reduce Maori risk of alcohol misuse.

All three key informants groups supported recognition of the Treaty of Waitangi in the development and implementation of gambling policy. They considered that Maori should be seen as a key stakeholder with the Crown in the development of gambling policy in New Zealand. Recognition of the Treaty of Waitangi also raised wider policy issues, such as who should benefit from gambling, the costs of encouraging communities to be dependent upon gambling to maintain essential social services and how should Maori benefit from gambling similar to other areas as the allocation of fishing quotas to generate Crown revenue.

Maori Gambling Research

Findings from this study support the need for Maori to initiate and lead their own gambling research agenda, which empowers tangata whenua (people of the land) to have their own information and to be an equal partner with the Government in the development of gambling policy. Research required includes the development of new tools, models and intervention for appropriate assessment, treatment and recovery from gambling. There is also a need for Maori community and tribal gambling prevalence studies to guide planning and funding of public health and treatment interventions, cost and benefit studies

to advise on the effects of gambling and problem gambling on Maori and tribal development, and research which supports a Maori public health approach to gambling and possibly compensation for the costs of Maori gambling related harm.

Funding for such research should be provided or coordinated by the Government and allocated to Maori and tribal organisations or individuals to implement such research for previous gambling studies commissioned in New Zealand with Crown support have not focussed specifically on Maori (Abbott & Volberg, 2000; Australian Institute for Gambling Research, 1998).

Four Principles for Gambling Policy

Four principles emerge from this study, which can provide a framework for development of gambling policy and public health interventions. Firstly it is important to recognise the cultural context of gambling within a population, community and the country as a whole. Information from other countries related to gambling, such as, prevalence studies may not be relevant as different cultural context exists (Mcmillen, 1996). Similarly interventions that are designed for one country may not be appropriate for use in another, as the experience of an indigenous population may not be considered in the analysis of findings or development of gambling policy.

Secondly it is important to recognise cultural identity and belonging as a major factor which influences people, both problem gamblers and affected others, to seek help with gambling. Problem gambling cannot be addressed in isolation from individuals, families and communities. All different groups, especially indigenous peoples need to be involved in the development and implementation of gambling policies.

Thirdly, gambling and problem gambling impacts upon the social capital and infrastructure of communities. Although gambling in New Zealand is promoted by the Government as a community benefit it creates real social costs, such as increased crime, imprisonment, break up of families, loss of economic resources, lower health status and distortion of individual or community values (Department of Internal Affairs, 2001b). Social and economic costs must be

considered when developing or reviewing gambling policy.

Fourthly, gambling is not risk free as it can lead to problems gambling affecting both the quality of life of problem gamblers and those people whom they closely associate with such as whanau members. Gambling and problem gambling in New Zealand requires recognition as a serious health issue, especially for Maori and should not be treated any differently than alcohol or tobacco which creates real harm for Maori in terms of health status (Durie, 2001).

Maori Public Health Plan

Drawing upon the findings of this study, policy principles, the following public health plan is proposed as a starting point to address Maori gambling related harm drawing upon the Rata as an icon to reduce Maori gambling related harm and the Government's Maori health policy "He Korowai Oranga" is proposed (Ministry of Health, 2002).[7]

"Ka hua te Rata ko tona hoa te uta"
The Rata thrives at the demise of its host

		Recommended Interventions
Ruia te Kakano **Sow the seed**	**Develop whanau, hapu and iwi**	■ Funding be provided to raise Maori and tribal awareness of the risks associated with gambling. ■ Government funding be provided for Maori community and cultural activities to reduce Maori dependency on gambling for essential Maori and tribal services. ■ The Treaty of Waitangi be incorporated in gambling legislation.

Awhitia te kaupapa **Support the program**	**Maori participation**	■ A comprehensive Maori focussed public health strategy be implemented with defined goals and outcomes for Maori within two to three years to have at most the same level of problem gambling as Europeans. ■ Maori health providers be resourced to deliver gambling public health interventions.
Tirohia nga painga **Examine the benefits**	**Effective health, accident, disability and related social services**	■ Tertiary education health programs be encouraged to include information in programs about the prevention and treatment of gambling related harm. ■ A Maori research agenda be funded to assist the prevention of Maori gambling related harm and to support Maori development. ■ Services for Maori be purchased to reduce Maori gambling related harm.

Amohia kia oti **Support the program to completion**	**Working across the sectors**	■ Research be undertaken to identify fully the social and economic costs of gambling for Maori so Maori and Crown Treaty of Waitangi rights and obligations can be recognised. ■ A co-ordinated Maori public health plan be implemented across government agencies and appropriate bodies to reduce Maori gambling-related harm.

Discussion

This study identifies that gambling and problem gambling is a public health issue for Maori. To redress the effects a comprehensive public health response is required which recognises New Zealand's cultural context of gambling and Treaty of Waitangi obligations. A public health strategy cannot be adapted and applied to New Zealand from overseas instead any program should evolve with Maori participation and with information which recognises the influence gambling has had on Maori development and being Maori in Aotearoa. Maori experience of problem gambling is similar to other indigenous populations, but New Zealand data provides evidence of the relationship between gambling, alcohol and indigenous imprisonment.

A Maori public health approach to address Maori gambling and problem gambling is urgently required. A public health approach offers many opportunities for Maori and in particular for the Treaty of Waitangi to be recognised and for interventions to be developed which focus on all parts of the epidemiological triangle (Korn & Gibbins, 2003; Korn & Shaffer, 2000; Politzer & Yesalis, 1992).

The pattern of Maori gambling and problem gambling today is symptomatic of

the position of Maori in Aotearoa/New Zealand. To change the position of Maori requires new gambling and related policies which recognise Treaty of Waitangi obligations, empower Maori to be able to conduct their own research, support the development of comprehensive health related services which focus on all Maori at risk to problem gambling, and result in the reallocation of economic wealth for Maori and tribal development (Durie, 2001).

A harm minimisation approach proposed in New Zealand to reduce gambling-related harm will achieve little for Maori if Treaty of Waitangi rights and obligations are ignored. To do so ignores the reality that the health status of Maori today, especially problem gambling, is a reflection of the interaction and reaction Maori whanau, hapu, iwi and communities have had with previous and current government policies (Durie, 2001; Dyall & Morrison, 2002).

Note 1: This study has been undertaken with the support of the Problem Gambling Committee. This committee is established under statute in which selected gambling industries are required pay an annual voluntary levy to fund specialist gambling treatment services for people with problems with gambling, especially those with a pathological gambling problem. Membership of the Problem Gambling Committee also includes representation from gambling treatment services and as body negotiate treatment services required for people with problems with gambling. Maori representation as of right does not exist on this committee only under the auspices as a treatment provider (Paton-Simpson & Gruys, 2001).

Note 2: In New Zealand there are over 22,000 gambling machines on approximately 2150 sites, 610 retail outlets selling New Zealand Lotteries Commission products, over 800 TAB sites to receive bets for track, sport, and internet betting and five casinos (Department of Internal Affairs, 2001b).

Note 3: The prevalence of problem and pathological gambling in the community was assessed by using an amended Southern Oaks Screening tool. This tool has since been used in other gambling prevalence studies and is assumed that its provides a reasonable assessment of problem or pathological gambling (Shaffer & Korn, 2002).

Note 4: No current prevalence rate for problem or pathological gambling was calculated for Maori (Abbott & Volberg, 2000).

Note 5: The total Maori population in 2001 was 526,281 or one in seven of the total New Zealand population.

Note 6: People in institutions such as mental health facilities, hospital and in prisons were excluded from the community studies.

Note 7: The Rata is noted in New Zealand for being an epiphyte, and for its beauty in the forest when its flowers in the summer months. The Rata grows from seeds, which live on a host tree, and overtime the Rata starves or kills the host tree and becomes a major tree in its own right. http://projectcrimson.org.nz/rata-fact-sheet.html (2003).

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