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29 SEP 2017

A Masters
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Ref: H201703550 and H201703551

Dear A Masters

Response to your request for official information

Thank you for your requests of 30 August 2017 under the Official Information Act 1982 (the Act) for 'a copy of the final report for the 2011/12 KPMG Outcomes report' and 'a copy of the final version of the 2012/13 KPMG Outcomes report'.

I am refusing your request (H201703550) under section 18(d) of the Act as the 2011/12 Outcomes report is already publicly available. It is available at http://www.health.govt.nz/publication/outcomes-framework-preventing-and-minimising-gambling-harm-baseline-report.

Regarding request H201703551, a copy of the 2012/13 Outcomes report is attached.

While the Ministry considered that the 2012/13 report needs to be seen within the context of wider research into gambling harm in New Zealand, and could have benefited from the inclusion of that context within its scope, we accept the report's high level findings and have been working to address identified issues. The findings informed the development of the *Strategy to Prevent and Minimise Gambling Harm 2016/17 to 2018/*19. In particular, improving outcomes for Māori is a focus of the 2016/17 to 2018/19 Strategy, and is very likely to continue to be a focus in the next Service Plan (due for development in 2018).

The Ministry is developing a new outcomes report, which will provide a longer-term trend in outcomes for gambling harm minimisation and include information from the 2012/13 financial year.

I trust this information fulfils your request.

Yours sincerely

Jill Lane
Director
Service Commissioning

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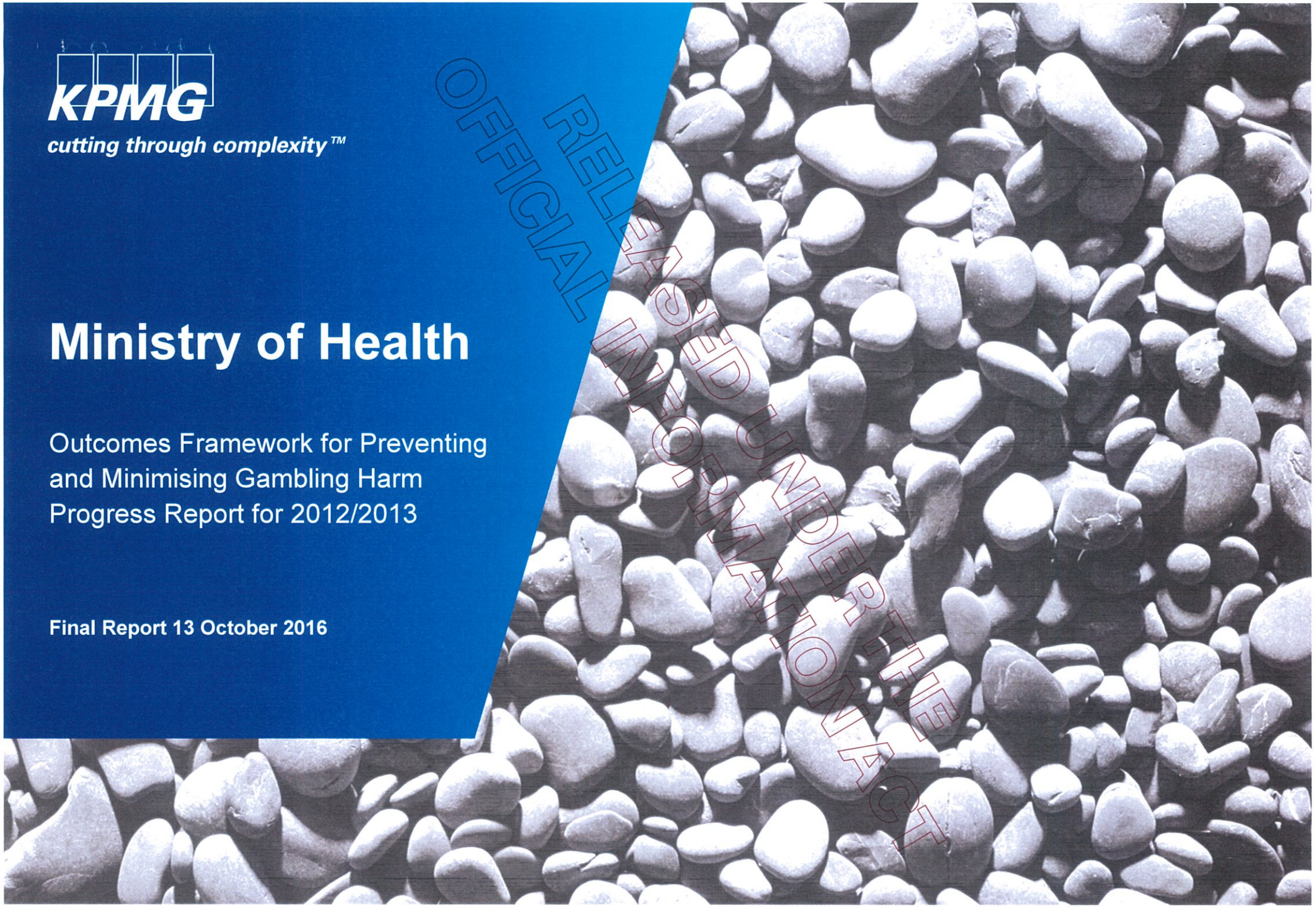
Ministry of Health

Outcomes Framework for Preventing and Minimising Gambling Harm Progress Report for 2012/2013

Final Report 13 October 2016



Disclaimer

Our report was prepared solely in accordance with the specific terms of reference set out in the contract agreed between ourselves and the Ministry of Health and for no other purpose. Other than our responsibility to the Ministry of Health, neither KPMG nor any member or employee of KPMG undertakes responsibility arising in any way from reliance placed by a third party on this report. Any reliance placed is that party's sole responsibility. KPMG expressly disclaim any and all liability for any loss or damage of whatever kind to any person acting on information contained in this report, other than the Ministry of Health.

The report is based upon qualitative and quantitative information provided by the Ministry of Health and other sources listed on page 11 of this document. KPMG have considered and relied upon this information. KPMG believe that the information provided was reliable, complete and not misleading and has no reason to believe that any material facts have been withheld. The information provided has been evaluated through analysis, enquiry and review for the purpose of this report. However, KPMG does not warrant that these enquiries have identified or verified all of the matters which an audit, extensive examination or due diligence investigation might disclose.

The statements and opinions expressed in this report have been made in good faith and on the basis that all relevant information for the purpose of preparing this report has been provided by the Ministry of Health and that all such information is true and accurate in all material aspects and not misleading by reason of omission or otherwise. Accordingly, neither KPMG nor their partners, directors, employees or agents, accept any responsibility or liability for any such information being inaccurate, incomplete, unreliable or not soundly based, or for any errors in the analysis, statements and opinions provided in this report resulting directly or indirectly from any such circumstances or from any assumptions upon which this report is based proving unjustified.

The report dated 12 October 2016 was prepared based on the information available at the time that relates to the period of the report. KPMG have no obligation to update our report or revise the information contained therein due to events and transactions occurring subsequent to the date of the report.

Contents

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Foreword from the Outcomes Framework Advisory Group

Tēnā koutou katoa. He mihi nui ki ngā ringa āwhina. He mahi nui, he mahi roa, he mahi pakeke. Ēngari, ko te mea nui he mahi whakahirahira. Mā whero mā pango ka oti ai te mahi!

Greetings to those who helped with this report, it was a large piece of work, a long piece of work, and a hard piece of work, however, a work of great importance. Together we have completed the work!

This report represents a significant milestone in the journey of preventing and minimising gambling harm for the people of New Zealand. This report has been developed through the combined efforts of a broad sector Advisory Group, the Ministry of Health and KPMG working closely together. This report assesses the progress made in preventing and minimising harm from gambling in New Zealand since the Outcomes Framework for Preventing and Minimising Gambling Harm Baseline Report 2011/12 (baseline) was established. This is the first of a series of progress reports that assess trends against the baseline.

The Advisory Group comprised key representatives from across the sector. An important principle was that the Advisory Group should cover all elements of the sector, from government agencies, problem gambling service providers, academia, to industry and consumers. This reflects an important component of the Ministry's strategic goal: 'Government, gambling industry, communities and families/whānau working together'.

This Progress Report was developed between March 2014 and October 2016. The Advisory Group established to help deliver the baseline report was re-convened to support the development of this progress report in a manner that has the support of the full sector. All agree that the group's members have worked well together and it has been an enjoyable process. The members of the group are shown in Table A (opposite).

The findings from this report have resulted from debate and discussion with the Advisory Group and Ministry of Health. This has greatly improved the rigour and relevance of this report. The Advisory Group support the findings of this report, subject to the limitations mentioned in each section.

KPMG would like to thank the Advisory Group and the Ministry of Health for the constructive and flexible way they have supported this project. We have very much enjoyed this project and working with this team. We believe this work, combined with the future progress reports, has the potential to make a substantial contribution towards preventing and minimising gambling harm for the people of New Zealand.

Table A: Advisory Group Membership

Sector	Representative
Asian problem gambling service provider	▪ John Wong
Department of Internal Affairs	▪ Neove Christoforou
Gambling industry	▪ Emma Lamont-Messer ▪ Scott Pearson ▪ Sifa Taumoepeau ▪ Bruce Robertson
Consumer sector	▪ Brenda McQuillan
Māori problem gambling service provider	▪ Layla Lyndon-Tonga ▪ Suaree Borell
Pacific problem gambling service provider	▪ Kotoni Fe'ao
Problem gambling service provider	▪ Lisa Campbell ▪ Bernie Smulders
Research and training	▪ Dr Maria Bellringer ▪ Dr Sean Sullivan

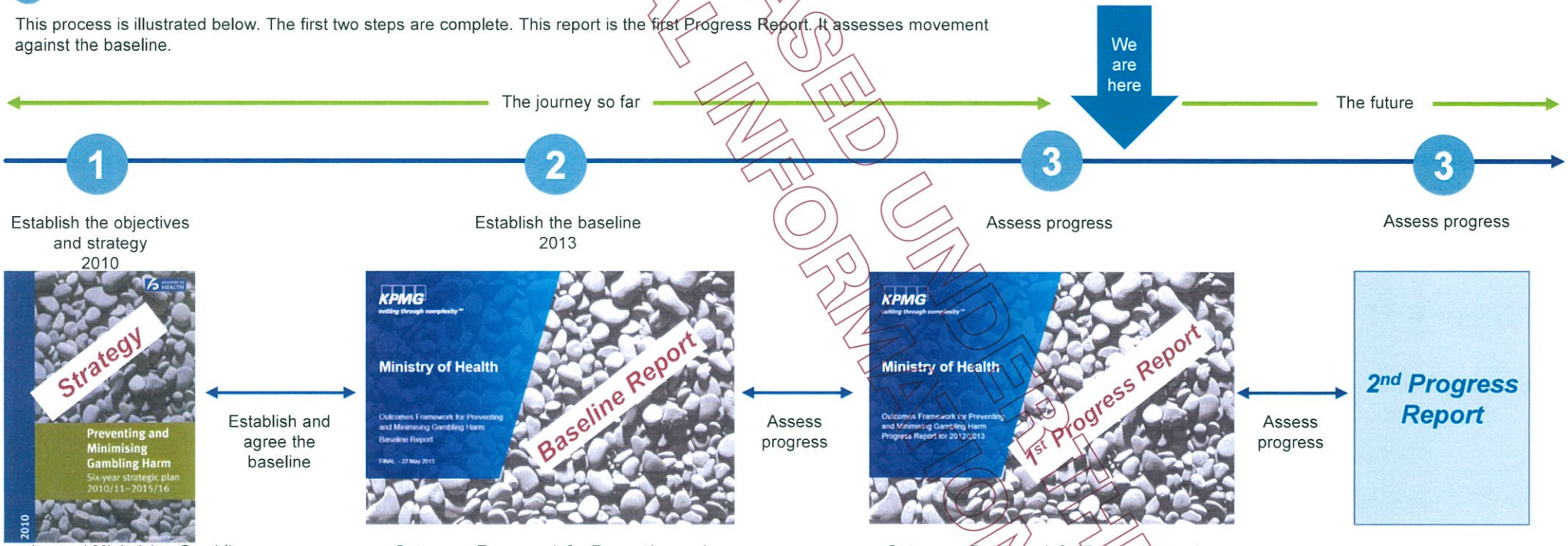
Introduction

Overview

The Ministry of Health's strategy to prevent and minimise harm from gambling is to:

1. *Establish and agree strategic objectives and how these can be met - the strategy*
2. *Determine the measurement framework and agree the baseline level of performance – the baseline*
3. *Assess progress against the baseline through progress reports – the progress reports.*

This process is illustrated below. The first two steps are complete. This report is the first Progress Report. It assesses movement against the baseline.



Preventing and Minimising Gambling Harm Six-Year Strategic Plan 2010/11 – 2015/16

http://www.health.govt.nz/publication/preventing-and-minimising-gambling-harm-six-year-strategic-plan-2010-11-2015-16

Outcomes Framework for Preventing and Minimising Gambling Harm Baseline Report 2011/12

http://www.health.govt.nz/publication/outcomes-framework-preventing-and-minimising-gambling-harm-baseline-report

Outcomes Framework for Preventing and Minimising Gambling Harm Progress Report 2012/13

Figure A: The journey so far

The strategy: the Preventing and Minimising Gambling Harm Six-Year Strategic Plan

In 2010, the Ministry of Health ("the Ministry") consulted widely with the sector to develop and publish the *Preventing and Minimising Gambling Harm Six-Year Strategic Plan 2010/11 – 2015/16*.

The **overall goal** of the Strategic Plan is:

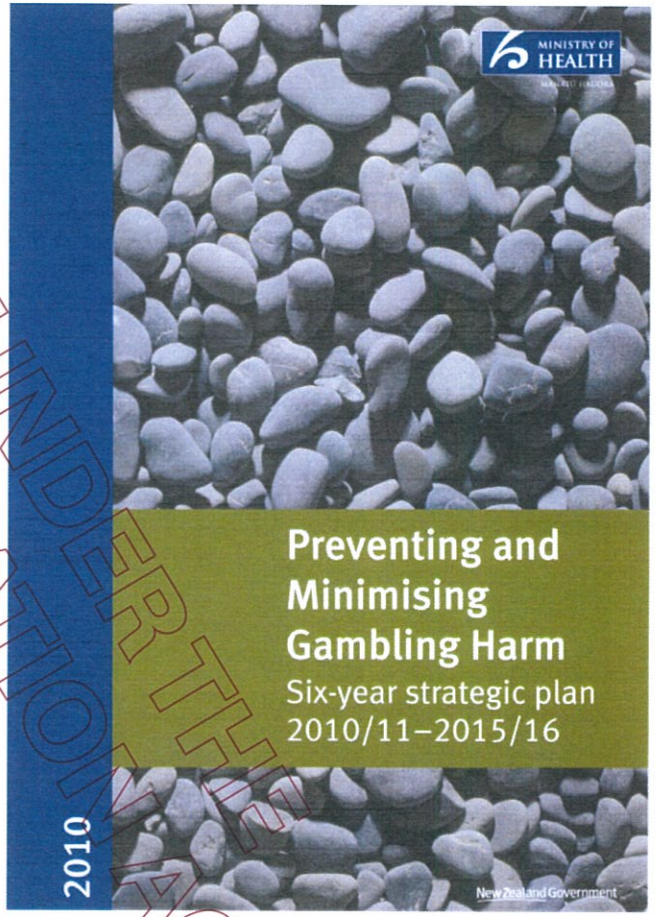
'Government, gambling industry, communities and families/whānau working together to prevent the harm caused by problem gambling and to reduce health inequalities associated with problem gambling'.

The Strategic Plan sets out 11 objectives to achieve this overall goal:

1. There is a reduction in health inequalities related to problem gambling
2. Māori families are supported to achieve their maximum health and well-being through minimising the negative impacts of gambling
3. People participate in decision-making about local activities that prevent and minimise gambling harm in their communities
4. Healthy policy at the national, regional and local level prevents and minimises gambling harm
5. Government, the gambling industry, communities, family/whānau and individuals understand and acknowledge the range of harms from gambling that affect individuals, families/whānau and communities
6. A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm
7. People have the life skills and the resilience to make healthy choices that prevent and minimise gambling harm
8. Gambling environments are designed to prevent and minimise gambling harm
9. Problem gambling services effectively raise awareness about the range of harms from gambling that affect individuals, families/whānau and communities for people who are directly and indirectly affected
10. Accessible, responsive and effective interventions are developed and maintained
11. A programme of research and evaluation establishes an evidence base, which underpins all problem gambling activities.

The Strategic Plan identifies 65 outcome indicators designed to measure progress towards achieving the 11 objectives. Further background on problem gambling, including a copy of Strategic Plan is available from http://www.health.govt.nz/our-work/mental-health-and-addictions/problem-gambling.

The Strategy



The baseline: The Outcomes Framework for Preventing and Minimising Gambling Harm

The Outcomes Framework for Preventing and Minimising Gambling Harm Baseline Report establishes the measurement framework. This report enabled the baseline to be set and progress to be monitored towards the achievement of strategic objectives or 'outcomes' and the overall goal set out in the Ministry's Strategic Plan. Colloquially, this report has become known as the baseline report and it is referred to as such in this report.

The overall intention of assessing the baseline was to be able to measure progress against the objectives of the Strategic Plan in the future, with the intention of improving services, reducing gambling harm and publishing data on gambling harm for all to use.

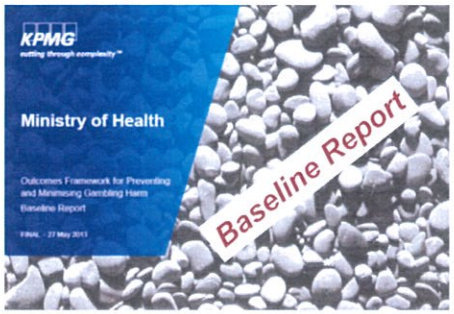
Figure B (below) illustrates the relationship between the 11 strategic objectives and the 65 outcome indicators that are used to determine progress against the objectives.

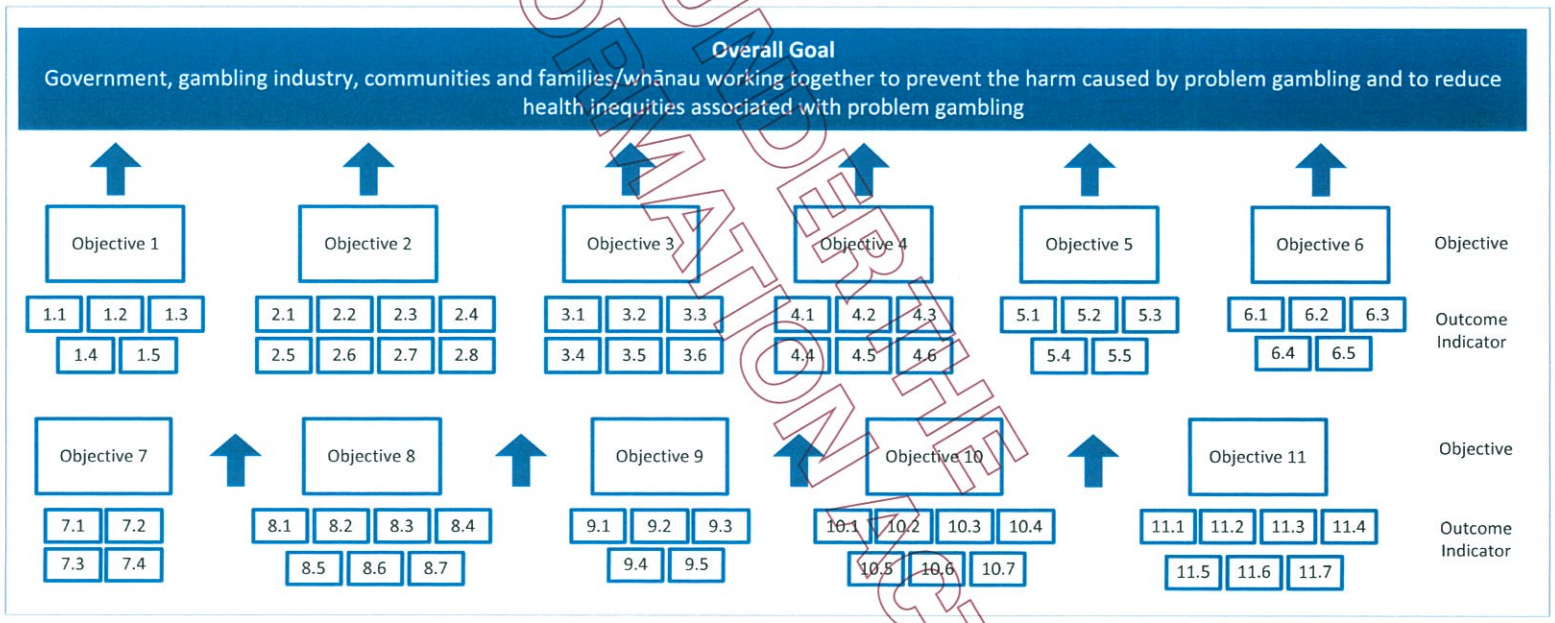
Information used to measure progress was gathered from an extensive set of sources across the preventing and minimising gambling harm sector.

The baseline report

The *Outcomes Framework for Preventing and Minimising Gambling Harm Baseline Report* (baseline report) defined the 65 outcome indicators and presented the first information on the status of each of the outcome indicators for the year ending 30 June 2012. The purpose of the baseline report was to assess the state of each of the outcome indicators. It provided a 'snapshot' of how things were in June 2012. In assessing the state of each outcome indicator, the baseline report considered the measurability, reliability, robustness and relevance of data.

Figure B. Relationship between strategic objectives and outcome indicators





The progress report

The purpose of this first progress report is to measure the change in performance or progress of a subset of the outcome indicators compared to the 2011/12 baseline. It establishes the second data point being measured, enabling movements between data points to be measured for the first time by comparing the baseline measures with data from 2012/13. Going forward, with additional data points, trends will begin to provide greater insight on the performance of the sector and the opportunity to improve performance and strategy. Figure C (below) identifies the subset of outcome indicators that are included in this progress report. Following on from this report, performance will be assessed through further progress reports. The release date for the second progress report is still to be determined.

Note regarding the use of the word trend: At least three data points are required for a "trend" to be identified. The word "trend" is used, however in this first report, this is actually only a movement from the baseline.

Scope of this first progress report

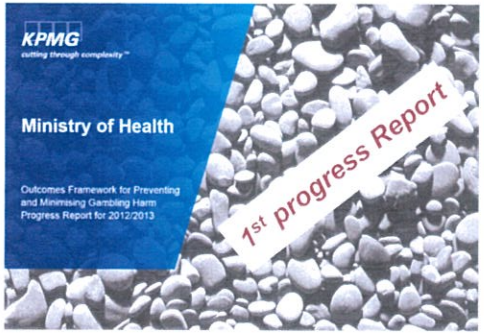
To maximise the value from this progress report the most critical outcome indicators have been selected. Of the 28 measurable annual outcome indicators 16 have been selected as indicated below (also refer full list in Appendix D). These 16 outcome indicators were selected by:

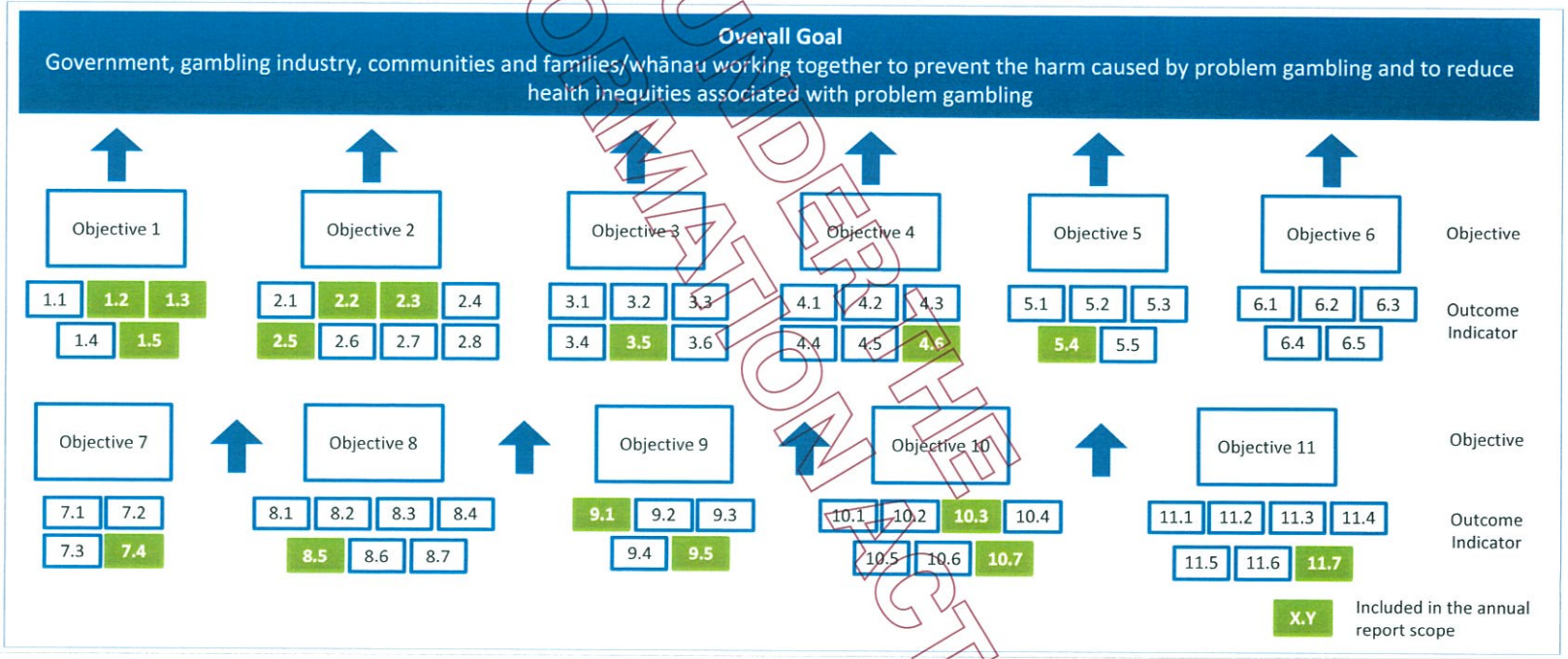
- Identifying outcome indicators that required annual assessment, as defined by the Six-Year Strategic Plan. Some outcome indicators are reported less frequently
- Identifying outcome indicators that are measured in the baseline report
- Assessing the relative value of measuring and reporting the remaining 28 outcome indicators.

While the baseline report was large (nearly 300 pages and over 300 figures and tables), it is important that progress reports are concise in order to increase their use.

Figure C (below) highlights the 16 outcome indicators included in this progress report (coloured boxes). The Ministry of Health made the final selection of which indicators should be included in the scope. For a full list of indicators reported in the progress report please refer Appendix D.

Figure C Progress Report scope





KPMG's role

In 2014, KPMG was appointed to develop this first progress report for the year ending 30 June 2013. Key steps undertaken:

1. Plan the scope of the Progress Report with the Ministry of Health

The project commenced with planning workshops with the Ministry of Health to determine the outcome indicators to be reported by the progress report.

2. Reform the Advisory Group

The Outcomes Framework Advisory Group ("Advisory Group") provided substantial value and credibility to the baseline report and ensured cross sector ownership of the main conclusions. The group was reformed with minor amendments to the membership. The Ministry made the final decision on the composition of the Advisory Group.

An important principle underlying the Advisory Group was that those on the Advisory Group represent their sector rather than their employer or other interests. Refer table A in the Foreword for the Advisory Group members.

The Advisory Group met once to review the draft progress report.

3. Collect data

Data collection commenced using the approach planned and agreed with the Advisory Group for the baseline report. Data was collated from secondary sources, through datasets and third party reports.

4. Analyse and report

Data collected was analysed and this progress report was developed. The analysis completed was guided by the analysis presented in the baseline report. Primarily the analysis compares data from 2011/12 with data from 2012/13.

A guide to reading this report

This report provides a large volume of detailed information on the status of a subset of objectives and outcome indicators and the overall current state of the preventing and minimising gambling harm sector. This report will have a variety of audiences, ranging from those only interested in the Executive Summary, to those wishing to drill down to see the full detail for outcome indicators. Consequently, the report has been structured with this in mind.

Report structure

The report is split into four main sections:

1. Introduction

- This introduction provides an overview of the purpose of the Outcomes Framework, glossary, data sources and a schematic to assist reading the report.

2. Executive Summary

- The executive summary is a stand alone section that summarises the purpose of this report and main conclusions.

3. Outcome Indicator Assessment

- This section provides detailed analysis for each of the 16 indicators. This provides the evidence to support the assessment of the current state of the indicator. The schematic on the next page describes the layout of each outcome indicator assessment.

4. Appendices

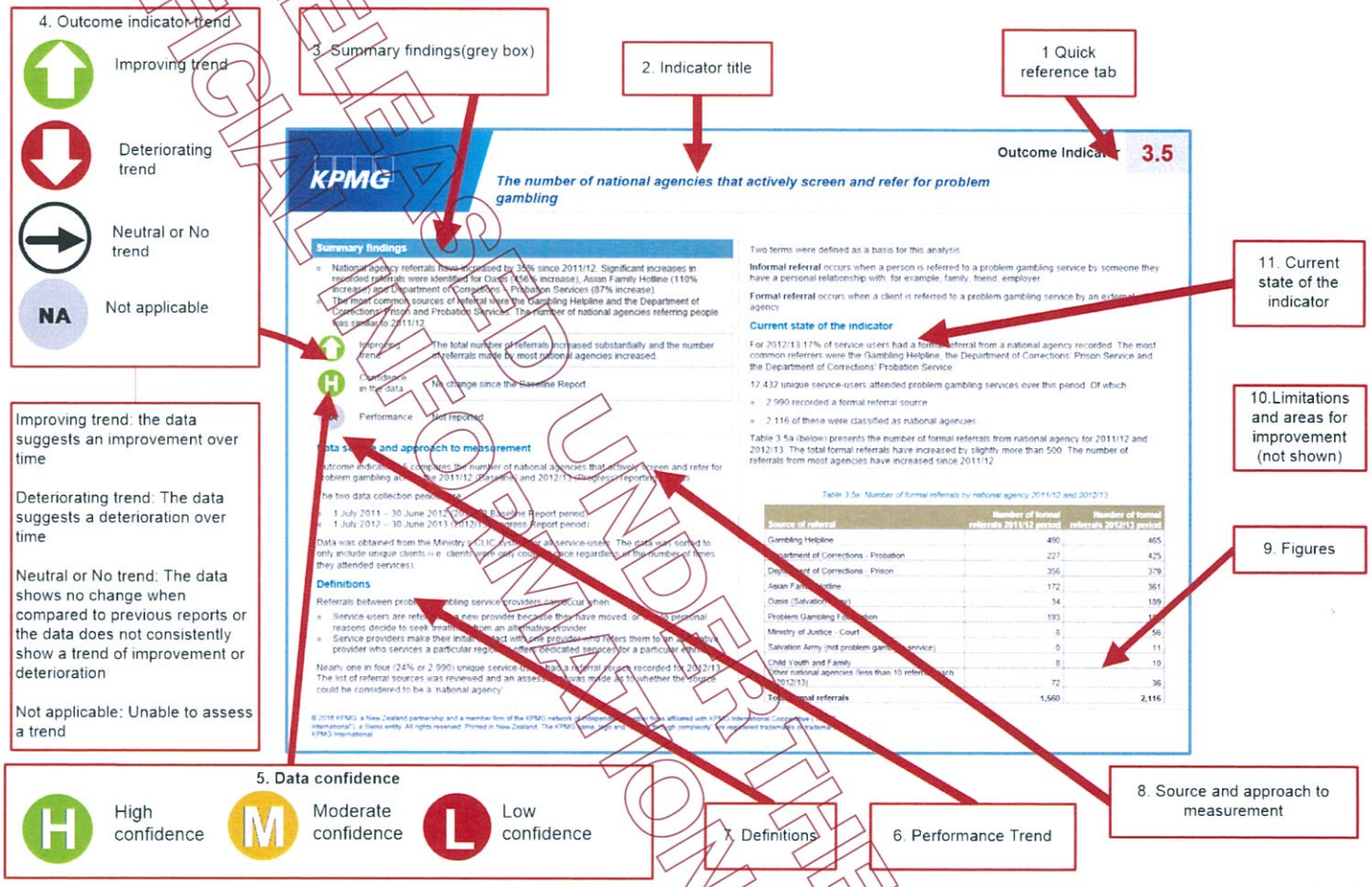
- Appendix A: Glossary
  - This section provides definitions for key terms and acronyms used throughout the report.
- Appendix B: Technical notes
  - This section describes the types of data and statistical techniques used in preparing this report.
- Appendix C: Selected bibliography
  - This section lists selected references used in preparing this report.

To make this report as easy to use as possible information on the 16 outcome indicators has been presented in a consistent format using the outcome indicator template illustrated in Figure D (right) and described below.

Each indicator slide can be read as follows:

1. **Quick reference tab** - indicates the objective the indicator relates to. In the example on the right, 3.5 means that this is outcome indicator five for objective three.
2. **Indicator title** - the name of the indicator also provides a guide about the type of information included within the outcome indicator.
3. **Summary Findings** - this lists the key findings of the indicator that are used to measure progress against the baseline.
4. **Outcome indicator "trend" and rationale** - describes our rationale for the assessment of the overall movement for the outcome indicator. The "trend" compares 2011/12 (baseline) and 2012/13 (this report). The symbols are used to indicate our assessment of trend against the baseline report. Refer page 7 for information on use of "trend".
5. **Data confidence assessment** - provides an indication of the overall reliability and robustness of data used to measure the outcome indicator. The comparability of the data is also considered. Symbols are used to indicate confidence in the indicator data.
6. **Performance trend** - not measured because performance targets have not been set for the outcome indicators.
7. **Definitions** - typically, these are definitions that inform data collection and analysis.
8. **Data source and approach to measurement** - summarises the approach taken to collect data for the indicator, including where data was obtained from and what periods the data was obtained for.

Figure D: How to read this report



9. **Figures** - within many indicators, Figures are used to present data. Figures are ordered alphabetically according to the indicator number, for instance 3.5a is the first Figure in outcome indicator 3.5. Data represented in the Figures is generally rounded to zero decimal places. However, when relevant or necessary it is rounded to one decimal place.
10. **Limitations and areas for improvement** - describes the key limitations as well as strategies that could be considered in the future to overcome the limitations (this section is provided on the last page of each outcome indicator and is not shown above).
11. **Current state of the indicator** - reports on the analysis of the indicator and is the basis of all key findings.

Introduction (cont.)

Data sources

The report and the baseline report draw upon a long list of data sources. These are described below:

1. New Zealand Health Survey (NZHS)

The NZHS provides information about the health and well-being of New Zealanders and provides a dedicated section covering participation and prevalence of problem gambling. Full survey results are available from http://www.health.govt.nz/nz-health-statistics/national-collections-and-surveys/surveys/current-recent-surveys/new-zealand-health-survey.

The NZHS is used in analysis for outcome indicators 1.2 and 2.2.

2. Client Information Collection (CLIC) database

The Ministry of Health's problem gambling service providers enter service utilisation data into the CLIC database. This database provides information on those screened for indicators of gambling harm and those seeking help for their own gambling, or that of a family member or affected other. Further information on service-user numbers, demographic data, treatment received and outcome measures is available from http://www.health.govt.nz/our-work/mental-health-and-addictions/problem-gambling/service-user-data.

Data from the CLIC database is used for outcome indicators 1.2, 2.2, 3.5, 7.4, 8.5, 9.1, 10.3, and 10.7.

3. Electronic Monitoring System (EMS) database

EMS collects information on the non-casino gambling machine expenditure at all Class 4 club and pub venues throughout New Zealand. This database also retains information on the number of venues, the number of electronic gambling machines and their locations. Reporting on gambling expenditure is available from http://www.dia.govt.nz/Gambling.

EMS data is used for outcome indicators 1.3 and 2.3.

4. Problem gambling service provider narrative reporting

The Ministry of Health's contracted problem gambling service providers report every six months to the Ministry of Health on the activities they have completed. KPMG developed a table template to be populated by service providers as part of this reporting to capture information on public health initiatives completed by service providers with a specific focus on the communities targeted by these initiatives.

The information collected on public health initiatives is used for outcome indicators 1.5, 2.5.

5. Class 4 gambling compliance investigation and audit data

Data was provided by the Department of Internal Affairs (DIA) on the types of investigations initiated into Class 4 gambling and also the results of audits completed at Class 4 gambling venues. These audit results were used for outcome indicators 5.4 and 8.5.

6. National Gambling Study (NGS) 2012

The NGS compliments the evidence provided by the NZHS and provides a more detail about gambling participation and problem gambling in the New Zealand environment. The full study information is available from http://www.health.govt.nz/our-work/mental-health-and-addictions/problem-gambling/research-and-evaluation/implementation-2007-2010/national-gambling-study.

The NGS is used in analysis for outcome indicators 1.2 and 2.2.

7. Gambling industry advertising spend

Data was provided by Nielsen Media Services to provide an indication of the spend and number of advertisements purchased by the gambling industry. Data on advertising spend was used for outcome indicator 4.6.

8. Advertising campaign evaluation

Data was provided by the Health Promotion Agency to analyse the effectiveness of the Kiwi Lives advertising campaigns. Data was used for outcome indicator 9.5.

9. Scholarship data for Ministry of Health funded gambling scholarships

Data was provided by the Ministry of Health showing the number of applications, acceptances and withdrawals. The data was used for outcome indicator 11.7.

10. Outcomes framework Advisory Group

As listed in the Foreword, an Advisory Group was established for this project comprising sector representatives. The Advisory Group provided substantial and invaluable input and direction throughout the project.

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Executive summary

Executive summary

Introduction

This first progress report represents the third significant milestone in the strategic journey that the Ministry of Health, the sector and KPMG are taking to help prevent and minimise harm from gambling in New Zealand. This report provides useful insights about the status of the gambling sector in New Zealand.

The overall goal is, "Government, gambling industry, communities and families/whānau working together to prevent the harm caused by problem gambling and to reduce health inequalities associated with problem gambling".

Background

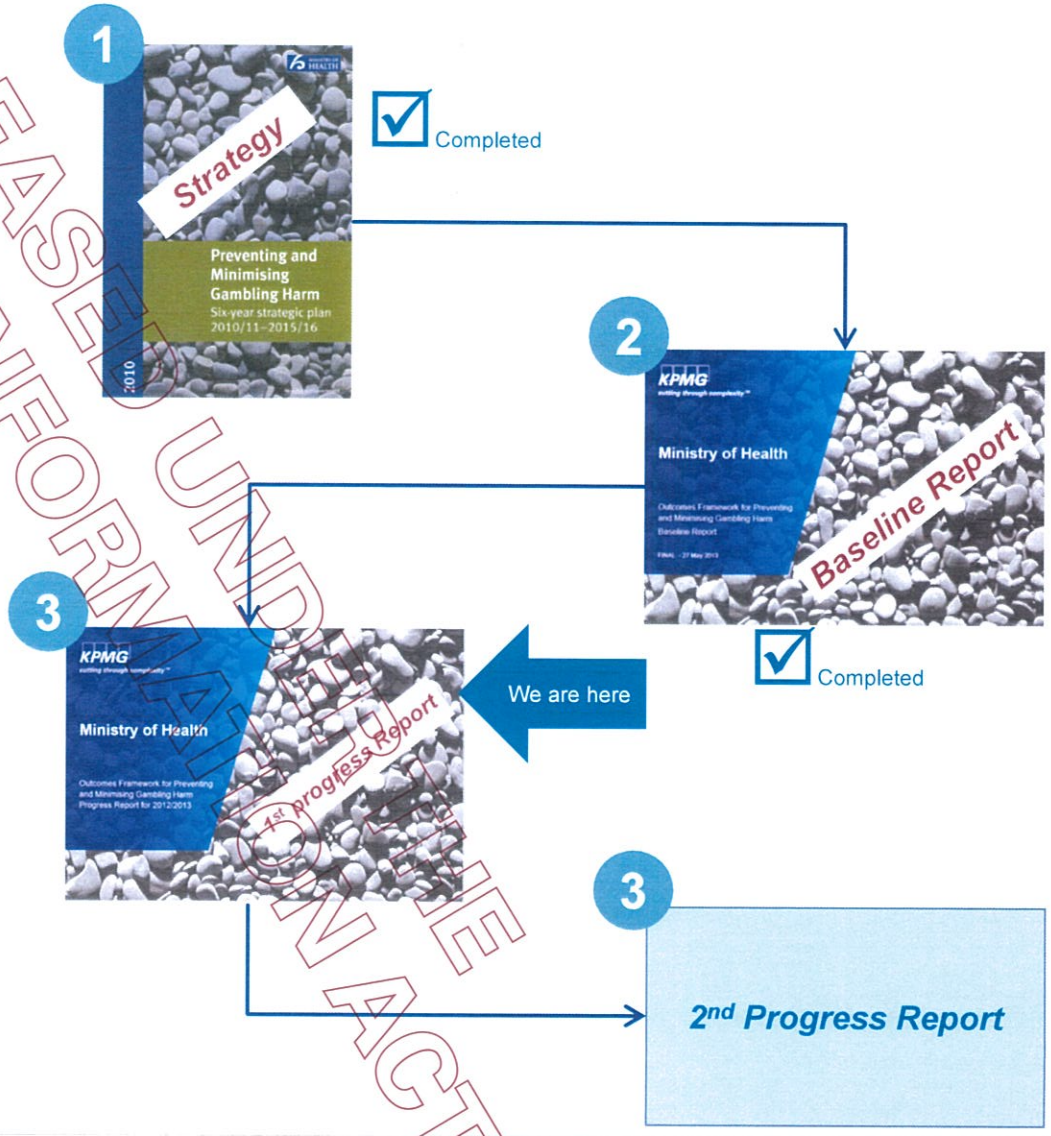
The strategic journey illustrated in Figure E (right), and described below, involves three key phases:

1. **Establish and agree strategic objectives and the strategy**. The Six-Year Strategic Plan 2010/11 – 2015/16 sets out 11 strategic objectives and 65 outcome indicators to assess progress against the strategy.
2. **Determine the measurement framework and agree the baseline level of performance**. The Outcomes Framework for Preventing and Minimising Gambling Harm Baseline Report established the measurement framework. This enabled the baseline to be set and progress to be monitored towards the achievement of strategic objectives or 'outcomes' and the overall goal set out in the Ministry's Six-Year Strategic Plan 2010/11 – 2015/16.
3. **Assess progress against the baseline through progress reports.** The purpose of this first progress report is to assess the new position for the sector for 2012/13 and to compare this against the baseline established in 2011/12, enabling trends to be measured for the first time.

   This progress report:

   - Enables progress from the baseline to be determined, however it only represents two measurement points. Subsequent progress reports will establish additional data points. These will begin to provide greater insight on the progress made in the sector and also provide opportunities to improve performance and strategy.
   - Reports progress, rather than assessing performance of individual indicators or the sector. To assess performance, good performance needs to be defined and measures would need to be set for the sector overall and for each indicator.
   - Measures progress against the baseline for 16 out of 65 indicators. As a result the report does not provide a comprehensive assessment of the strategy. Refer to the introductory section of this report for information about how indicators were selected and refer Appendix D for the complete list of indicators.

Figure E: Strategic journey



Executive summary (cont.)

Summary of key findings – the headlines

Within this executive summary, a series of relevant strategic questions have been posed to provide greater insight into the status of the sector, trends, and the effectiveness of the strategy to prevent and minimise harm from gambling. As more data is analysed over time, the status and trends should become more complete and robust, enabling actions to be identified to improve the performance of the sector and help prevent and reduce harm from gambling. It is too early in this strategic journey to fully answer some of the questions posed, however, future progress reports should increasingly be able to address these.

1. *Has the risk of harmful gambling changed?*

Too early to state for the sector overall. While a full answer to this question is not feasible presently, the data within this report indicates that the risk of harmful gambling has decreased slightly for most participants since 2011/12.

Spending per person per annum on Class 4 gambling (electronic gaming machines outside of casinos) is slightly lower in 2012/13 across low, medium and high socioeconomic communities. The largest decline was 3.5% in high socioeconomic communities. Gaming venue numbers and electronic gaming machine numbers are also slightly lower across low, medium and high socioeconomic communities. The largest decline was a 3.1% decline in gambling venue numbers in high socioeconomic communities. Refer outcome indicator 1.3 for more information.

2. *Is the Ministry of Health's Preventing and Minimising Gambling Harm Strategy working?*

Too early to state because this progress report focused on a subset of indicators. The outcome indicators measured showed some positive signs that the strategy is working.

For instance, sample sizes for the CLIC datasets were larger, more referrals were being entered into CLIC, and more public health initiatives were reported. Refer outcome indicators 1.2 and 1.5, also refer to the answers to question 6 and 7.

3. *Are gambling services effective? Are they becoming more effective?*

Gambling services that prevent and minimise harm from gambling are effective overall for the people that use the services. The effectiveness of the services is similar to 2011/12.

A comparison of the average initial and subsequent treatment scores for the Problem Gambling Severity Index (PGSI) score and Gambler Outcome Control score for individuals attending services in 2012/13 highlighted that individuals had lower levels of behaviours indicative of problem gambling and had more control over their gambling after treatment.

The second indicator for effectiveness is the money individuals spent on gambling. This decreased for individuals after they sought treatment. Refer outcome indicators 1.2 and 2.2 for more information.

4. *Are any sub-groups within New Zealand more affected by gambling than others?*

Yes, lower socioeconomic communities and communities with higher than average Māori populations are more likely to be at risk of harm from problem gambling. This has not changed significantly from 2011/12.

In low socioeconomic communities:

- Spend on gambling is five times higher than gambling spend in high socioeconomic communities (gambling spend is an indicator of participation).
- There are four times as many class 4 venues and almost five times as many electronic gaming machines when compared to high socioeconomic communities.

For Māori :

- Participation in gambling is almost 11 times higher and there are more Class 4 venues (10 times more) and electronic gaming machines (11 times more) in communities with higher than average Māori populations when compared to communities that do not have higher than average Māori populations.

For low socioeconomic communities with higher than average Māori populations:

- Participation in gambling is more than 4 times the participation of medium socioeconomic communities with higher than average Māori populations and almost 8 times higher than high socioeconomic communities with higher than average Māori populations.
- There are more opportunities to access venues and electronic gaming machines compared to medium and high socioeconomic communities with higher than average Māori populations.

The data analysed does not show significant differences for other ethnicities, age groups or genders. Refer outcome indicators 1.2, 2.2, 1.3 and 2.3 for more information.

5. *Are more people experiencing harm from internet gambling?*

This progress report has not included outcome indicators which relate to this question.

As more data points are noted, subsequent progress reports will provide more insight and trends relating to the prevalence of harm from internet gambling.

The Ministry of Health advises that there has been no significant change in the percentage of people seeking help for internet gambling. The proportion of clients reporting harmful gambling from an overseas gambling source has remained low at 1.48% of all clients seeking help in 2012/13. This compares to 2.39% for the 2011/12 year. Additional information on overseas gambling can be obtained from the NGS report.

Executive summary (cont.)

6. What should the sector be proud of?

- **Effective treatment services.** Increasing evidence indicates that treatment services are effective. Refer the answer to question three above.
- **Host responsibility audit pass rates remain high.** The majority of pub/club venues continue to pass their Department of Internal Affairs audits and this has not changed substantially since 2011/12 (2011/12 - 92%, 2012/13 - 93%). Refer outcome indicator 5.4 for more information.
- **Increased referrals to treatment.** The number of recorded referrals to problem gambling services has increased from 19% of all service users to 24%. Referrals come from a wide range of sources including national agencies, health providers, and community service providers. For example, Department of Corrections Probation Services referrals have increased by 87%. Referrals from alcohol and drug services have also increased. This may indicate increased awareness of the need to prevent and minimise gambling harm and/or more awareness of services available to help those with gambling issues. Refer outcome indicator 3.5, 7.4, 8.5 and 9.1 for more information.
- **Targeting of public health messages has improved and at-risk groups are recalling the messages.** More recent public health social marketing campaigns, aiming to improve awareness of problem gambling, are increasingly being delivered to groups that are at risk of problem gambling. Refer outcome indicator 9.5 for more information.

7. What areas need particular focus by the sector going forward?

- **Reducing inequality for Māori and low socioeconomic communities**. As noted in question four above, Māori are more at-risk from gambling harm than other ethnicities. Also low socioeconomic communities are significantly more at-risk from gambling harm than medium and high socioeconomic communities. This was a conclusion of the Baseline Report in 2011/12 and remains a conclusion for 2012/13.
- **Recording of information**. There is an opportunity to continue to improve information recording to ensure that data reported is as complete and accurate as possible.

Additional findings

Additional findings are noted below that do not warrant being termed headlines but do provide insight into the nature of this sector and how it has changed since 2011/12.

- ***Drugs appear to be an increasing issue for those seeking help for their gambling.*** Compared to 2011/12, 10% more women and 10% more Māori who are seeking help for gambling also felt the need to cut down their use of prescription or other drugs. Refer outcome indicator 10.3 for more information.
- ***Of those seeking help for their gambling, more are disclosing suicidal thoughts; however treatment services appear to be addressing this.*** Approximately 21% of male and 20% of female gamblers have had thoughts about suicide before their initial session for problem gambling. This is an increase of 8% for males and 5% for females from 2011/12. Over time, after engaging in problem gambling services, the number of people still with suicidal thoughts almost halved. Refer outcome indicator 10.3 for more information.
- ***Radio advertising by gambling services has increased.*** The number of radio advertisements related to participation in gambling activities has increased by nearly 47% since 2011/12. Refer outcome indicator 4.6 for more information.
- ***Diversity of scholarships is maintained, but the uptake has declined.*** The ethnic diversity of recipients of gambling related research scholarships has been maintained. This should allow different perspectives on problem gambling harm that can be built into future research. While one post-doctoral scholarship was awarded in 2012/13, successful scholarship applications decreased by 50%. Refer outcome indicator 11.7 for more information.

Data confidence and key limitations

In general the rigor and confidence in the data used for this report is high. The main limitations come from using:

- 2006 New Zealand Census data for outcome indicators 1.5 and 2.5. While this means the data is comparable between years, there may have been changes in population demographics e.g. ethnicity, age, gender.
- Deprivation 2006 data or outcome indicators 1.5 and 2.5. While this means the data is comparable between years, there may have been changes in the location of low socioeconomic communities between 2006 and 2013.
- The National Gambling Study to estimate likelihood of gambling within different population groups in 2012/13. The New Zealand Health Survey was used to generate this information in 2011/12. This limitation impacts the comparability of 2011/12 and 2012/13 data in outcome indicators 1.2 and 2.2.
- Public Health data to count the number of programmes to educate people about problem gambling is used for outcome indicators 1.5 and 2.5. The data was not complete, i.e. more initiatives occurred than are reported in the analysis for 2011/12 and 2012/13. This limitation impacts the comparability of the information.

Executive summary (cont.)

Summary of the trends from the outcome indicators

The table below summarises the trend, data confidence and performance against 2011/12 baseline for each of the 16 outcome indicators included in this progress report. Descriptions of the symbols used to describe the status of each outcome indicator are on the right. Refer the Outcome Indicator Assessment section of this report for more information. Performance against the baseline is not assessed for any outcome indicators because performance targets have not been set (i.e. 'good performance' has not been defined).

Outcome indicator trend

- Improving trend
- Deteriorating trend
- Neutral or No trend
- NA — Not applicable

Data confidence

- H — High confidence
- M — Moderate confidence
- L — Low confidence

Outcome indicator		Trend	Confidence in the data	Performance against baseline
1.2	Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends	NA	H	NA
1.3	Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable prevalence of gambling participation and opportunities in low socioeconomic communities	→	H	NA
1.5	Review of problem gambling provider reports for the range of low socioeconomic communities targeted by public health initiatives	↓	L	NA
2.2	Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends for Māori	NA	H	NA
2.3	Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable prevalence of gambling participation and opportunities in Māori and low socioeconomic communities with high Māori populations	→	H	NA
2.5	Review of problem gambling provider reports for the range and number of Māori communities targeted by public health initiatives	↑	L	NA
3.5	The number of national agencies that actively screen and refer for problem gambling	↑	H	NA
4.6	Analysis of industry marketing expenditure and sponsorship activities	↑	L	NA
5.4	Analysis of Department of Internal Affairs annual reports of gambling industry host responsibility compliance	→	H	NA
7.4	Analysis of Ministry service-user data for referral from and referral to life skills and resiliency programmes	↑	H	NA
8.5	Analysis of client data for referrals from gambling venues	→	H	NA
9.1	Analysis of client data for referrals from health sector and community services	→	H	NA
9.5	Assessment of the percentage of social marketing activities delivered specifically to at-risk groups	↑	H	NA
10.3	Analysis of client data for trends in comprehensive assessment and identification of multiple needs	↓	M	NA
10.7	Analysis of the diversity of client characteristics (ethnicity, age, and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services)	→	H	NA
11.7	Analysis of the diversity of applications and successful awards for Ministry of Health-funded gambling harm scholarships	↓	H	NA

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Outcome Indicator Assessment

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Objective 1

There is a reduction in health inequalities related to problem gambling

	Analysis and presentation of outcome indicators for objective 1	Previous measurement point
1.1	Analysis of New Zealand Health Survey data for trends indicating (in)equitable gambling and problem gambling prevalence	2011/12 Baseline Report
1.2	Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends	This Report
1.3	Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable prevalence of gambling participation and opportunities in low socioeconomic communities	This Report
1.4	Analysis of the proportion of charitable trust gambling grants allocated to communities with New Zealand social deprivation scores between decile 7 and 10	2011/12 Baseline Report
1.5	Review of problem gambling provider reports for the range of low socioeconomic communities targeted by public health initiatives	This Report

Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends

Summary findings

- There are only small differences in presentation rates between different population groups (gender, ethnicity, age) attending problem gambling services.
- The proportion of Māori who use problem gambling services is 7% less than the prevalence of problem gambling for Māori. Other ethnicities had more comparable utilisation and prevalence.

NA	Unable to assess trend	The trend cannot be assessed as the approach has changed. 2011/12 information is not presented. Refer explanation at the start of the "Current state of the indicator section".
H	Confidence in the data	Confidence in the 2012/13 NGS data is high.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 1.2 summarises problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness for the 2012/13 Progress reporting period.

Data for outcome indicator 1.2 was obtained from two sources:

- Data on presentations, service utilisation and effectiveness was obtained from the Ministry's CLIC database. The CLIC database is used to record data on people attending problem gambling services.
- Data on the prevalence of problem and moderate risk gambling for the 2012/13 Progress Report was obtained from the NGS 2012.

The data collection period for this outcome indicator is 1 July 2012 to 30 June 2013 (2012/13 Progress Report).

Data was analysed by gender, ethnicity and age for each of the measures discussed on the following pages. All analysis in this indicator is completed for gamblers only. Presentations or service usage by family members/affected others are excluded from this analysis.

Note: 'Other' includes New Zealand Europeans.

Definitions

Presentations measures the number of unique service-users (i.e. only counting each service-user once) receiving a session (brief, full, facilitation or follow-up) at a problem gambling provider.

The presentation rate divides the number of presentations to problem gambling services in a year for a population group by the prevalence of problem and moderate risk gamblers for the same population group. For the purpose of illustration, presentation rates for brief and non-brief (full, facilitation and follow up) presentations are displayed separately in Figures throughout this indicator. The presentation rate provides a measure of how many of those at risk of gambling harm engage with services.

(In)equitable presentation occurs when one population group has a presentation rate different to other population groups.

Service utilisation measures the number of sessions delivered by problem gambling service providers in a year for each population group.

(In)equitable service utilisation occurs when service utilisation for one population group occurs at a rate different to the prevalence for the same population group.

Effectiveness is measured by movements in a service-user's level of gambling harm (as measured by the PGSI), dollars spent on gambling and control over gambling measures as assessed in an intervention session compared with original scores recorded.

(In)equitable effectiveness occurs when measures of effectiveness for one population group are different than those for other population groups.

Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends (cont.)

Current state of the indicator

The approach used to generate this 2012/13 data is different to the approach that was used to generate the 2011/12 data. As there are differences in the basis of information presented in this outcome indicator, the 2011/12 data is not presented within this outcome indicator to limit the likelihood of any inaccurate conclusions being drawn from the information shown. We have not presented the 2011/12 information on advice from the Advisory Group. The approach changes are:

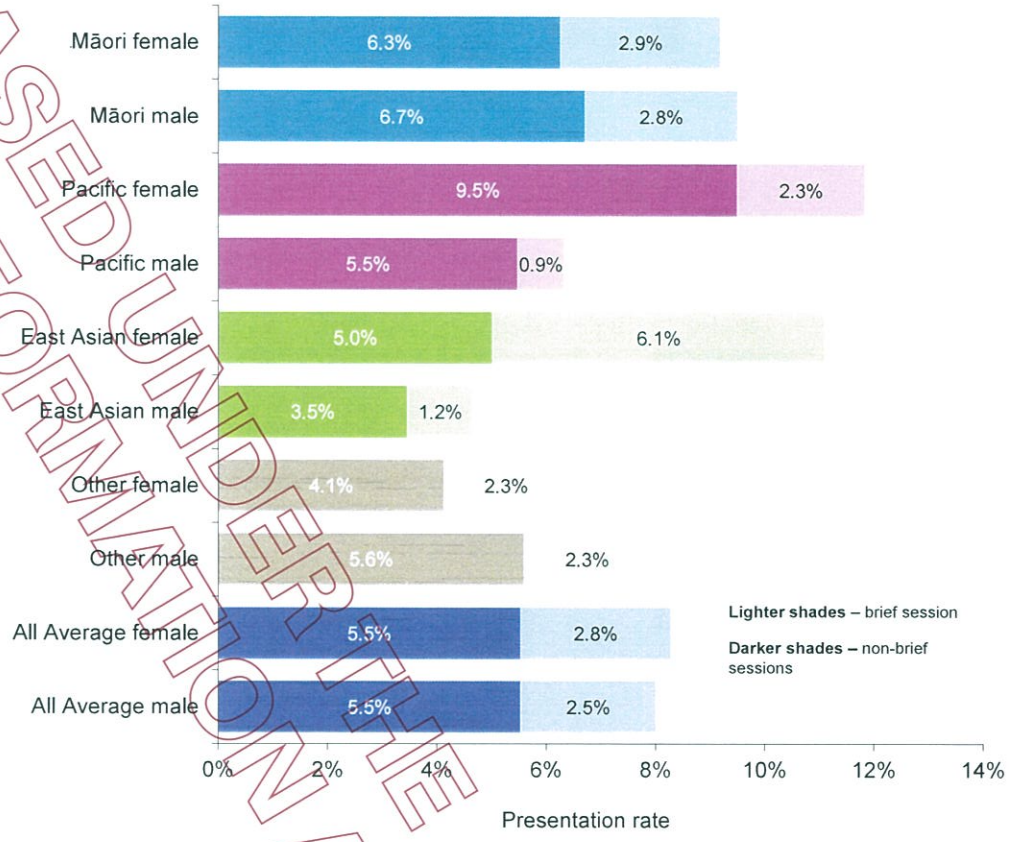
- Data for the prevalence of problem gambling was obtained from the NGS 2012 for the 2012/13 Progress Report instead of the NZHS 2011/12. The prevalence rates reported by this study are different to those reported by the NZHS 2011/12. The NGS 2012 was used because the study is more current and more specific to gambling.
- Presentation rates within the 2011/12 Baseline Report focused on "brief sessions" vs. "full sessions". In the 2012/13 Progress Report the presentation rates show "brief sessions" vs. "non-brief sessions", where non-brief sessions include full sessions, as well as facilitation and follow-up sessions. This change was made because facilitation and follow-up sessions are part of the client pathways and pattern of care. This is unlikely to have a significant effect when counting the number of presenting clients as most clients who have a facilitation or follow-up will have also had a full intervention and would have been included in the data. This will, however, have an effect when assessing service utilisation where the number of individual sessions are counted.

(In)equitable presentation

Figure 1.2a (opposite) sets out the presentation rate to problem gambling services for males and females across the four ethnicity groups. The average presentation rate to problem gambling services for males is 8%, with females roughly the same at 8.3%. The average presentation rate for non-brief presentations is similar at 2.5% for males and 2.8% for females.

Note: The averages take into account the population size of each ethnic group. This analysis only includes gamblers that present to services. Presentations by family members/affected others are excluded from this analysis. This analysis includes clients regardless of PGSI score recorded so some may be more severe than others.

Figure 1.2a: Presentation rate by gender and ethnicity for gamblers (n=6,919) (non age standardised), 2012/13



Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends (cont.)

(In)equitable presentation (cont.)

Figure 1.2b (opposite top) shows the total presentation rate for the four main ethnic groups. Key findings:

a. The average presentation rate across all ethnicities is 7.9%

b. The presentation rate for Other (7.4%) and East Asian (6.5%) groups is lower than the average

c. The presentation rates for Pacific (8%) and Māori (9.4%) are higher than the average

d. A higher proportion of service-users are attending non-brief sessions compared to brief sessions across all ethnicities.

Figure 1.2c (opposite bottom) presents the presentation rate for six age brackets. Key findings:

a. The highest rates of presentations occur for 45-54, 55-64 and 65+ service users for 2012/13

b. The lowest rates are for 18-24 year olds (3.9%) for the same period

c. More non-brief than brief sessions are delivered across all age groups.

Figure 1.2b: Presentation rate by ethnicity for gamblers (n=6,919) (non age and gender standardised), 2012/13

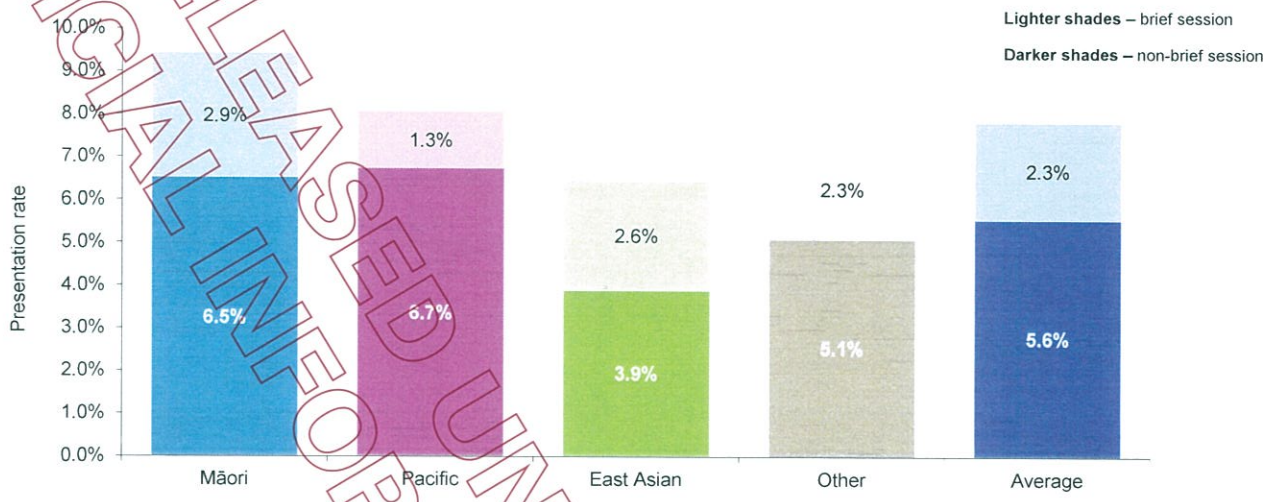


Figure 1.2c: Presentation rate by age for gamblers (n=6,159), 2012/13

Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends (cont.)

(In)equitable service utilisation

Figure 1.2d (below) compares service utilisation (n=33,055 sessions) and prevalence of problem and moderate risk gambling for males and females (n=75,527 problem gambling prevalence population). This presents a similar message to the presentation rate analysis discussed previously, the differences are that service utilisation measures all intervention sessions (including the same service-user attending on multiple occasions), whereas presentations focuses on unique service-users receiving a brief or full session. As with the analysis of presentations, this only includes service utilisation by gamblers. Service utilisation by family members or affected others is excluded.

Results of analysis show that:

a. 57.4% of problem and moderate risk gamblers are male
b. 42.9% of the intervention sessions were delivered to males.

Figure 1.2d: Service utilisation by gender compared with prevalence, 2012/13

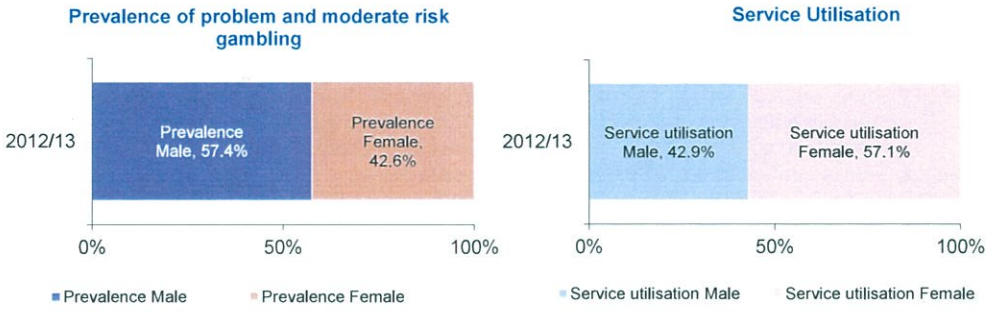
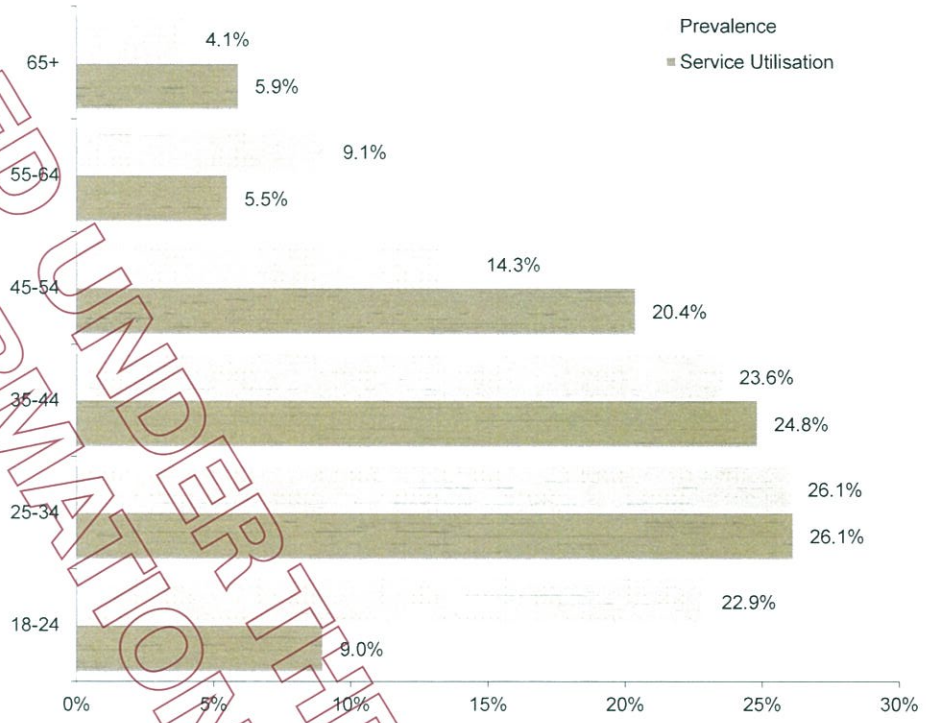


Figure 1.2e (opposite) compares service utilisation and prevalence of problem and moderate risk gambling across six age brackets. Inequity in service utilisation is measured by the difference between the light and dark coloured bars. The greatest inequity occurs in the:

a. 45-54 group, where prevalence is 14.3% compared with service utilisation of 20.4%.
b. 18-24 group, where the prevalence is 22.9% compared with service utilisation of 9.0%.

Figure 1.2e: Service utilisation (n=32,218) by age grouping compared with prevalence of the total problem gambling and moderate risk gambling population (n=75,499 at-risk gambler population), 2012/13



Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends (cont.)

(In)equitable service utilisation (cont.)

Figure 1.2f (below) compares service utilisation and prevalence for each ethnic group. Inequity is evident across most ethnic groups:

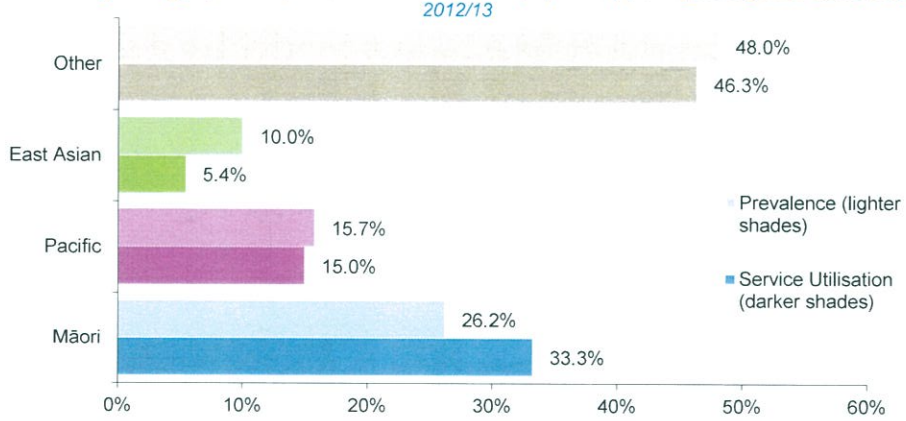
a. East Asian, where service utilisation is 5% compared with prevalence of 10%
b. Māori, where service utilisation is 33% compared with prevalence of 26%
c. The difference between the service utilisation and prevalence for Other and Pacific were much smaller.

During an intervention session clinicians apply a series of screens to assess the severity of a service-user's gambling harm. Effectiveness can be assessed by comparing the scores recorded in an initial session to those recorded in subsequent sessions. Inequity can be measured by comparing effectiveness results across demographic groups. For this outcome indicator, comparisons are limited to gender and age bracket that had each of the screens completed for Māori versus Non-Māori due to the limited number of service-users in each ethnic group.

Service providers are required to complete screens to assess a service-user's gambling harm and record these in client notes, but are not required to record these in the CLIC database.

In addition, the analysis of effectiveness only includes service-users that had more than two scores recorded and excludes any 'affected others' that are seeking help in respect of problems associated with someone else's gambling. Consequently, the number of service-users for which analysis of effectiveness can be completed is lower than the total number of service-users.

Figure 1.2f: Service utilisation (n=33,055) by ethnicity compared with prevalence of the total problem gambling and moderate risk gambling population (n=86,935 – at-risk gambler population) (non age and gender standardised), 2012/13



(In)equitable effectiveness

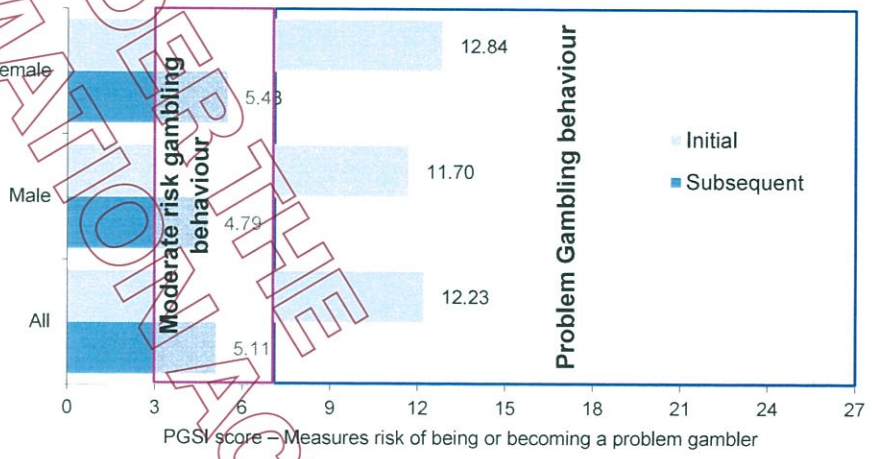
The CLIC database includes 1,536 service-users that had an initial and subsequent PGSI score assessment recorded. Where these service-users also attended services in years prior to 2012/13, data from their earliest session with a score recorded was used to determine their initial score.

A high PGSI score implies that an individual is at high risk of being or becoming a problem gambler. The highest possible score on the PGSI is 27 and is calculated based on the responses provided to nine questions each with a score of between 0 and 3 based on the frequency the service-user reports specific gambling behaviours.

As presented in Figure 1.2g (below), the average PGSI score for service-users reduced from 12.2 to 5.1 between the initial and subsequent sessions for 2012/13. This means the service-user's likelihood of risky problem gambler behaviour decreased after treatment. There was no major difference in PGSI scores by gender. There was very little difference between the scores for 2011/12 and 2012/13. Prevalence is not used to assess effectiveness, therefore a comparison to 2011/12 is relevant. Refer to the Baseline report for the 2011/12 data.

Scores of between 3 and 7 are considered to be indicators of moderate risk gambling behaviour and scores of greater than 7 are indicators of problem gambling behaviour.

Figure 1.2g: PGSI scores from initial and subsequent sessions by gender, 2012/13 (n=1,536)



Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends (cont.)

(In)equitable effectiveness (cont.)

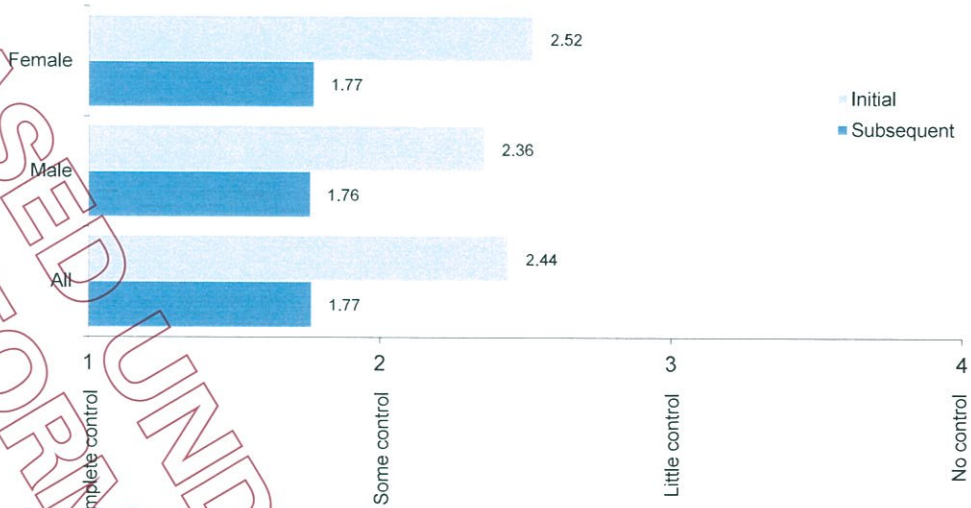
Figure 1.2h (opposite) compares the gambler outcome-control scores from the earliest and latest sessions attended by service-users in 2012/13. The gambler outcome-controls score asks service-users to select the most appropriate of four statements below. Their selection is then allocated a corresponding score of between 1 and 4:

1. I have had complete control over my gambling
2. I have had some control over my gambling
3. I have had little control over my gambling
4. I have had no control over my gambling.

As recorded in CLIC, 1,130 service-users had an initial and subsequent outcome-control score assessment completed. The average gambler control score reduced from 2.44 to 1.77 between the earliest and latest sessions. This shows that, after attending problem gambling service, people felt more in control of their gambling.

There was very little difference between the scores for 2011/12 and 2012/13. Prevalence is not used to assess effectiveness, therefore a comparison to 2011/12 is relevant. Refer to the Baseline report for the 2011/12 data.

Figure 1.2h: Initial and subsequent gambler outcome-control scores by gender, 2012/13 (n=1,130)



Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends (cont.)

(In)equitable effectiveness (cont.)

Figure 1.2h (opposite) compares the gambler outcome-control scores from the earliest and latest sessions attended by service-users in 2012/13. The gambler outcome-controls score asks service-users to select the most appropriate of four statements below. Their selection is then allocated a corresponding score of between 1 and 4:

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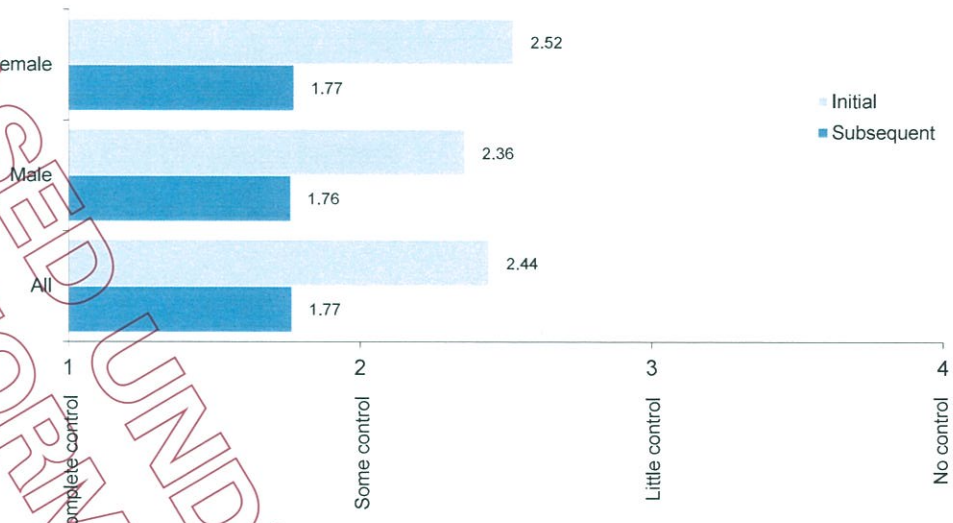
As recorded in CLIC, 1,130 service-users had an initial and subsequent outcome-control score assessment completed. The average gambler control score reduced from 2.44 to 1.77 between the earliest and latest sessions. This shows that, after attending problem gambling service, people felt more in control of their gambling.

There was very little difference between the scores for 2011/12 and 2012/13. Prevalence is not used to assess effectiveness, therefore a comparison to 2011/12 is relevant. Refer to the Baseline report for the 2011/12 data.

Figure 1.2h: Initial and subsequent gambler outcome-control scores by gender, 2012/13 (n=1,130)



Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends (cont.)

(In)equitable effectiveness (cont.)

The CLIC database includes 1,396 service-users that had an initial and subsequent assessment of dollars spent on gambling completed.

Figure 1.2i (opposite) compares the dollars spent from the earliest and latest sessions attended by service-users in 2012/13. Service-users were asked:

'In the last month when you were gambling, roughly what amount of money did you spend on gambling?'

This excludes any money won and subsequently gambled. Figure 1.2i counts the dollars spent in groups and shows that (as expected) the dollars spent by service-users fell between the initial and subsequent sessions except for the $1-$100 category.

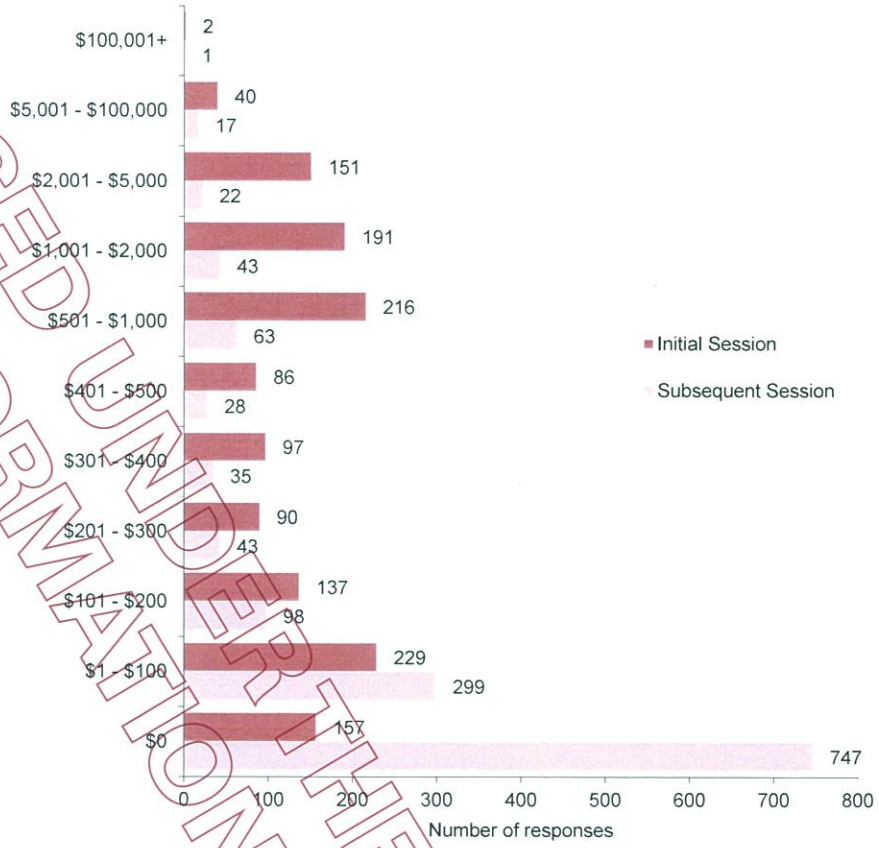
Key findings:

a. A substantial number of service-users (54%) had stopped spending money on gambling when assessed at their subsequent session.

b. Overall 57% of service-users reported that they spent $500 or less on gambling in the previous month in their initial session.

Note: There was very little difference between the dollars spent in 2011/12 and 2012/13. Prevalence is not used to assess dollars spent, therefore a comparison to 2011/12 is relevant. Refer to the Baseline report for the 2011/12 data.

Figure 1.2i: Dollars spent on gambling prior to initial and after subsequent sessions, 2012/13 (n = 1,396)



Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends (cont.)

Limitations and areas for improvement

The approach used to generate the 2012/13 data is different to the approach that was used to generate the 2011/12 data. This change is explained at the start of the "Current state of the indicator" section for this outcome indicator.

Our analysis of (in)equitable effectiveness does not include analysis by ethnicity or age. There were insufficient service-user records to complete this analysis in most ethnic groups. However, outcome indicator 2.2 provides Māori specific analysis. Our analysis is also not adjusted for the age of different population groups (commonly referred to as age standardisation). Differences between the measures of effectiveness for males and females may be due to differences in the age structure of females compared with males.

The measures of effectiveness require service-users to attend multiple sessions and have the effectiveness measures recorded in the CLIC database. That creates a limitation in that people who do not consider services are beneficial may not attend multiple sessions and will therefore be excluded from this analysis. This analysis only provides a snapshot of intervention data over a 12 month period.

As the NGS was used in this report compared to the NZHS used in the previous report, the statistics in this indicator are not directly comparable with the 2011/12 Baseline report. As the NGS is a gambling focused study, it is considered to be a more accurate depiction of the total populations' gambling activity. The NGS should be used in future reporting.

The PGSI tool used for measuring gambling harm, although not validated in New Zealand, has been tested extensively. Initial research by Clarke et al, (2012); and Devlin and Walton (2012), concluded that the PGSI works well in measuring problem gambling in men, women, Māori, Pacific and Asian adults.

The measures of dollars spent on gambling are in response to the question:

'In the last month when you were gambling, roughly what amount of money did you spend on gambling?'.

Clinicians are encouraged to ensure that this only includes dollars lost on gambling (i.e. money taken to gamble with plus any additional money obtained and ignoring any money won). Responses are subjective and therefore the analysis should be treated with caution.

Future iterations of this outcome indicator could be improved by developing confidence intervals for the presentation rate analysis. This would provide greater confidence in the analysis.

For further information

Refer Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable gambling participation and opportunities in low socioeconomic communities

Summary findings

- Spending per person per annum on gambling, gambling venues per 10,000 adults, and Electronic Gaming Machines (EGMs) per 10,000 people, remain (in)equitable in low socioeconomic communities compared with medium and high socioeconomic communities. This inequity has not changed.
- Opportunities to gamble and participation in gambling are very similar to 2011/12. For each of the metrics reported, the change between 2011/12 and 2012/13 was a decline of between 1% and 3.5%.

→	No trend	Overall, (in)equitable gambling participation and opportunities have not changed for low socioeconomic communities, compared with medium and high socioeconomic communities.
H	Confidence in the data	Confidence in 2011/12 and 2012/13 data is high.
NA	Performance	Not reported.

Data source and approach to measurement

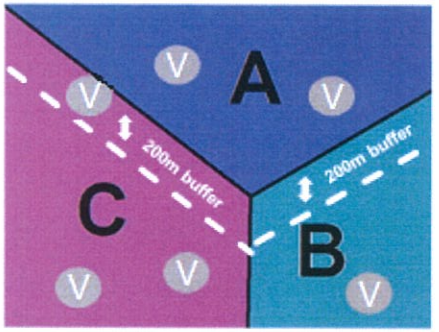
Outcome indicator 1.3 compares Class 4 revenue data against the New Zealand deprivation index (NZDep2013) across two periods: 1 July 2011 to 30 June 2012 (2011/12 Baseline Report data), and 1 July 2012 to 30 June 2013 (2012/13 Progress Report data).

Data for outcome indicator 1.3 was obtained from the Department of Internal Affairs (DIA) Electronic Monitoring System (EMS) for Class 4 gambling. DIA requires all gaming machines in pubs and clubs to be connected to EMS. The EMS obtains accurate and timely information about gaming machine usage. The information provided by the EMS includes:

- The amount of money gambled on gaming machines
- The location and number of machines
- Other technical data on machine faults and the amount due to be banked (not analysed for this outcome indicator).

The Ministry's Gambling Harm Prevention and Minimisation team categorised each venue according to the socioeconomic status of the meshblock, as set out in the New Zealand deprivation index. The meshblock is the smallest geographical area collected by the 2013 census. This is typically a grouping of streets within a suburb. Analysis was performed using Geographic Information Systems (GIS).

Figure 1.3a: Example of how buffer is applied



The GIS approach to analysing data reviews each meshblock and compares the adult population within that meshblock with the number of gambling venues, machines and the gambling spend. Meshblocks vary in size depending on the population within; for example in highly dense urban areas a meshblock may be as small as a city block or large apartment building whereas in less populated rural areas, meshblocks can be large.

A 200 metre buffer was applied to this GIS analysis. The buffer means that when determining the number of gambling venues, Electronic Gaming Machines (EGMs), or gambling expenditure, parts of other neighbouring meshblocks that are within 200 metres of a particular meshblock are included.

For example, in Figure 1.3a (above) meshblock A is in a low socioeconomic community. Meshblocks B and C are not. When determining the number of gambling venues in meshblock A, venues in meshblock B and C and within 200 metres of meshblock A are also included. In this scenario, there are three gambling venues in low socioeconomic communities.

The underlying assumption to this analysis is that people gamble in a community near where they live. The 200 metre buffer takes into account that people living in meshblock A may travel some way into meshblock B or C to gamble, but are less likely to travel long distances to gamble.

The analysis of participation and opportunities for gambling is based on the population aged 20 years and over as recorded in the 2013 census (approximately 3.1 million adults). Approximately 960,000 (31%) of the population were recorded as residing in low socioeconomic areas.

The 2011/12 baseline data has been revised to correct errors that were identified in the data when this progress report was being developed.

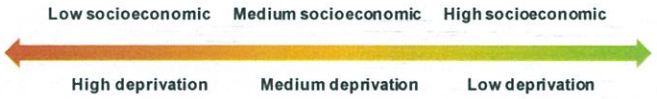
Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable gambling participation and opportunities in low socioeconomic communities (cont.)

Definitions

- **Class 4 gambling** refers to gambling on EGMs outside of a Casino, commonly in a club/pub.
- **Gambling participation** is defined as the expenditure on Class 4 gambling as measured by the EMS.
- **Gambling opportunities** are measured by the number of Class 4 venues and Class 4 EGMs compared with the adult population.
- **A low socioeconomic community** is defined as a community of decile 8, 9 and 10 on the NZDep2013 deprivation scale. The NZDep scale of deprivation is prepared by the University of Otago and divides New Zealand into tenths based on nine variables from the census. A score of 10 indicates that the community is in the most deprived 10 per cent of areas in New Zealand and a score of 1 indicates that the community is in the least deprived 10 per cent of areas.
- **A medium socioeconomic community** is a community of decile 4, 5, 6 or 7 on the NZDep2013 deprivation scale.
- **A high socioeconomic community** is a community of decile 1, 2 or 3 on the NZDep2013 deprivation scale.

Figure 1.3b (below) presents the three categories of socioeconomic status and their relationship to deprivation. High deprivation areas are equivalent to low socioeconomic areas and vice versa.

Figure 1.3b: Deprivation continuum



Current state of the indicator

Gambling participation (measured through spend)

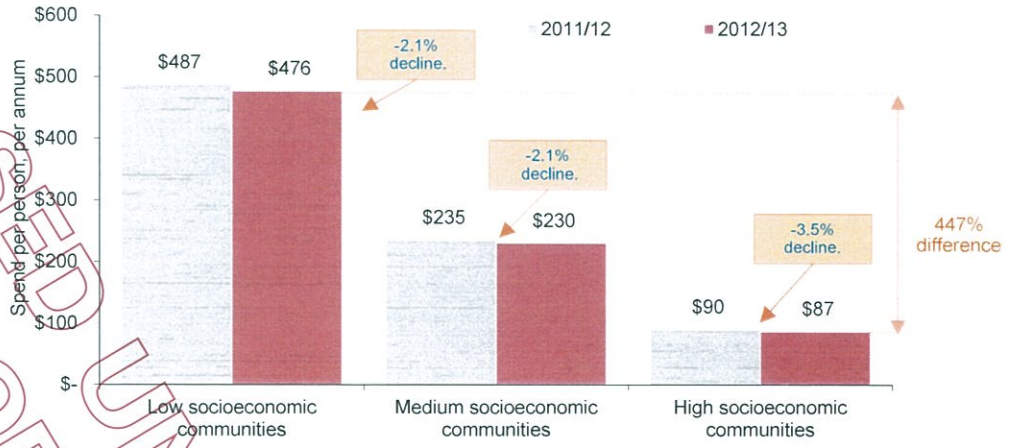
Figure 1.3c (opposite) compares the spend on Class 4 gambling per person per annum in low socioeconomic communities with medium and high socioeconomic communities, for 2011/12 and 2012/13. The analysis shows:

a. (In)equitable spend in gambling in low socioeconomic areas and a strong link between socioeconomic status and the spend on gambling.

b. The average spend per person on Class 4 gambling per annum in low socioeconomic communities is over five times as high as the spend in high socioeconomic communities.

c. The spend per person across each of the community types is similar between 2011/12 and 2012/13.

Figure 1.3c: Gambling spend per person in low, medium and high socioeconomic communities. 2011/12 vs. 2012/13



Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable gambling participation and opportunities in low socioeconomic communities (cont.)

Gambling opportunities

In addition to analysing the participation in gambling, this outcome indicator analyses the opportunities for gambling, in terms of the number of venues and the number of EGMs, for the 2011/12 and 2012/13 periods. Figures 1.3d and 1.3e (opposite) show:

a. (In)equitable gambling opportunities. There are four times as many venues per 10,000 adults in low socioeconomic areas compared to high socioeconomic areas, and almost five times as many EGMs per 10,000 people in low socioeconomic areas compared to high socioeconomic areas.

b. Gambling opportunities, both in terms of venue numbers per 10,000 adults and EGMs per 10,000 people were similar between reporting periods. The actual number of EGMs and venues showed a small decrease; there were 264 less EGMs and 32 less venues.

Figure 1.3d: Gambling venue numbers per 10,000 adults (20 and over) in low, medium and high socioeconomic communities, 2011/12 vs. 2012/13

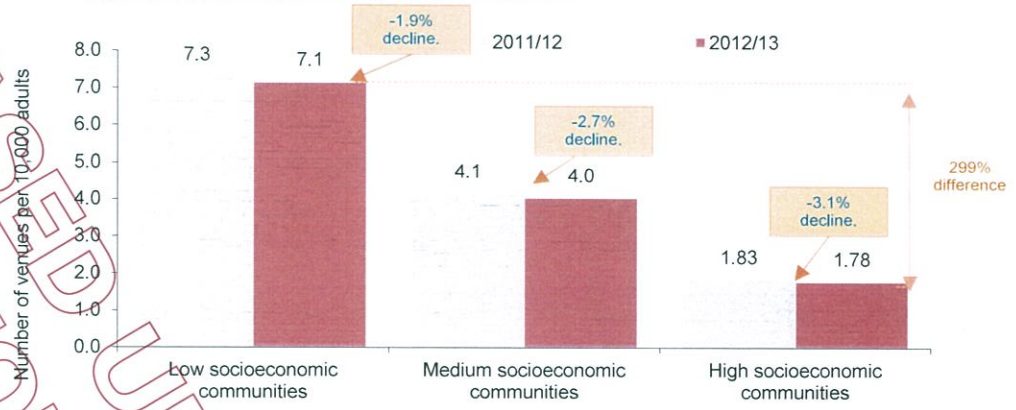
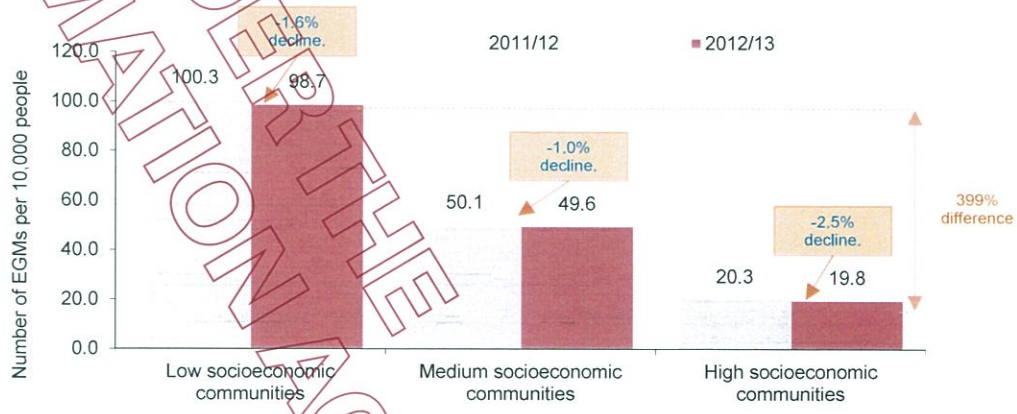


Figure 1.3e: Electronic Gaming Machines per 10,000 people in low, medium and high socioeconomic communities, 2011/12 vs. 2012/13



Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable gambling participation and opportunities in low socioeconomic communities (cont.)

Limitations and areas for improvement

This analysis is restricted to Class 4 gambling and does not include other forms of gambling, including Casino, Lotteries and NZ Racing Board gambling.

The geographical analysis is based on the assumption that people gamble near where they live, rather than travelling to visit a gambling venue. A 200 metre buffer has been applied (refer to source of information and approach to measurement section). This buffer has the effect of increasing the ratio of gambling venues, EGMs and spend per adult. In figure 1.3a, the three venues illustrated would be counted in each of the three meshblocks. This buffer has the effect of providing a more realistic measure of gambling participation and opportunities but has the unintended effect of increasing the ratio of gambling venues, EGMs and spend per adult. The focus should therefore be on the size of the difference between each of the measures rather than the values.

This analysis for 2011/12 and 2012/13 uses information from Census2013 and NZDep13. While the census and NZDep are for 2013, which is after the 2011/12 reporting period, we believe that this data provides a more accurate reflection of the demographic profile than Census2006 and NZDep2006.

For further information

Refer Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

Review of problem gambling provider reports for the range of low socioeconomic communities targeted by public health initiatives

Summary findings

- A decline in the proportion of public health initiative events targeted towards **low socioeconomic communities** (deprivation scores of 8 to 10), between 2012 (25.1%) and 2013 (16.7%).
- An increase in the proportion of public health initiative events targeted towards **medium socioeconomic communities** (communities with a deprivation score between 4 and 7), between 2012 (74.7%) and 2013 (77.9%).
- An increase in the number of public health initiative events targeted towards high **socioeconomic communities** (communities with a deprivation score between 1 and 3), between 2012 (0.2%) and 2013 (5.4%).

↓	Deteriorating trend	There is a general trend away from targeting low socioeconomic communities between 2012 and 2013.
L	Confidence in the data	Low confidence in data because: ▪ There is judgement in the collection approach ▪ The data sets for 2011/12 and 2012/13 are not complete ▪ The data was only collected for six months of each year assessed.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 1.5 assesses six-monthly provider reports to identify the range of low socioeconomic communities targeted by public health initiatives, for 1 January 2012 to 30 June 2012 (2012 Baseline Report) and 1 January 2013 to 30 June 2013 (2013 Progress Report).

All service providers contracted to prevent and minimise harm from gambling submit reports to the Ministry of Health on a six-monthly basis. Service providers that are contracted to deliver public health initiatives include a narrative description of the focus of public health activities over the reporting period and a description of public health initiatives completed. This reporting does not capture the socioeconomic status of communities targeted.

Outcome indicator 1.5 uses two reporting periods to assess the range of low socioeconomic communities targeted by public health initiatives. These are:

- Six-monthly reports for the period: 1 January 2012 to 30 June 2012 (2012 Baseline Report data)
- Six-monthly reports for the period: 1 January 2013 to 30 June 2013, (2013 Progress Report data).

A data request was sent to all service providers asking them to report back on all initiatives completed over the periods outlined. This request sought:

- A brief description of the initiative
- Whether the initiative was targeted at a specific census area unit, territorial authority or all of New Zealand
- The specific census area unit or territorial authority targeted (one or more)
- The deprivation index for the targeted area
- Whether the community targeted was Māori
- Whether the initiative was community action-based
- The purchase unit from the service specification that the initiative best related to.

Responses from service providers were aggregated, cleansed for consistency and analysed by socioeconomic status and the community targeted. Prior period (2012) figures have been adjusted where necessary in Figure 1.5a.

Note: for the 2012 period, all providers submitted completed templates. However, six service providers out of 24 did not submit their data set for the 2013 period.

Definitions

- **A low socioeconomic community** is a community of decile 8, 9 and 10 on the NZDep2006 deprivation scale. The NZDep2006 scale of deprivation is prepared by the University of Otago and divides New Zealand into tenths based on nine variables from the 2006 census. A decile of 10 indicates that the community is in the most deprived 10 percent of areas in New Zealand and a decile of 1 indicates that the community is in the least deprived 10 percent of areas.
- **Range** is measured for this outcome indicator by differences in the socioeconomic scale.
- A **public health initiative** can be defined as any initiative that fits within the public health service specifications that form part of each problem gambling service provider's contract with the Ministry.
- A **community** refers to the territorial authority or census area unit targeted by an initiative.
- A **census area unit** is one of the 1,770 geographic areas (commonly suburbs) as defined within the Census and NZDep2006 index.

Current state of the indicator

In 2012, service providers reported that 371 initiatives were completed and that 678 initiative events were held. Most initiatives targeted more than one community. Common examples were initiatives that targeted all territorial authorities within a region or initiatives that targeted several neighbouring census area units. This observation also holds for the 2013 period, where the majority of initiatives (there were 949 different initiatives and 1,319 initiative events) targeted a number of communities or territorial authorities.

Review of problem gambling provider reports for the range of low socioeconomic communities targeted by public health initiatives (cont.)

Figure 1.5a (below) illustrates that between 2012 and 2013 there was:

a. A substantial decrease (57% to 43%) in the proportion of territorial authorities targeted by public health initiatives.

b. A substantial increase (40% to 51%) in the proportion of communities targeted by public health initiatives.

Figure 1.5a: Spread of public health initiative events by territory, 2012 (n=678) and 2013 (n=1,319)

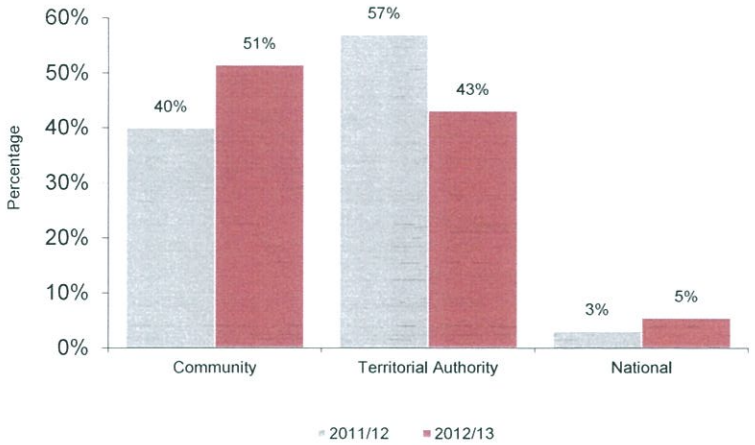


Figure 1.5b (opposite), illustrates the socioeconomic range of communities targeted by public health initiatives, for 2012 and 2013. Results of analysis show:

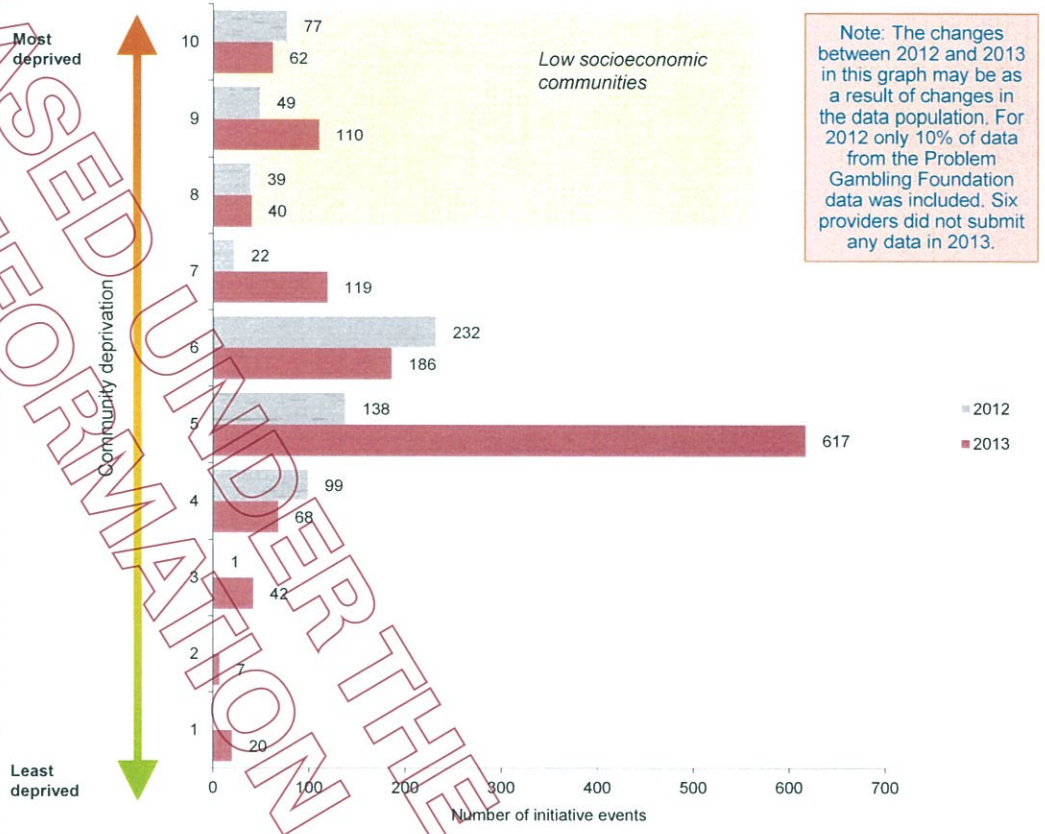
a. A decline in the percentage of public health initiative events targeted towards **low socioeconomic** communities (deprivation scores of 8 to 10), from 25.1% in 2012 to 16.7% in 2013.

b. An increase in the percentage of public health initiative events targeted towards **medium socioeconomic** communities (communities with a deprivation score between 4 and 7), from 74.7% in 2012 to 77.9% in 2013.

c. A small increase in the percentage of public health initiative events targeted towards **high socioeconomic** communities (communities with a deprivation score between 1 and 3), from 0.2% in 2012 to 5.4% in 2013.

NOTE: the actual number for initiative events targeted at low socioeconomic communities increased from 165 in 2012 to 212 in 2013.

Figure 1.5b: Range of socioeconomic communities or territorial authorities targeted, 2012 (n=678) and 2013 (n=1,319)



Note: The changes between 2012 and 2013 in this graph may be as a result of changes in the data population. For 2012 only 10% of data from the Problem Gambling Foundation data was included. Six providers did not submit any data in 2013.

NOTE: Initiatives that indicated they were targeted at a national level or had an invalid DPI score are excluded from this analysis.

Review of problem gambling provider reports for the range of low socioeconomic communities targeted by public health initiatives (cont.)

Limitations and areas for improvement

This analysis only covers two six month periods i.e. 1 January 2012 to 30 June 2012 and 1 January 2013 to 30 June 2013. Analysis of a full year may provide a more complete view of progress towards this outcome.

Service providers were asked to make an assessment of the community targeted and record their best estimate. This required judgement in determining whether an initiative targeted a wide area such as a territorial authority or specific communities within that territorial authority.

The NZDep2006 data has been analysed at a census area unit level. A census area unit is approximately equivalent in size to a suburb. Consequently, initiatives targeting part of a census area unit (perhaps part that is low socioeconomic amongst a high socioeconomic area) will not be recorded as a low socioeconomic community in this analysis.

The 2012 period (1 January 2012 to 30 June 2012) analysis includes a sample of approximately 10% of the initiatives completed by the Problem Gambling Foundation. This was the first time that detailed data was collected on public health initiatives by service providers. Previously service providers have not been required to collect this information. The Problem Gambling Foundation maintains a database for recording public health initiatives but this did not record the same information required by this outcome indicator. Due to time and resourcing constraints, it was agreed to collect this information for 10% of initiatives. The Problem Gambling Foundation is funded for the largest amount of public health FTE. This limitation is not present for the data which covers the 2013 period (1 January 2013 to 30 June 2013).

This outcome indicator is subject to a degree of bias in that service providers are most likely to deliver public health initiatives within the region that they are located. This influences the geographical spread of initiatives and also the socioeconomic communities targeted. The Ministry contracts service providers in the areas of highest need.

For the 2013 data set (period between 1 January 2013 and 30 June 2013), six service providers did not submit data to the Ministry of Health.

For further information

Refer Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

KPMG
cutting through complexity

Objective 2

Māori families are supported to achieve their maximum health and well-being through minimising the negative impacts of gambling

Analysis and presentation of outcome indicators for objective 2		Previous measurement point
2.1	Analysis of New Zealand Health Survey data for trends indicating (in)equitable gambling and problem gambling prevalence for Māori	2011/12 Baseline Report
2.2	Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends for Māori	This Report
2.3	Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable prevalence of gambling participation and opportunities in Māori and low socioeconomic communities with high Māori populations	This Report
2.4	Analysis of the proportion of charitable trust gambling grants allocated to Māori communities and organisations	2011/12 Baseline Report
2.5	Review of problem gambling provider reports for the range and number of Māori communities targeted by public health initiatives	This Report
2.6	Review of the number and quality of opportunities for Māori to provide advice into Ministry processes around problem gambling activities	2011/12 Baseline Report
2.7	Analysis of periodic cultural audits to identify levels of cultural responsiveness of general and Māori intervention and public health services	2011/12 Baseline Report
2.8	Analysis of client data for trends in Māori specific presentations compared to New Zealand Health Survey prevalence data	2011/12 Baseline Report

Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends for Māori

Summary findings

- The presentation rate for Māori (9.4%) is slightly higher than Non-Māori (8.7%) for 2012/13.
- Māori moderate-risk and problem gamblers service utilisation is similar for females and males.
- Service effectiveness (measured through the PGSI and gambler control outcome score) was similar for Māori and Non-Māori.

NA	Unable to assess trend	The trend cannot be assessed as the approach has changed. 2011/12 information is not presented. Refer explanation at the start of the "Current state of the indicator section".
H	Confidence in the data	Confidence in the 2012/13 NGS data is high.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 2.2 analyses problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness for Māori for the 2012/13 Progress reporting period.

Data for outcome indicator 2.2 was obtained from two sources:

- Data on presentations, service utilisation and effectiveness was obtained from the Ministry's CLIC database. The CLIC database is used to record data on people attending problem gambling services.
- Data on the prevalence of problem gambling for the 2012/13 Progress Report was obtained from the NGS 2012.

The data collection period for this outcome indicator is 1 July 2012 to 30 June 2013 (2012/13 Progress Report).

Data was analysed by gender, ethnicity and age for each of the measures discussed on the following pages. All analysis in this indicator is completed for gamblers only. Presentations or service usage by family members/affected others are excluded from this analysis.

Definitions

Presentations measures the number of unique service-users (i.e. only counting each service-user once) receiving a session (brief, full, facilitation or follow-up) at a problem gambling provider.

The presentation rate divides the number of presentations to problem gambling services in a year for a population group by the prevalence of problem and moderate risk gamblers for the same population group. For the purpose of illustration, presentation rates for brief and non-brief (full, facilitation and follow up) presentations are displayed separately in Figures throughout this indicator. The presentation rate provides a measure of how many of those at risk of gambling harm engage with services.

(In)equitable presentation occurs when one population group has a presentation rate different to other population groups.

Service utilisation measures the number of sessions delivered by problem gambling service providers in a year for each population group.

(In)equitable service utilisation occurs when service utilisation for one population group occurs at a rate different to the prevalence for the same population group.

Effectiveness is measured by movements in a service-user's level of gambling harm (as measured by the PGSI), dollars spent on gambling and control over gambling measures as assessed in an intervention session compared with original scores recorded.

(In)equitable effectiveness occurs when measures of effectiveness for one population group are different than those for other population groups.

Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends for Māori (cont.)

Current state of the indicator

The approach used to generate this 2012/13 data is different to the approach that was used to generate the 2011/12 data. As there are differences in the basis of information presented in this outcome indicator, the 2011/12 data is not presented within this outcome indicator to limit the likelihood of any inaccurate conclusions being drawn from the information shown. We have purposefully not presented the 2011/12 information on advice from the Advisory Group. The approach changes are:

- Data for the prevalence of problem gambling was obtained from the NGS 2012 for the 2012/13 Progress Report instead of the NZHS 2011/12. The prevalence rates reported by this study are different to those reported by the NZHS 2011/12. The NGS 2012 was used because the study is more current and more specific to gambling. This decision was made by the Ministry of Health.
- Presentation rates within the 2011/12 Baseline Report focused on "brief sessions" vs. "full sessions". In the 2012/13 Progress Report the presentation rates show "brief sessions" vs. "non-brief sessions", where non-brief sessions include full sessions, as well as facilitation and follow-up sessions. This change was made because facilitation and follow-up sessions are part of the client pathways and pattern of care. This is unlikely to have a significant effect when counting the number of presenting clients as most clients who have a facilitation or follow-up will have also had a full intervention and would have been included in the data. This will, however, have an effect when assessing service utilisation where the number of individual sessions are counted.

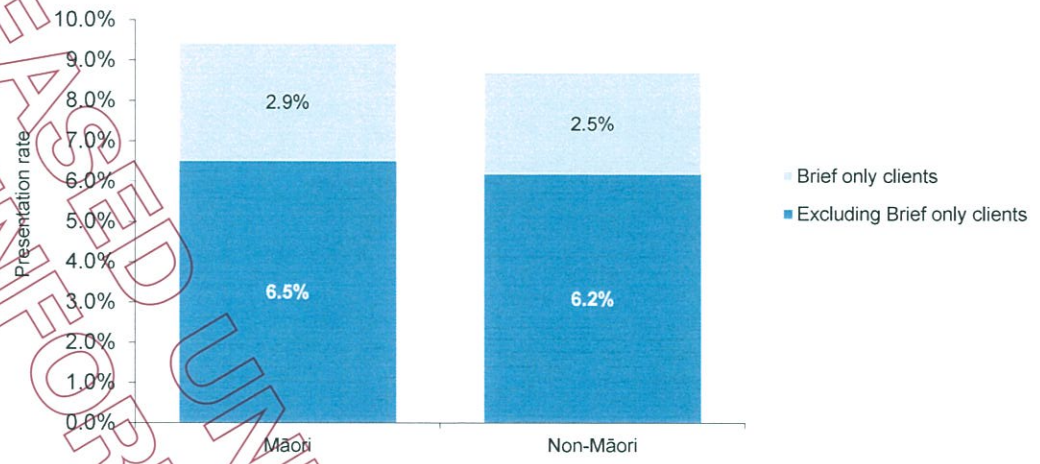
(In)equitable presentation

Figure 2.2a (opposite) shows the presentation rate to problem gambling services for males and females and compares Māori with Non-Māori. This analysis only includes gamblers that present to services. Presentations by family members/affected others are excluded from this analysis.

Key finding:

a. The presentation rate for Māori (9.4%) is slightly higher than for Non-Māori (8.7%) for 2012/13. This analysis only includes gamblers that present to services. Presentations by family members/affected others are excluded from this analysis.

Figure 2.2a: Presentation rate comparison Māori and Non-Māori (non age and gender standardised), 2012/13 (n=6,919 sessions, n=77,584 at-risk gamblers)

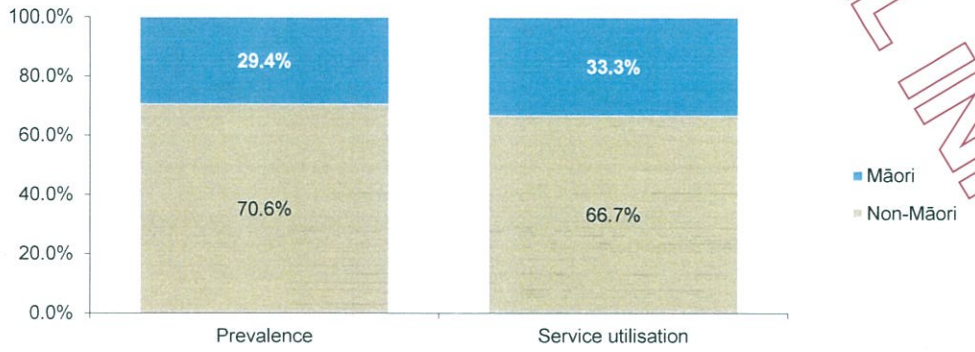


Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends for Māori (cont.)

(In)equitable presentation and service utilisation

Figure 2.2b (below) compares service utilisation and prevalence for Māori and Non-Māori without also considering gender. This analysis shows that 29.4% of moderate-risk and problem gamblers are Māori, and 33.3% of the intervention services delivered were to Māori.

Figure 2.2b: Service utilisation (n=33,055) by ethnicity compared with prevalence (n=77,584) (non age and gender standardised), 2012/13



Figures 2.2c (opposite top) and 2.2d (opposite bottom) compare service utilisation and prevalence for Māori and Non-Māori males and females. This presents a similar message to the presentation rate analysis discussed previously but differs in that service utilisation measures all intervention sessions (including the same service-user attending on multiple occasions), whereas presentations focuses on unique service-users receiving an intervention session. As with the analysis of presentations, this only includes service utilisation by gamblers, service utilisation by family members or affected others is excluded. The key findings are:

a. Māori prevalence is 2.7% higher for females (16.2%) compared to males (13.5%).

b. Māori moderate-risk and problem gamblers service utilisation is similar for females and males.

Figure 2.2c: Service utilisation (n=33,055) by ethnicity and gender compared with prevalence (n=77,584) (non age standardised) – males, 2012/13

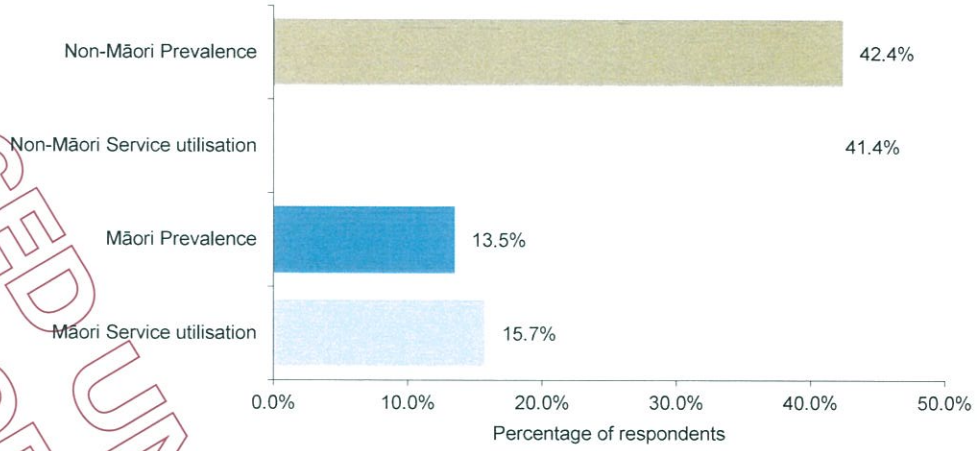
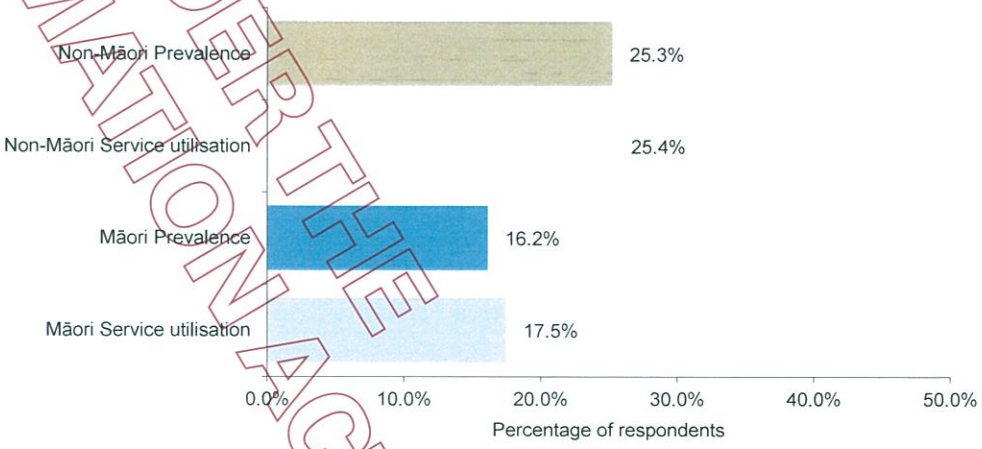


Figure 2.2d: Service utilisation (n=33,055) by ethnicity and gender compared with prevalence (n=77,584) (non age standardised) – females, 2012/13



Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends for Māori (cont.)

(In)equitable effectiveness

During brief and full intervention sessions, clinicians apply a series of screens to assess the severity of a service-user's gambling harm. Effectiveness can be assessed by comparing the scores recorded in an initial session to those recorded in subsequent sessions. Inequity can be measured by comparing effectiveness results across demographic groups.

Service providers are required to complete screens to assess a service-user's gambling harm and record these in client notes, but are not required to record these in the CLIC database.

In addition, the analysis of effectiveness only includes service-users who had at least two full sessions and excludes any 'affected others' that are seeking help in respect of problems associated with someone else's gambling. Consequently, the number of service-users for which analysis of effectiveness can be completed is lower than the total number of service-users.

The CLIC database includes 1,536 service-users that had an initial and subsequent PGSI score assessment completed (447 of which were Māori). Where these service-users also attended services in years prior to 2012/13, data from their first session was used to determine their initial score.

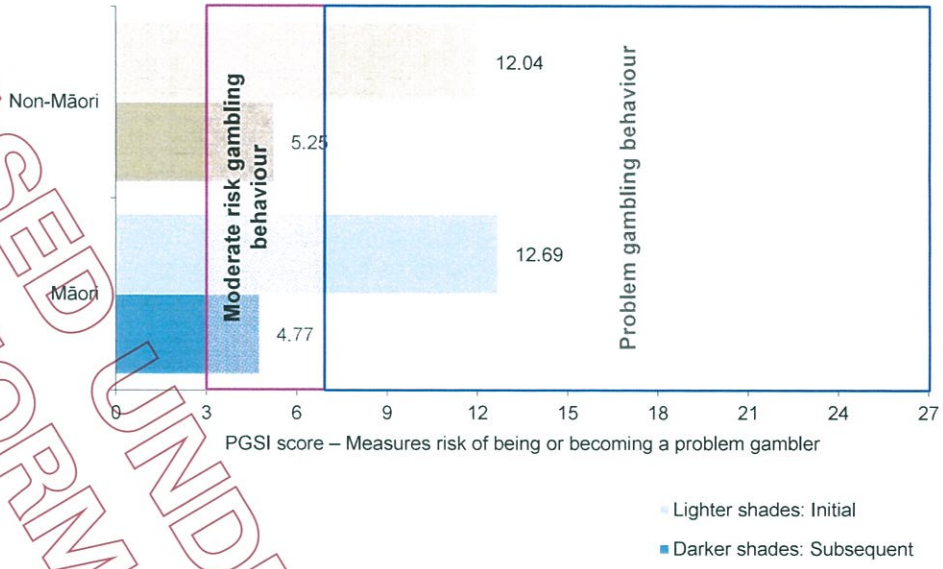
The highest possible score on the PGSI is 27 and is calculated based on the responses provided to nine questions each with a score of between zero and three based on the frequency the service-user reports specific gambling behaviours.

As illustrated in Figure 2.2e, the average PGSI score for Māori service-users reduced from 12.7 to 4.7 between the initial and subsequent sessions compared with Non-Māori where the PGSI score reduced from 12.0 to 5.3. This shows the services were marginally more effective for Māori when compared to Non-Māori, a PGSI score change of 7.9 compared with a score change of 6.8 respectively.

Scores of between 3 and 7 are considered to be indicators of moderate risk gambling behaviour and scores of greater than seven are indicators of problem gambling behaviour.

Note: There was very little difference between the PGSI scores in 2011/12 and 2012/13. Prevalence is not used to assess PGSI scores, therefore a comparison to 2011/12 is relevant. Refer to the Baseline report for the 2011/12 data.

Figure 2.2e: PGSI scores from initial and subsequent sessions Māori compared with Non-Māori, 2012/13, (n=1,536)



Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends for Māori (cont.)

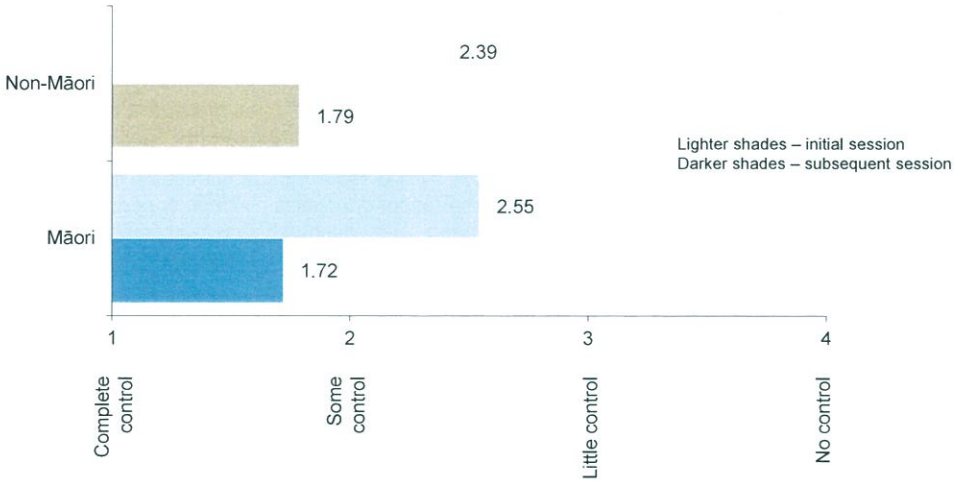
Figure 2.2f (below) compares the gambler outcome-control scores from the earliest and latest sessions attended by service-users in 2012/13. The gambler outcome-controls score asks service-users to select the most appropriate of four statements below and they are allocated the corresponding score of between 1 and 4.

1. I have had complete control over my gambling
2. I have had some control over my gambling
3. I have had little control over my gambling
4. I have had no control over my gambling.

The CLIC database includes 1,130 service-users that attended more than one full intervention session and had an initial and subsequent outcome-control score assessment completed (of which 379 were Māori). This analysis shows that the average gambler control score for Māori reduced from 2.55 to 1.72 between the earliest and latest sessions. This change is marginally more than the Non-Māori score change.

Note: There was very little difference between the gambler outcome-control scores in 2011/12 and 2012/13. Prevalence is not used to calculate this score, therefore a comparison to 2011/12 is relevant. Refer to the Baseline report for the 2011/12 data.

Figure 2.2f: Initial and subsequent gambler outcome-control scores for Māori compared with Non-Māori, 2012/13, (n=1,130)



Limitations and areas for improvement

The approach used to generate the 2012/13 data is different to the approach that was used to generate the 2011/12 data. This change is explained at the start of the "Current state of the indicator" section for this outcome indicator.

The measures of effectiveness require service-users to attend multiple sessions and have the effectiveness measures recorded in the CLIC database. This creates a limitation in that people who do not consider services are beneficial may not attend multiple sessions and will therefore be excluded from this analysis. This analysis only provides a snapshot of intervention data over the reporting periods.

Our analysis is also not adjusted for the age of different population groups (commonly referred to as age standardisation). Differences between the measures of effectiveness for males and females may be due to differences in the age structure of females compared with males.

NGS estimates the prevalence of problem gambling for each ethnic group based on the number of problem gamblers in each ethnic group identified within the survey. This is subject to a margin of error.

Ethnicity data for this outcome indicator is not standardised for differences in the age or gender of each of the ethnic groups. Differences in the age and gender make-up of each group may have an impact on the estimated number of problem gamblers and the rate of presentations and service utilisation.

The PGSI tool used for measuring gambling harm, although not validated in New Zealand, has been tested extensively. Initial research by Clarke et al, (2012); and Devlin and Walton (2012), concluded that the PGSI works well in measuring problem gambling in men, women, Māori, Pacific and Asian adults.

The measures of dollars spent on gambling are in response to the question:
'In the last month when you were gambling, roughly what amount of money did you spend on gambling?'.

Clinicians are encouraged to ensure that this only includes dollars lost on gambling (i.e. money taken to gamble with plus any additional money obtained and ignoring any money won). Responses are subjective and therefore the analysis should be treated with caution.

For further information

Refer Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable gambling participation and opportunities in Māori and low socioeconomic communities with high Māori populations

Summary findings

- Gambling participation and opportunities remain (in)equitable in communities with higher than average Māori populations compared to communities without higher than average Māori populations.
- Opportunities to gamble and participation in gambling are very similar to 2011/12. For each of the metrics reported, the range of change from 2011/12 to 2012/13 was between -3.1% and +3.9%.
- Gambling participation and opportunities are also slightly less (in)equitable in low socioeconomic communities with higher than average Māori populations compared to 2011/12.

→	No trend	Overall, (in)equitable gambling participation and opportunities have not changed significantly for communities with higher than average Māori populations, or low socioeconomic communities with higher than average Māori populations.
H	Confidence in the data	Confidence in 2011/12 and 2012/13 data is high.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 2.3 analyses Class 4 revenue data against census data on the Māori population in communities and the New Zealand deprivation index (NZDep2013) across two periods: 1 July 2011 to 30 June 2012 (2011/12 Baseline Report data), and 1 July 2012 to 30 June 2013 (2012/13 Progress Report data).

Data for outcome indicator 2.3 was obtained from the DIA EMS for Class 4 gambling. The DIA requires all gaming machines in pubs and clubs to be connected to EMS. The EMS obtains accurate and timely information about gaming machine usage. The information provided by the EMS includes:

- The amount of money gambled on gaming machines
- The location and number of machines
- Other technical data on machine faults and the amount due to be banked (not analysed for this outcome indicator).

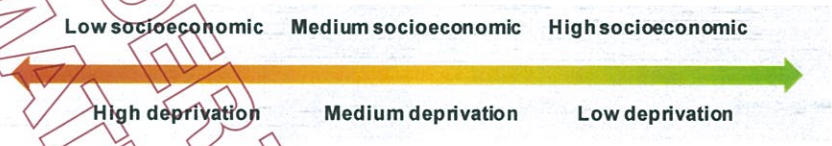
Full detail on the approach to analysis is set out in outcome indicator 1.3.

Definitions

- **Class 4 gambling** refers to gambling on EGMs outside of a Casino, commonly in a club/pub.
- **Gambling participation** is defined as the expenditure on Class 4 gambling as measured by the EMS.
- **Gambling opportunities** are measured by the number of Class 4 venues and Class 4 EGMs compared with the adult population.
- **A low socioeconomic community** is a community of decile 8, 9 and 10 on the NZDep2013 deprivation scale. The NZDep2013 scale of deprivation is prepared by the University of Otago and divides New Zealand into tenths based on nine variables from the 2013 census. A score of 10 indicates that the community is in the most deprived 10 per cent of areas in New Zealand and a score of 1 indicates that the community is in the least deprived 10 percent of areas.
- **A medium socioeconomic community** is a community of decile 4, 5, 6 or 7 on the NZDep2013 deprivation scale.
- **A high socioeconomic community** is a community of decile 1, 2 or 3 on the NZDep2013 deprivation scale.
- **Communities with high Māori populations** are defined for the purposes of this outcome indicator as a meshblock (smallest geographical measure collected by the census) with greater than the census average of Māori, that is equal to or greater than 12.4%.

Figure 2.3a (below) presents the three categories of socioeconomic status and their relationship to deprivation. High deprivation areas are equivalent to low socioeconomic areas and vice versa.

Figure 2.3a: The deprivation continuum



The 2011/12 baseline data has been revised to correct errors that were identified in the data when this progress report was being developed.

Current state of the indicator

The analysis of participation and opportunities for gambling is based on the population aged 20 years and over as recorded in the 2013 census (approximately 3.1 million adults). This outcome indicator analyses gambling participation and opportunities in communities with high Māori populations, with further analysis into gambling participation and opportunities in communities with high Māori populations that also meet the definition of low socioeconomic.

The adult population recorded as living in communities with high Māori populations is approximately 232,000, or 8% of the total adult population. Of this population, 169,000 (or 73%) were recorded as living in low socioeconomic communities with high Māori populations.

Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable gambling participation and opportunities in Māori and low socioeconomic communities with high Māori populations (Cont.)

Gambling participation (measured through spend)

Figure 2.3b (opposite top) compares the spend on Class 4 gambling per person, per annum in communities with high Māori populations (defined on the previous page) with communities that do not have high Māori populations, for 2011/12 and 2012/13. The analysis in Figure 2.3b shows:

- (In)equitable participation in gambling in high Māori populations:
  - 2011/12 data showed that the average spend per person on Class 4 gambling per annum in communities with high Māori populations was 965% greater than communities that did not have high Māori populations.
  - 2012/13 data shows that inequity has increased slightly. Average spend per person on Class 4 gambling per annum in communities with high Māori populations is 976% greater than that of communities without high Māori populations.

This outcome indicator further analyses the spend per person in communities with high Māori populations by socioeconomic status. A comparison of 2011/12 and 2012/13 data (refer Figure 2.3c, opposite bottom) shows:

- (In)equitable participation in gambling in low socioeconomic communities with high Māori populations:
  - 2011/12 showed that spending per person in low socioeconomic communities with high Māori populations was 700% greater than high socioeconomic communities with high Māori populations.
  - 2012/13 shows that inequity has declined slightly with the average spend per person per annum in low socioeconomic communities with high Māori populations now being 659% greater than spending per person in high socioeconomic communities with high Māori populations.

Figure 2.3b: Gambling spend per person in gambling in communities with higher than average Māori populations compared to communities without high Māori populations, 2011/12 vs. 2012/13

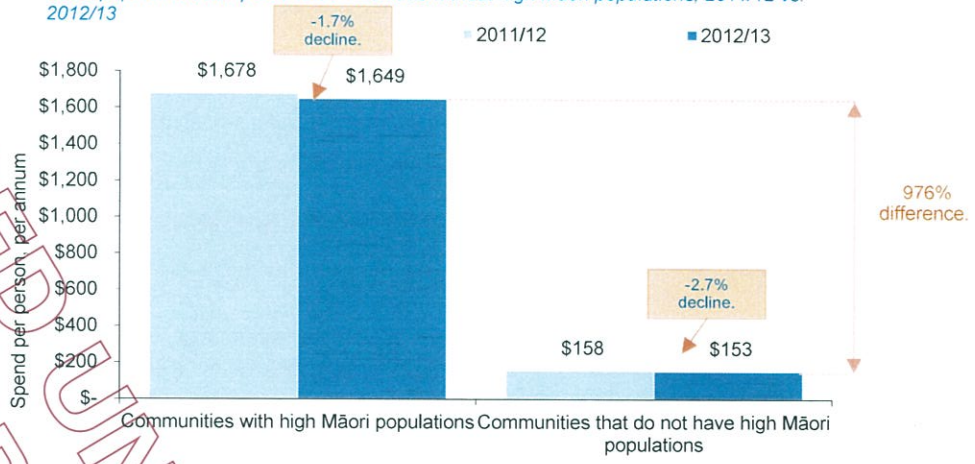
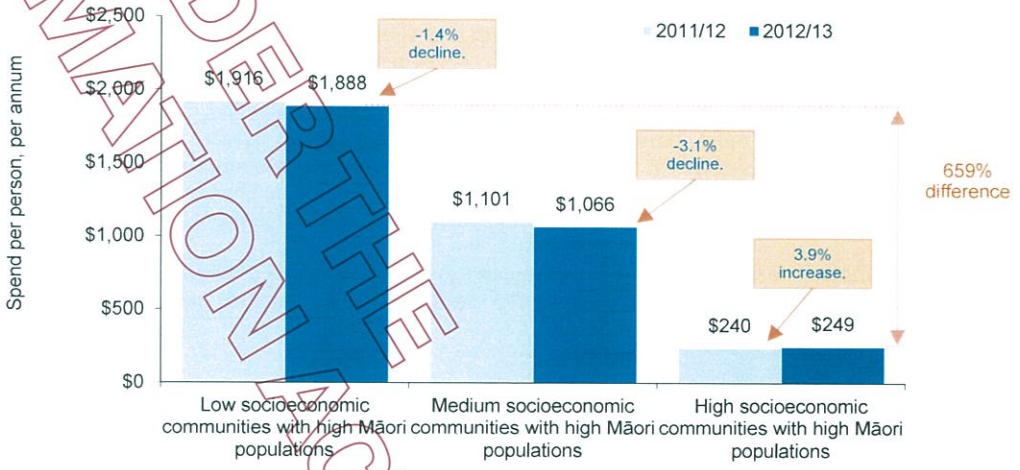


Figure 2.3c: Comparison of gambling spend per person in communities with higher than average Māori populations by socioeconomic status. 2011/12 vs. 2012/13



Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable gambling participation and opportunities in Māori and low socioeconomic communities with high Māori populations (Cont.)

Gambling opportunities

Figure 2.3d (opposite top) compares the number of gambling venues in communities with higher than average Māori populations, with communities that do not have higher than average Māori populations, for 2011/12 and 2012/13. The analysis in Figure 2.3d shows:

a. (In)equitable gambling opportunities, in terms of venue numbers per 10,000 people, in communities with higher than average Māori populations:
   - 2011/12 showed that venue numbers per 10,000 people in communities with higher than average Māori populations, was 891% greater than venue numbers per 10,000 people in communities without high Māori populations.
   - 2012/13 shows that this inequity has increased slightly to 903%.

Figure 2.3e (opposite bottom) shows similar inequity in terms of EGMs per 10,000 adults in communities with higher than average Māori populations:

a. 2011/12 showed that EGMs per 10,000 people in communities with higher than average Māori populations, was 996% greater than venue numbers per 10,000 people in high socioeconomic communities without high Māori populations.
b. 2012/13 shows that this inequity has increased to 1002%.

Figure 2.3d: Gambling venue numbers per 10,000 people in communities with higher than average Māori populations, compared to communities without high Māori populations, 2011/12 vs. 2012/13

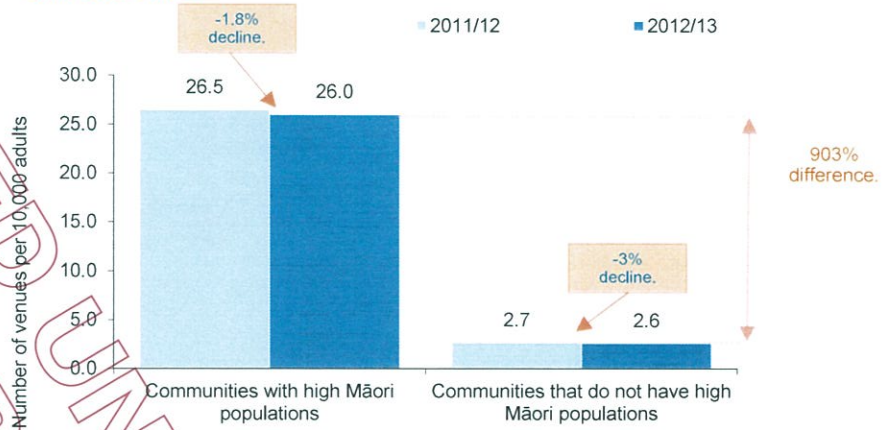


Figure 2.3e: Electronic Gaming Machine numbers per 10,000 adults in communities with higher than average Māori populations, compared to communities without high Māori populations, 2011/12 vs. 2012/13

Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable gambling participation and opportunities in Māori and low socioeconomic communities with high Māori populations (Cont.)

Gambling opportunities (Cont.)

Figure 2.3f (opposite top) compares the number of gambling venues per 10,000 adults in low, medium and high socioeconomic communities with higher than average Māori populations, for 2011/12 and 2012/13. The analysis in Figure 2.3f shows:

a. (In)equitable gambling opportunities, in terms of venue numbers per 10,000 people, in low socioeconomic communities with higher than average Māori populations:
   - 2011/12 showed that proportionate venue numbers per 10,000 adults in low socioeconomic communities with higher than average Māori populations, was 160% greater than venue numbers per 10,000 people in high socioeconomic communities.
   - 2012/13 shows that inequity between low and high socioeconomic communities with higher than average Māori populations has decreased slightly to 156%.

Similarly, Figure 2.3g (opposite bottom) shows slightly decreasing inequity in terms of EGMs per 10,000 adults in low socioeconomic communities with higher than average Māori populations:

a. 2011/12 showed that EGMs per 10,000 adults in low socioeconomic communities with higher than average Māori populations, was 284% greater than venue numbers per 10,000 people in high socioeconomic communities, with higher than average Māori populations.

b. 2012/13 shows that this inequity has decreased slightly (278% difference).

Figure 2.3f: Venues per 10,000 adults in low, medium and high socioeconomic communities with higher than average Māori populations, 2011/12 vs. 2012/13

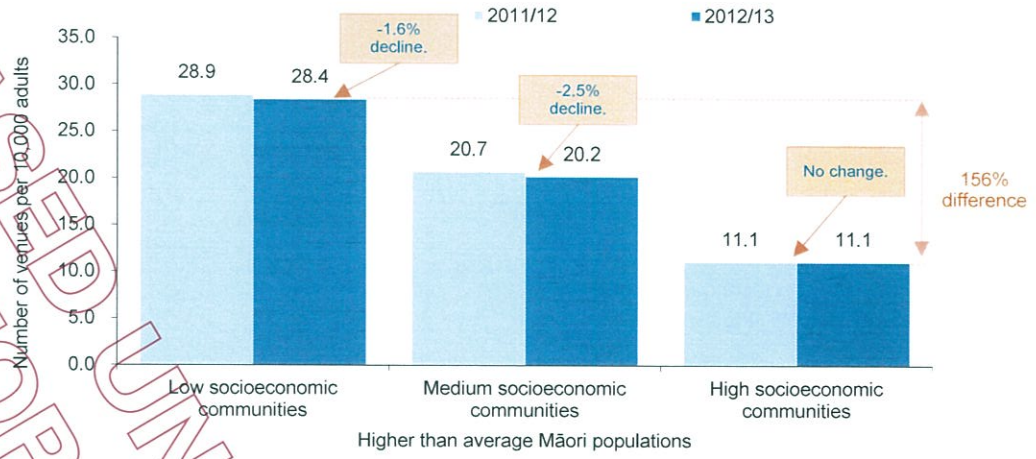
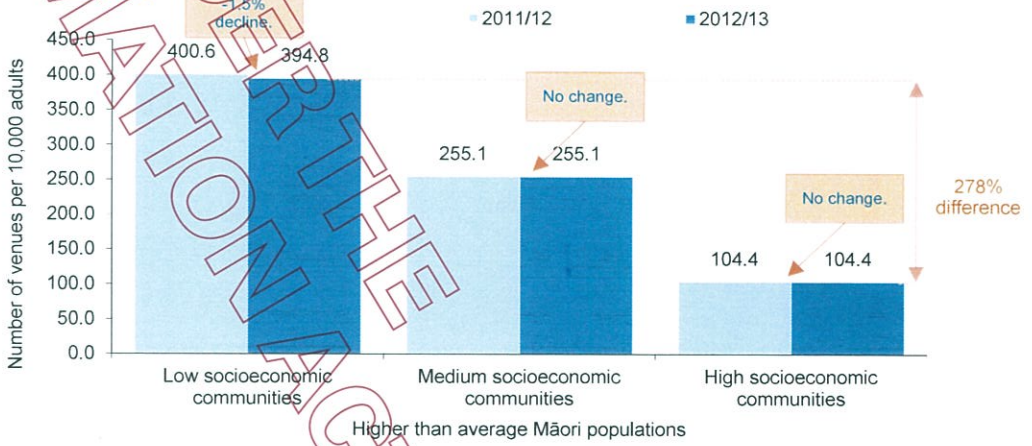


Figure 2.3g: Electronic Gaming Machines per 10,000 people in low, medium and high socioeconomic communities with higher than average Māori populations, 2011/12 vs. 2012/13



Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable gambling participation and opportunities in Māori and low socioeconomic communities with high Māori populations (Cont.)

Limitations

This analysis is restricted to Class 4 gambling and does not include other forms of gambling, including Casino, Lotteries and NZ Racing Board gambling.

The geographical analysis is based on the assumption that people gamble near where they live, rather than travelling to visit a gambling venue. A 200 metre buffer has been applied (refer Figure 1.3a). This buffer has the effect of increasing the ratio of gambling venues, EGMs and spend per adult. In the example described in Figure 1.3a (page 27), the three venues illustrated would be counted in each of the three meshblocks. This buffer has the effect of providing a more realistic measure of gambling participation and opportunities but has the unintended effect of increasing the ratio of gambling venues, EGMs and spend per adult. The focus should therefore be on the size of the difference between each of the measures rather than the values.

This analysis for 2011/12 and 2012/13 uses information from Census2013 and NZDep13. While the census and NZDep are for 2013, which is after the 2011/12 reporting period, we believe that this data provides a more accurate reflection of the demographic profile than Census2006 and NZDep2006.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

Review of problem gambling provider reports for the range and number of Māori communities targeted by public health initiatives

Summary findings

- The total number of public health initiatives for both Māori and Non-Māori increased (2012 – 371, 2013 – 949) and the proportion of initiative events targeting low-socioeconomic Māori communities increased (2012 – 33%, 2013 – 36%). However, the proportion of initiative events targeting Māori decreased. Overall, the number of public health initiative events for Māori increased.

↑	Improving trend	The number of public health initiatives for Māori is increasing (as is the number for Non-Māori). Additionally, the number of initiatives targeting low-socioeconomic Māori communities is increasing.
L	Confidence in the data	Low confidence in data because: ▪ There is judgement in the collection approach ▪ The data sets for 2011/12 and 2012/13 are not complete ▪ The data was only collected for six months of each year assessed.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 2.5 reviews the range and number of public health initiatives and compares 1 January 2012 to 30 June 2012 (2012 Baseline Report) and 1 January 2013 to 30 June 2013 (2013 Progress Report) data to understand if there has been any change in the range and number of Māori communities targeted.

All service providers contracted to prevent and minimise harm from gambling submit reports to the Ministry of Health on a six-monthly basis. Service providers that are contracted to deliver public health initiatives include a narrative description of the focus of public health activities over the reporting period and a description of public health initiatives completed. This report does not capture whether communities targeted were Māori in a format that can be analysed.

Outcome indicator 2.5 uses two reporting periods to assess the range of low socioeconomic communities targeted by public health initiatives. These are:

- Six-monthly reports for the period: 1 January 2012 to 30 June 2012 (2012 Baseline Report data)
- Six-monthly reports for the period: 1 January 2013 to 30 June 2013 (2013 Progress Report data).

A data request was sent to all service providers asking them to report back on all initiatives completed over the periods outlined. The full detail of the data request is provided as part of outcome indicator 1.5. The components of the request which are relevant to this indicator included:

- The socioeconomic deprivation score
- Whether the community targeted was Māori.

Responses from service providers were aggregated, cleansed for consistency and analysed to determine the socioeconomic status and whether the community was Māori.

Note: for the 2012 period, all providers submitted completed templates. However, six service providers out of 24 did not submit their data set for the 2013 period.

Definitions

- **A low socioeconomic community** is a community of decile 8, 9 and 10 on the NZDep2006 deprivation scale. The NZDep2006 scale of deprivation is prepared by the University of Otago and divides New Zealand into tenths based on nine variables from the 2006 census. A decile of 10 indicates that the community is in the most deprived 10 percent of areas in New Zealand and a decile of 1 indicates that the community is in the least deprived 10 percent of areas.
- A **Māori community** was defined in two ways:
  1. Whether the community targeted had a greater proportion of Māori than the census average, or
  2. Service providers could self-identify a community as Māori. This was considered important in circumstances where an initiatives targeted a specific area e.g. a Marae within a community that did not meet the population-based definition above.
- **Range** is measured for this outcome indicator by differences in the socioeconomic scale and whether the community was Māori or not.
- A **public health initiative** can be defined as any initiative that fits within the public health service specifications that form part of each provider's contract with the Ministry.
- A **community** is one of the 1,770 geographic areas (commonly called suburbs) as defined within the NZDep2006 index.

Review of problem gambling provider reports for the range and number of Māori communities targeted by public health initiatives (cont.)

Current state of the indicator

Service providers reported that 371 different initiatives were completed between 1 January 2012 and 30 June 2012 and that 678 initiative events were held. For the 2013 period, service providers reported 949 different initiatives, and 1,319 initiative events.

Figure 2.5a shows that 52% of communities or territorial authorities targeted by service providers were Māori during 2012. The percentage of communities or territorial authorities targeted by Māori service providers decreased to 34% in 2013. This decrease is due to a proportionally large increase in the total number of communities targeted that were Non-Māori as described below.

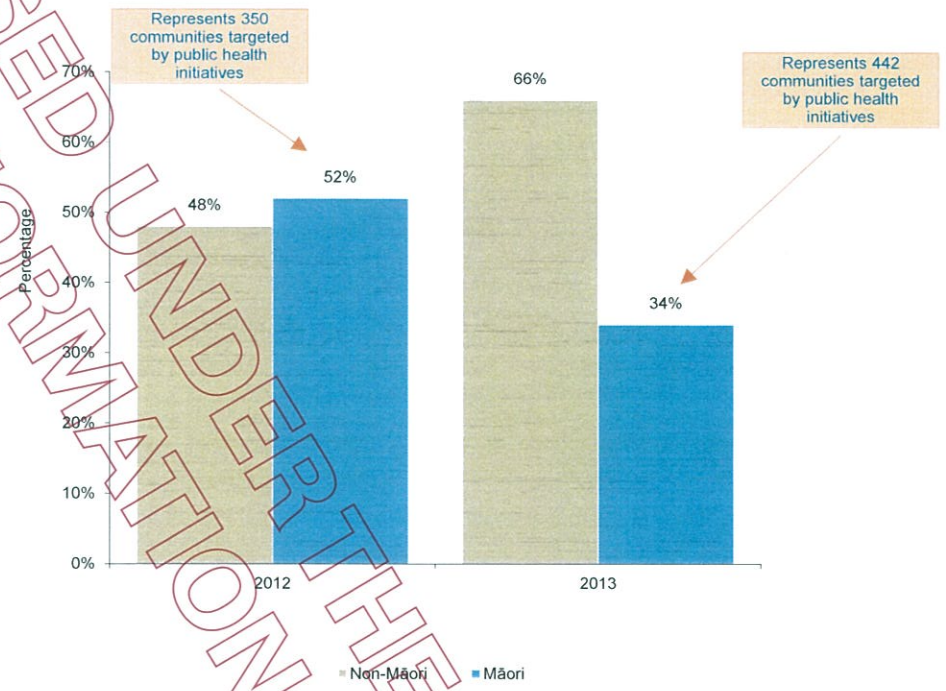
For the 2012 period, 350 Māori communities were targeted by service providers whereas 442 Māori communities were targeted in the 2013 period, an increase of 92 Māori communities.

The number of initiative events targeted towards Non-Māori communities increased at a greater rate than that for Māori communities in the 2013 period. For the 2013 period 876 Non-Māori communities were targeted by public health initiative events, an increase of approximately 185% from the 307 Non-Māori communities targeted in the 2012 period.

Note: initiatives that indicated that they were targeted at a national level are excluded from this analysis. There were 21 national initiatives in 2012 and 1 national initiative in 2013.

Note: Figure 2.5b has been rounded to the nearest whole number (e.g. 33.56% becomes 34%), therefore percentage calculations represented in graphs should be considered as approximations only.

Figure 2.5a: Proportion of communities or territorial authorities targeted that were Māori, 2012 (n=657) and 2013 (n=1,318)



Review of problem gambling provider reports for the range and number of Māori communities targeted by public health initiatives (cont.)

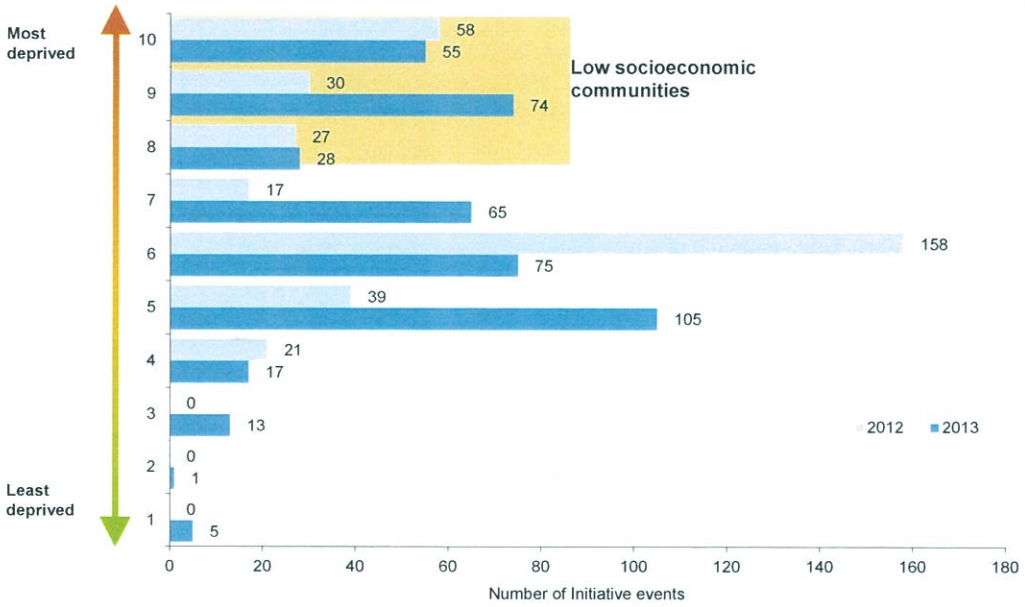
Figure 2.5b (below) shows the socioeconomic status of Māori communities targeted by public health initiatives. The key conclusions from this analysis are that:

a. For the 2012 period, most initiative events (82.9% or 290) targeted communities with a score of 6 or above on the deprivation index. In 2013 a lower percentage (67.8%) of initiative events targeted communities with a score of 6 or above on the deprivation index, however the number of initiative events delivered was similar (2013 - 297).

b. There was a small increase in the number of initiative events targeting low socioeconomic Māori communities, 32.9% of the initiative events were targeted at these communities in 2012 and 35.8% were targeted in 2013. The yellow shading highlights low-socioeconomic Māori communities (those with a deprivation score of 8 and above).

c. There has been an increase in the number of initiative events targeted toward Māori communities. There were 350 Māori targeted initiative events in the 2012 period and 438 Māori initiative events in the 2013 period (this population excludes one national Māori initiative* and three initiatives that did not have a valid deprivation index score recorded).

Figure 2.5b: socioeconomic status of Māori communities or territorial authorities targeted, 2012 (n=350) vs. 2013 (n=438)



* *The Māori national initiative was by Hapai Te Hauora Tapui Ltd for Māori Netball*

Limitations and areas for improvement

This analysis only covers two six month periods i.e. 1 January 2012 to 30 June 2012 and 1 January 2013 to 30 June 2013. Analysis of a full year may provide a more complete view of progress towards this outcome.

Service providers were asked to make an assessment of the community targeted and record their best estimate. This required judgement in determining whether an initiative targeted a wide area such as a territorial authority or specific communities within that territorial authority.

The NZDep2006 data has been analysed at a census area unit level. A census area unit is approximately equivalent in size to a suburb. Consequently, initiatives targeting part of a census area unit (perhaps part that is low socioeconomic amongst a high socioeconomic area) will not be recorded as a low socioeconomic community in this analysis.

The 2012 period (1 January 2012 to 30 June 2012) analysis includes a sample of approximately 10% of the initiatives completed by the Problem Gambling Foundation. This was the first time that detailed data was collected on public health initiatives by service providers. Previously service providers have not been required to collect this information. The Problem Gambling Foundation maintains a database for recording public health initiatives but this did not record the same information required by this outcome indicator. Due to time and resourcing constraints, it was agreed to collect this information for 10% of initiatives. The Problem Gambling Foundation is funded for the largest amount of public health FTE. This limitation is not present for the data which covers the 2013 period (1 January 2013 to 30 June 2013).

This outcome indicator is subject to a degree of bias in that service providers are most likely to deliver public health initiatives within the region that they are located. This influences the geographical spread of initiatives and also the socioeconomic communities targeted. The Ministry contracts service providers in the areas of highest need.

For the 2013 data set (period between 1 January 2013 and 30 June 2013), six service providers did not submit data to the Ministry of Health.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

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Objective 3

People participate in decision-making about local activities that prevent and minimise gambling harm in their communities

Analysis and presentation of outcome indicators for objective 3		Previous measurement point
3.1	Analysis of community awareness and concern indicators from the Ministry-funded Behaviour Change Survey	2011/12 Baseline Report
3.2	Periodic review of public health provider reports to the Ministry to assess the state of local communities and progress against community readiness assessments for community action and community policy implementation	2011/12 Baseline Report
3.3	Regional interest in and involvement with Ministry of Health Strategic Plan development, including the diversity of submissions	2011/12 Baseline Report
3.4	The number and diversity of submissions received by a sample of local government bodies in relation to gambling decision-making, including assessment of the level of input from low socioeconomic communities or representatives	2011/12 Baseline Report
3.5	The number of national agencies that actively screen and refer for problem gambling	This Report
3.6	Review of the number and quality of opportunities for Māori, Asian and Pacific representation in the Ministry of Health, National Problem Gambling Team and Department of Internal Affairs processes for decision-making in relation to problem gambling	2011/12 Baseline Report

The number of national agencies that actively screen and refer for problem gambling

Summary findings

- National agency referrals have increased by 35% since 2011/12. Significant increases in recorded referrals were identified for Oasis (456% increase), Asian Family Hotline (110% increase) and Department of Corrections – Probation Services (87% increase).
- The most common sources of referral were the Gambling Helpline and the Department of Corrections' Prison and Probation Services. The number of national agencies referring people was similar to 2011/12.

↑	Improving trend	The total number of referrals increased substantially and the number of referrals made by most national agencies increased.
H	Confidence in the data	No change since the Baseline Report.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 3.5 compares the number of national agencies that actively screen and refer for problem gambling across the 2011/12 (Baseline) and 2012/13 (Progress) reporting periods.

The two data collection periods are:

- 1 July 2011 – 30 June 2012 (2011/12 Baseline Report period)
- 1 July 2012 – 30 June 2013 (2012/13 Progress Report period).

Data was obtained from the Ministry's CLIC system for all service-users. The data was sorted to only include unique clients (i.e. clients were only counted once regardless of the number of times they attended services).

Definitions

Referrals between problem gambling service providers can occur when:

- Service-users are referred to a new provider because they have moved, or due to personal reasons decide to seek treatment from an alternative provider.
- Service providers make their initial contact with one provider who refers them to an alternative provider who services a particular region or offers dedicated services for a particular ethnicity.

Nearly one in four (24% or 2,990) unique service-users had a referral source recorded for 2012/13. This has increased from 2011/12 where 19% or 2,381 unique service-users had a referral source recorded. The list of referral sources was reviewed and an assessment was made as to whether the source could be considered to be a 'national agency'.

Two terms were defined as a basis for this analysis:

Informal referral occurs when a person is referred to a problem gambling service by someone they have a personal relationship with, for example, family, friend, employer.

Formal referral occurs when a client is referred to a problem gambling service by an external agency.

Current state of the indicator

For 2012/13 17% of service-users had a formal referral from a national agency recorded. The most common referrers were the Gambling Helpline, the Department of Corrections' Prison Service and the Department of Corrections' Probation Service.

12,432 unique service-users attended problem gambling services over this period. Of which:

- 2,990 recorded a formal referral source
- 2,116 of these were classified as national agencies.

Table 3.5a (below) presents the number of formal referrals from national agency for 2011/12 and 2012/13. The total formal referrals have increased by slightly more than 500. The number of referrals from most agencies have increased since 2011/12.

Table 3.5a: Number of formal referrals by national agency 2011/12 and 2012/13

Source of referral	Number of formal referrals 2011/12 period	Number of formal referrals 2012/13 period
Gambling Helpline	490	465
Department of Corrections - Probation	227	425
Department of Corrections - Prison	356	379
Asian Family Hotline	172	361
Oasis (Salvation Army)	34	189
Problem Gambling Foundation	193	184
Ministry of Justice - Court	8	56
Salvation Army (not problem gambling service)	0	11
Child Youth and Family	8	10
Other national agencies (less than 10 referrals each in 2012/13)	72	36
Total formal referrals	**1,560**	**2,116**

The number of national agencies that actively screen and refer for problem gambling (cont.)

Figure 3.5b (opposite) shows the number of formal referrals by national agency for the top six agencies in 2012/13 (by number of formal referrals). The national problem gambling service providers have a * next to the name.

The key findings are:

a. Total referrals from these agencies have increased by slightly more than 500.

b. The largest increase in number of recorded referrals was the Department of Corrections – Probation services (198 referrals increase), followed closely by the Asian Family Hotline (189 increase) and Oasis (155 increase).

c. In terms of percentage change, Oasis referrals increased by 456%, Asian Family Hotline referrals increased by 110% and the Department of Corrections – Probation services increased by 87%.

Limitations and areas for improvement

This analysis only includes agencies that have referred a service-user to a problem gambling service in 2011/12 or 2012/13 where the referral source was recorded in CLIC. It is possible other agencies have screened for problem gambling but not made a referral during the year or that a client was referred by an external agency, but did not make that known to their problem gambling practitioner.

An increase in the number of referrals between reporting periods may be the result of improved data capture, rather than more referrals occurring.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

Figure 3.5b: Number of referrals by national agency 2011/12 (n=1,472) and 2012/13 (n=2,003) (top six agencies by number of referrals)

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Objective 4

Healthy policy at the national, regional and local level prevents and minimises gambling harm

	Analysis and presentation of outcome indicators for objective 4	Previous measurement point
4.1	The number of government departments actively participating and collaborating with the Ministry of Health and the Department of Internal Affairs to reduce gambling-related harm	2011/12 Baseline Report
4.2	Analysis of government sector strategic documents (i.e., annual reports and statements of intent) for commitment to addressing gambling-related harm	2011/12 Baseline Report
4.3	Analysis of a six-yearly survey of the attitudes of local government councillors to awareness of problem gambling and perceptions of gambling-related harm	2011/12 Baseline Report
4.4	Analysis of a Ministry-funded Behaviour Change Survey on the attitudes of participants employed in decision-making roles in relation to problem gambling and perceptions of gambling-related harm (i.e., policy makers, gambling industry leaders, church leaders, school principals, kuia and kaumātua)	2011/12 Baseline Report
4.5	Review of the percentage of territorial local authority gambling venue policies that reflect an active awareness of the potential harms of gambling	2011/12 Baseline Report
4.6	Analysis of industry marketing expenditure and sponsorship activities	This Report

Analysis of industry marketing expenditure and sponsorship activities

Summary findings

- Industry marketing expenditure increased by 5.7%. The total number of advertisements increased by 42%. Sky City Ltd showed the greatest increase in expenditure while the Totalisator Agency Board (TAB) had the greatest increase in advertising incidence.

Note: this indicator has several important limitations discussed in the limitations section of this indicator.

⇧	Increasing trend *	Industry marketing expenditure and incidence increased in 2012/13.
L	Confidence in the data	No change since the Baseline Report.
NA	Performance	Not reported.

* Note: Our summary findings show an increase in marketing spend and we have not labelled this 'improving' or 'deteriorating'. This is because the analysis does not assess the appropriateness of the marketing i.e. the extent that it avoids contributing to harm from gambling.

Data source and approach to measurement

Outcome indicator 4.6 compares the marketing expenditure across the 2011/12 (Baseline) and 2012/13 (Progress) reporting periods.

The two data collection periods are:

- 1 July 2011 – 30 June 2012 (2011/12 Baseline Report period)
- 1 July 2012 – 30 June 2013 (2012/13 Progress Report period).

Data was collected on industry marketing expenditure from the Nielsen Company, a provider of media research information. The Nielsen Company maintains a database of advertising expenditure (referred to as 'spend') and volume (referred to as 'incidence') within New Zealand. Nielsen prepared a report for the Outcomes Framework on the advertising spend by organisations that provide gambling within New Zealand. The reports (for the 2012 and 2013 periods) prepared by Nielsen were analysed to only include advertisements specifically for gambling, and, wherever identifiable, to exclude advertising for other services such as restaurants and accommodation.

Note: this indicator has several important limitations discussed in the limitations section of this indicator.

Definitions

Spend is measured through 'rate-card' values which represent the full rate for the advertising slots purchased. As discussed in the limitations section, this is unlikely to reflect actual expenditure but is an indicator of spend.

Incidence refers to the number of individual advertisements purchased.

Current state of indicator

Advertising Spend

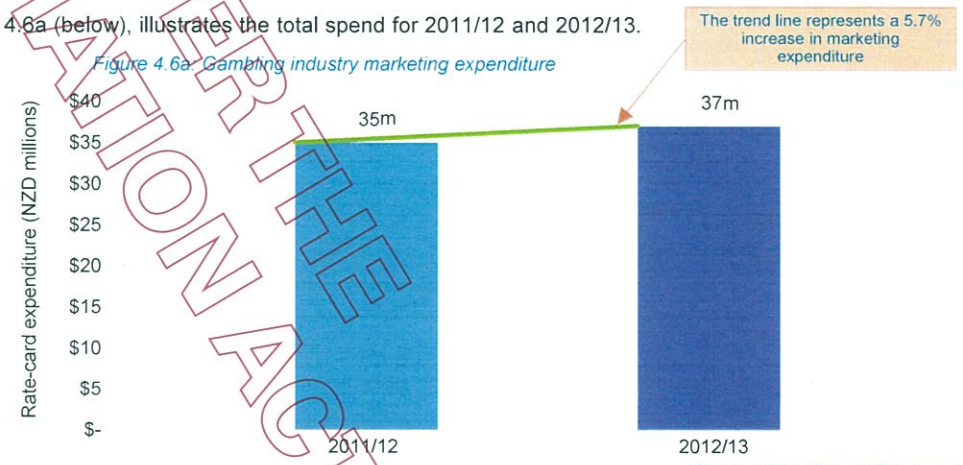
The total spend on advertising for the 2011/12 was $35 million, of this $28.9 million related to advertising by the New Zealand Lotteries Commission which is the highest spend by a single organisation. The total spend for 2012/13 increased 5.7% to $37 million, of this $30.5 million was spent by the New Zealand Lotteries Commission.

The next highest spend by organisation, after the New Zealand Lotteries Commission in 2011/12 was by websites that offer gaming and gambling services on the internet (most notably Grandreef.tv) at $3 million and the Totalisator Agency Board (TAB) who spent $2.4 million. The next highest spend for 2012/13, after the New Zealand Lotteries Commission was by the TAB, closely followed by internet gaming providers.

The advertisements from Grandreef.tv are advertising their free 'gaming' website, which is distinct from Grandreef.com which provides internet 'gambling' services to the New Zealand market. Advertising overseas gambling is prohibited under s16 of the Gambling Act 2003.

Figure 4.6a (below), illustrates the total spend for 2011/12 and 2012/13.

Figure 4.6a: Gambling industry marketing expenditure



(Source: The Nielsen Company)

Analysis of industry marketing expenditure and sponsorship activities (cont.)

Advertising Spend (cont.)

There has been slight increases in the amount of advertising expenditure for Television, Radio, Outdoor and On Line. Television and Radio advertising accounted for approximately 88% of the spend in 2011/12 and 92% of the spend in 2012/13. Outdoor and On Line advertising expenditure combined was 9% of the spend for 2011/12 and 10% for 2012/13.

Table 4.6c (overleaf) illustrates the trend by category for industry marketing expenditure and sponsorship activities. Expenditure by the Christchurch Casino, Class 4 Venues, Internet gaming providers and the TAB all decreased. Lasseters Wharf Casino, the New Zealand Lotteries Commission and Sky City Ltd all show increased levels of expenditure for 2012/13.

Dunedin Casino did not record any marketing expenditure and or sponsorship activities specifically relating to gambling in 2011/12 but did record spending $28,000 in marketing expenditure for 2012/13.

The organisation with the greatest increase in marketing expenditure was SkyCity Ltd which spent $2.1 million in 2012/13 compared to approximately $0.7 million in 2011/12, an increase of 220%.

Comparing the top five, the most substantial change is an increase in the spend and ranking of the Lotto – General, and SkyCity advertising campaigns, refer table 4.6b (below).

Table 4.6b: Top five advertising campaigns by spend 2011/12 and 2012/13

2011/12		Total spend ($000)	2012/13		Total spend ($000)
1	Lotto – 'Man on boat with lucky dog - Wilson'	3,639	1	Lotto – General	7,889
2	Lotto – General*	2,481	2	Lotto - Laptop, Boat, Dog holding a lotto ticket	2,147
3	Lotto – Powerball	2,417	3	Lotto - Man on boat with lotto winning numbers	1,639
4	Big Wednesday – 'What a difference a day makes' Split screen	2,386	4	SkyCity	1,540
5	Big Wednesday – General	1,604	5	Lotto – Powerball	1,366

Advertising incidence

Incidence is a useful measure of advertising expenditure as it is not affected by changes in the discount rate that affect spend as described in the limitations section. The incidence of advertising shows the New Zealand Lotteries Commission, TAB, SkyCity and internet gambling/gaming services recording the highest incidence for both the 2011/12 and 2012/13 periods.

Table 4.6c (overleaf) shows that 173,523 advertisements were purchased by the gambling industry for the 2011/12 period. This increased to 246,339 for the 2012/13 period, an increase of 72,816 advertisements across all categories.

Table 4.6c (overleaf) presents both the spend and incidence of advertising for each form of gambling in greater detail for the 2011/12 and the 2012/13 periods.

In 2011/12 table 4.6c also included data for an EGM Manufacturer with advertising incidence of 2 and spend of $2,992. No expenditure was reported for the manufacturer in 2012/13 so this information is not included in the table overleaf.

*Note: the rank order of advertising campaigns for 20111/12 was corrected.

Analysis of industry marketing expenditure and sponsorship activities (cont.)

Table 4.6c Gambling industry marketing expenditure and advertising incidence

Category	Spend Trend	Year	Advertising Incidence / Advertising Spend	Television	Radio	Newspaper	Magazines	Cinema	Outdoor	Unadressed Direct Mail	On Line	Total
Christchurch Casino	↓	2012	Incidence	-	76	8	-	-	6	4	-	94
			Spend	$0	$4,484	$19,133	$0	$0	$27,500	$11,040	$0	$62,157
		2013	Incidence	-	-	16	-	-	-	1	-	17
			Spend	$0	$0	$49,904	$0	$0	$0	$1,976	$0	$51,880
Class 4 Venues	↓	2012	Incidence	-	-	12	-	-	-	-	-	12
			Spend	$0	$0	$10,422	$0	$0	$0	$0	$0	$10,422
		2013	Incidence	-	-	20	-	-	-	-	-	20
			Spend	$0	$0	$8,176	$0	$0	$0	$0	$0	$8,176
Dunedin Casino	↑	2012	Incidence	-	-	-	-	-	-	-	-	-
			Spend	$0	$0	$0	$0	$0	$0	$0	$0	$0
		2013	Incidence	-	-	49	-	-	-	-	-	49
			Spend	$0	$0	$28,160	$0	$0	$0	$0	$0	$28,160
Internet gaming providers	↓	2012	Incidence	1,890	-	-	-	-	-	-	-	1,890
			Spend	$2,981,401	$0	$0	$0	$0	$0	$0	$13,150	$2,994,551
		2013	Incidence	2,941	-	-	-	-	-	-	-	2,941
			Spend	$2,160,620	$0	$0	$0	$0	$0	$0	$0	$2,160,620
Lasseters Wharf Casino	↑	2012	Incidence	-	-	1	-	-	-	-	-	1
			Spend	$0	$0	$450	$0	$0	$0	$0	$0	$450
		2013	Incidence	-	-	5	-	-	-	-	-	5
			Spend	$0	$0	$11,000	$0	$0	$0	$0	$0	$11,000
NZ Lotteries Commission	↑	2012	Incidence	12,079	152,057	22	2	161	2,085	-	-	166,406
			Spend	$20,801,465	$6,199,289	$280,143	$20,263	$80,500	$1,000,281	$0	$552,291	$28,934,232
		2013	Incidence	12,237	210,986	49	4	520	1,148	-	-	224,944
			Spend	$18,928,644	$8,606,641	$349,015	$38,780	$172,880	$1,409,325	$0	$1,021,958	$30,527,243
Sky City Ltd	↑	2012	Incidence	-	2,411	8	18	-	6	-	-	2,443
			Spend	$0	$355,059	$27,617	$57,125	$0	$204,750	$0	$15,035	$659,586
		2013	Incidence	-	5,824	119	10	-	316	-	-	6,269
			Spend	$0	$907,437	$524,697	$41,390	$0	$553,957	$0	$80,974	$2,108,455
Totalisator Agency Board (TAB)	↓	2012	Incidence	2,632	-	43	-	-	-	-	-	2,675
			Spend	$909,519	$0	$233,842	$0	$0	$0	$0	$1,258,464	$2,401,825
		2013	Incidence	2,172	9,890	32	-	-	-	-	-	12,094
			Spend	$1,356,650	$355,180	$18,170	$0	$0	$0	$0	$437,609	$2,167,609
Total expenditure	↑	2012	Incidence	16,601	154,544	94	20	161	2,097	4	-	173,521
			Spend	$24,692,385	$6,558,832	$571,607	$77,388	$80,500	$1,232,531	$11,040	$1,838,940	$35,063,223
		2013	Incidence	17,350	226,700	290	14	520	1,464	1	-	246,339
			Spend	$22,445,914	$9,869,258	$989,122	$80,170	$172,880	$1,963,282	$1,976	$1,540,541	$37,063,143

(Source: The Nielsen Company)

During the year ended **30 June 2012**, there were:

154,544

Radio advertisements for gambling; and

16,601

Television advertisements for gambling.

During the year ended **30 June 2013**, there were:

226,700

Radio advertisements for gambling; and

17,350

Television advertisements for gambling.

CHANGE

UP 46.7%

UP 4.5%

Analysis of industry marketing expenditure and sponsorship activities (cont.)

Limitations and areas for improvement

The advertising expenditure analysis is derived from 'rate-cards' which represent the full rate before any discounts offered by the media outlet. The discount offered varies based on the advertisers respective size and market conditions. Large and regular advertisers will receive large discounts off these rates.

Data is not available on the advertising spend with SKY Television due to a different pricing structure. SKY Television advertising is sold in packages therefore it is not possible to identify the individual rate for advertisements. Data is only collected from the main internet publishers. Advertising with other internet publishers is not included in this analysis.

Data was not available on the level of expenditure on sponsorship activities. Sponsorship or advertising for Class 4 gambling societies or venues is prohibited however, sponsorship is allowable for other forms of gambling. The Casino sector sponsors national basketball, rugby league, regional rugby union, golf and horse-racing. Specific advertising by sponsors during or adjacent to sports events is captured by this analysis.

This analysis excludes the TAB's trackside television channel which broadcasts horse and dog racing and could be considered to meet the definition of marketing expenditure.

The number of radio advertisements is substantially higher than television advertisements. This is because radio advertising is purchased regionally, i.e. advertising slots are required to be purchased for each regional variant of a radio station, whereas television advertising is national, with one slot purchased and delivered nationwide for each channel.

On Line expenditure data is collected by Nielson, however On Line incidence data is not collected. This limitation reduces the accuracy of the incidence reporting as an overall summary.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

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Objective 5

Government, the gambling industry, communities, family/whānau and individuals understand and acknowledge the range of harms from gambling that affect individuals, families/whānau and communities

Analysis and presentation of outcome indicators for objective 5		Previous measurement point
5.1	Analysis of government sector annual reports and statements of intent for commitment to addressing gambling-related harm	2011/12 Baseline Report
5.2	Analysis of the Department of Internal Affairs survey on community attitudes to gambling and problem gambling	2011/12 Baseline Report
5.3	Analysis of Ministry-funded survey on community attitudes to gambling and problem gambling	2011/12 Baseline Report
5.4	Analysis of Department of Internal Affairs annual reports of gambling industry host responsibility compliance	This Report
5.5	Analysis of the attitudes of national key decision-makers (i.e., Ministry of Health and Department of Internal Affairs officials, the Gambling Commission, industry leaders, local government councillors) compared to national Ministry-funded attitudes survey responses	2011/12 Baseline Report

Analysis of Department of Internal Affairs reports on gambling industry host responsibility compliance

Summary findings

- The positive results from the DIA audits of pub/club gaming venues are very similar to 2011/12 (2011/12 - 92%, 2012/13 - 93%). The main causes of non-compliance remain similar, except signage that increased slightly (2011/12 – 2%, 2012/13 – 8%).
- The number of venue inspections reduced by 414 (62%) and society audits also decreased by three (27%) in 2012/13.
- The proportion of Class 4 investigations related to host responsibility increased from 5% to 13% in 2012/13.

→	No trend	The pass rate for audit procedures has increased slightly on a declining population of audits focused on host responsibility compliance.
H	Confidence in the data	No change since the Baseline Report.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 5.4 analyses the DIA reports on gambling industry host responsibility compliance and compares 2011/12 (Baseline Report) data with the 2012/13 data to understand if there has been any change in gambling industry host responsibility compliance.

Two datasets covering two periods were obtained from the DIA, the first period is between 1 July 2011 to 30 June 2012 (2011/12 period) and the second period is between 1 July 2012 to 30 June 2013 (2012/13 period). The two data sets each cover:

- Reporting on the results of audits of Class 4 pub and club venues and societies
- Reporting on the number of investigations opened into Class 4 gambling activity.

The two datasets were reviewed, issues grouped and the proportion and type of audit investigations that related to host responsibility were analysed. This analysis was then compared across the 2011/12 and 2012/13 periods.

The DIA is responsible for ensuring that gambling in New Zealand is safe, fair, well regulated and that proceeds generated through Class 4 gambling benefit the community. One of the ways the DIA meets these responsibilities is by conducting Class 4 audits (DIA, 2014). The Class 4 audits follow a standard process with areas of focus determined each year through the DIA's business planning process and are carried out periodically by DIA.

Refer the DIA website for detailed information about how audits are conducted (http://www.dia.govt.nz/diawebsite.nsf/wpg_URL/Services-Casino-and-Non-Casino-Gaming-Compliance-Investigations-and-Audits).

Requirements related to host responsibility are grouped into five areas. These are:

- **Signage:** including signage on the policy for identifying problem gamblers, affordable levels of gambling and how to seek help. This includes internal and external signage.
- **Policy or documentation:** including the host responsibility policy, and pamphlets on the odds of winning.
- **Training:** whether staff are aware of and able to apply the host responsibility policy.
- **Exclusion orders:** whether staff are aware of the exclusion order requirements and able to issue exclusion orders on request.
- **Other:** including potential issues related to access by minors and the location of ATM machines.

Non-compliance with the above requirements is considered a breach under Schedule 6 of the Gambling Act 2003 and venues can be issued with infringement notices: (http://www.legislation.govt.nz/act/public/2003/0051/latest/DLM211293.html?search=sw_096be8ed813e8dce_infringement+offences_25_se&p=1)
For simplicity, this outcome indicator reports non-compliance as 'fail' or 'minor fail' based on what the DIA considers minor or larger instances of non-compliance with components of Schedule 6. A 'minor fail' is often able to be rectified while the audit is occurring, a 'fail' is more significant and may require remediation after the audit.

Current state of the indicator

Figure 5.4a (overleaf) compares the total number of "passed" audit procedures for 2011/12 and 2012/13. The "pass" rate for the periods were 92% and 93% respectively. Other possible audit results reported are: Not applicable or Null, Minor (Non-compliant) or Non-compliant. Figure 5.4c (overleaf) illustrates the results of audit procedures which did not pass across the reporting periods.

The DIA regularly audits Class 4 gambling venues and societies for compliance with the requirements of the Gambling Act and associated regulations. Overall, there has been a decrease in both society audits and venue inspections by the DIA in 2012/13. Specifically, in 2011/12 11 society audits and 664 venue inspections were completed compared to eight society audits and 250 venue inspections in 2012/13.

Analysis of Department of Internal Affairs reports on gambling industry host responsibility compliance (cont.)

Figure 5.4a: Passed audit procedures 2011/12 (n=8,358) and 2012/13 (n=2,882) (Class 4 venue and society audits specific to host responsibility)

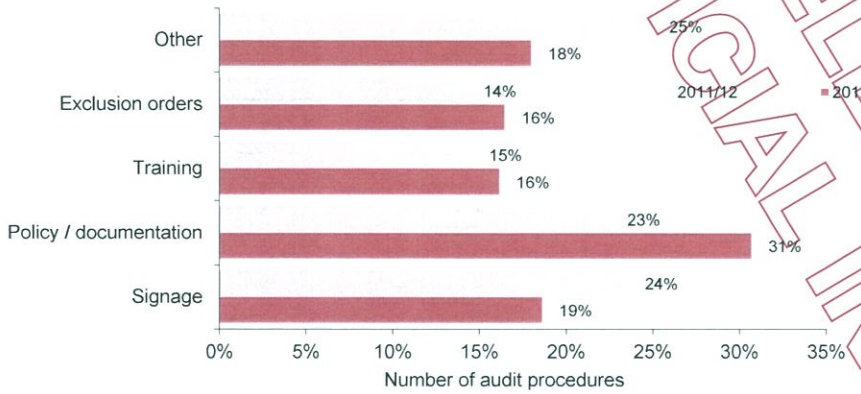


Figure 5.4c (opposite) illustrates the result of Class 4 venue and society audits specific to host responsibility. The audit procedures assess: Exclusion orders, Training, Policy/documentation, Other and Signage.

Note about venue numbers: In 2011/12 there were 1,400 venues, compared to 1,356 in 2012/13.

Key findings:

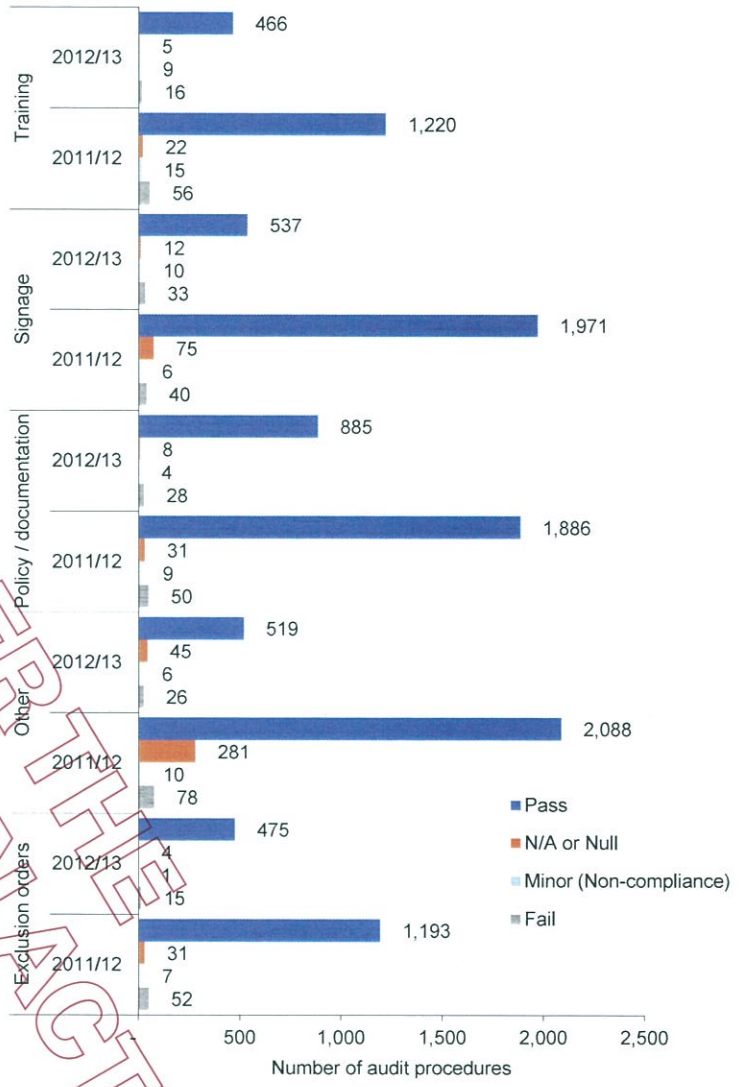
a. In 2011/12 92% of all audits relating to gambling harm passed compared to 93% in the 2012/13 period. This overall increase in pass rates is due to an increase in pass rates for Other, Exclusion Orders, Training and Policy/documentation as a percentage of total audits which relate to gambling harm minimisation.
b. Signage was the only theme to have an increase in the number of Minor (non-compliance) results.
c. Signage was the only theme where the proportion of Pass rates relating to gambling harm minimisation decreased in the 2012/13 period compared to the 2011/12 period.
d. Non-compliance for signage increased from 2% of all signage audit procedures in 2011/12 to 8% of all signage audit procedures in 2012/13.

Table 5.4b below summarises the information shown in Figure 5.4c.

Table 5.4b summary of results for Class 4 venue and society audits to host responsibility

	Fail			Minor (fail)			N/A or Null			Pass		
Year	2011/12	2012/13	% change	2011/12	2012/13	% change	2011/12	2012/13	% change	2011/12	2012/13	% change
Signage	2%	6%	+4%	0%	2%	+1%	4%	2%	-2%	94%	91%	-4%
Policy / documentation	3%	3%	+0%	0%	0%	-0%	2%	1%	-1%	95%	96%	+0%
Training	4%	3%	-1%	1%	2%	+1%	2%	1%	-1%	93%	94%	+1%
Exclusion orders	4%	3%	-1%	1%	0%	-0%	2%	1%	-2%	93%	96%	+3%
Other	3%	4%	+1%	0%	1%	+1%	11%	8%	-4%	85%	87%	+2%
Total % change	**3%**	**4%**	**1%**	**1%**	**1%**	**0%**	**5%**	**3%**	**-2%**	**92%**	**93%**	**1%**
Total count	**276**	**118**		**47**	**30**		**440**	**74**		**8358**	**2882**	

Figure 5.4c: Results of Class 4 venue and society audits specific to host responsibility of Other, Exclusion orders, Training, Policy/documentation and signage 2011/12 and 2012/13

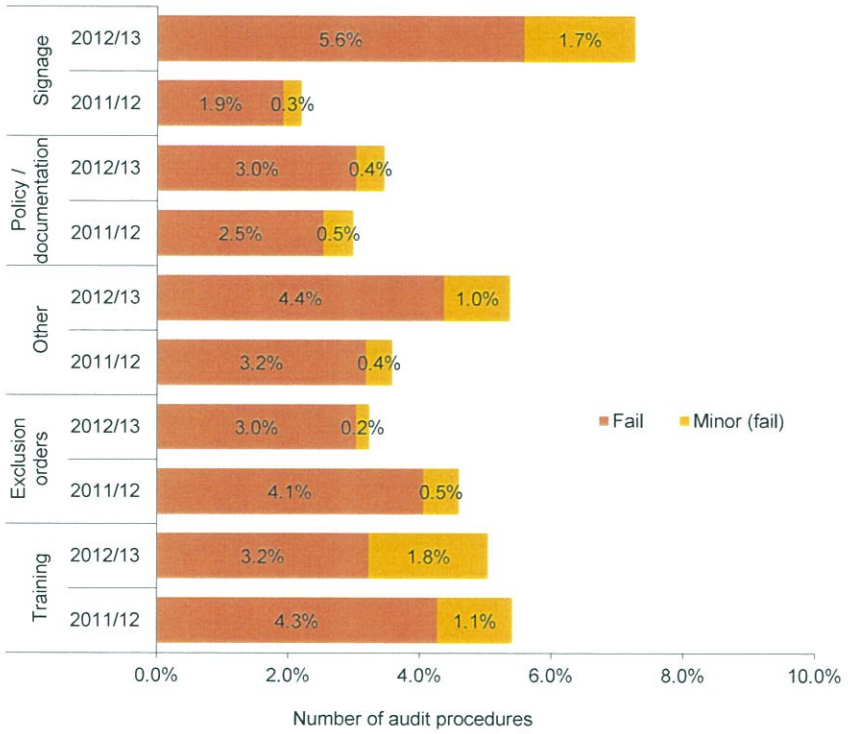


Analysis of Department of Internal Affairs reports on gambling industry host responsibility compliance (cont.)

Figure 5.4d (below), illustrates the percentage of audits that receive a Non-compliant or Minor (Non-compliant) result. Key findings:

- The highest rate of non-compliance relating to host responsibility was for signage in the 2012/13 period.

Figure 5.4d Results of Class 4 venue and society audits specific to host responsibility, 2011/12 (n=323) and 2012/13 (n=148)

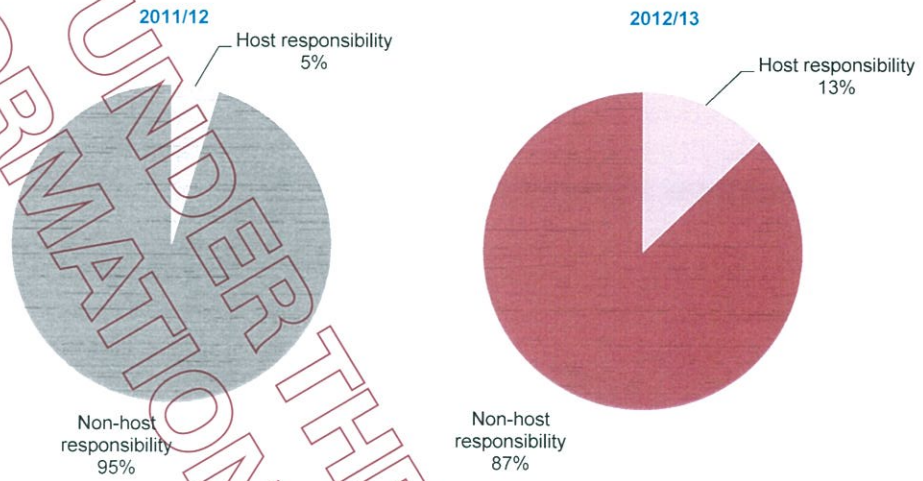


The DIA also undertakes investigations into Class 4 gambling. Figure 5.4e (below) sets out the proportion of Class 4 investigations related to host responsibility for the 2011/12 and 2012/13 periods.

For the 2011/12 period, the DIA opened 932 investigations into Class 4 gambling activity, 5% or 44 of these were related to host responsibility. For the 2012/13 period, the DIA opened 748 investigations into Class 4 gambling activity, 13% or 96 of these related to host responsibility while 652 or 87% related to non-host responsibility.

Overall, the number of investigations opened decreased by 184 or 19.7% in the 2012/13 period when compared to the 2011/12 period.

Figure 5.4e Proportion of Class 4 investigations related to host responsibility for the 2011/12 (n=932) and 2012/13 (n=748) periods



Analysis of Department of Internal Affairs reports on gambling industry host responsibility compliance (cont.)

Limitations and areas for improvement

This analysis is restricted to the Class 4 gambling sector and does not include monitoring and reporting on host responsibility compliance related to New Zealand Lotteries Commission or New Zealand Racing Board venues. The New Zealand Lotteries Commission and New Zealand Racing Board are not audited or inspected by the DIA.

The DIA does have a role monitoring Casino host responsibilities. However, this focuses on whether the processes within the Host Responsibility Policy (as approved by the Gambling Commission) are followed rather than the compliance focus based on the Gambling Act 2003 applied through venue inspections and society audits for the Class 4 sector. Consequently, it is not possible to analyse the rate of compliance (or similar).

The reporting in Figure 5.4e on Class 4 investigations opened for the year ended 30 June 2012 and the year ended 30 June 2013 does not consider the results of the investigations, and therefore some investigations may be closed due to a lack of evidence or because compliance had occurred.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

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Objective 6

A skilled workforce is developed to deliver effective services to prevent and minimise gambling harm

Analysis and presentation of outcome indicators for objective 6		Previous measurement point
6.1	Analysis of problem gambling practitioners' (public health and intervention) employment patterns and conditions, such as duration of employment and pay ranges compared to other sectors	2011/12 Baseline Report
6.2	Analysis of the number of problem gambling practitioners (public health and intervention) who have the relevant problem gambling competencies for the work they deliver	2011/12 Baseline Report
6.3	Analysis of the number of problem gambling practitioners (public health and intervention) who have received relevant tertiary training	2011/12 Baseline Report
6.4	Assessment of the availability of culturally specific training programmes for problem gambling practitioners	2011/12 Baseline Report
6.5	Analysis of the diversity of the problem gambling workforce, including a) ethnic diversity (Māori, Pacific and Asian), age and gender, b) the percentage of Māori, Pacific and Asian practitioners who are working in mainstream organisations, c) the range of languages spoken by the problem gambling workforce, d) the percentage of the workforce that speaks te reo Māori, e) the percentage of the problem gambling workforce who identify as recovering gamblers or who have used problem gambling intervention services in the past	2011/12 Baseline Report

Note: There were no indicators assessed for Objective 6 as part of this Progress Report (2012/13).

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Objective 7

People have the life skills and the resilience to make healthy choices that prevent and minimise gambling harm

	Analysis and presentation of outcome indicators for objective 7	Previous measurement point
7.1	Analysis of the prevalence of protective and resiliency factors demonstrated in the New Zealand Health Survey for different population groups	2011/12 Baseline Report
7.2	Analysis of community involvement in the Ministry-funded Behaviour Change Surveys	2011/12 Baseline Report
7.3	Review and summary of the range of public health initiatives reported to the Ministry by public health service providers that are community action-based and have community policy implementation	2011/12 Baseline Report
7.4	Analysis of Ministry service-user data for referral from and referral to life skills and resiliency programmes	This Report

Analysis of Ministry service-user data for referral from and referral to life skills and resiliency programmes

Summary findings

- **Referrals from** life skills and resiliency programmes recorded for service-users have increased by 151% since 2011/12. The most common referrer was budget advice services. The referrals from these services increased almost nine-fold. The total number of service-users with a referral recorded was small (123).
- **Referrals to** life skills and resiliency programmes (facilitation sessions) recorded for service-users have almost doubled between reporting periods. Service-users were most commonly referred for venue exclusions, financial advice and support, and mental health programmes.

↑	Improving trend	Referrals from and to life skills and resiliency programmes have both increased.
H	Confidence in the data	No change since the Baseline Report, however the volume of data for part of this outcome indicator (referrals from life skills and resiliency programmes) is very small (123 people).
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 7.4 analyses the referrals from and referrals to life skills and resiliency programmes across the 2011/12 (Baseline) and 2012/13 (Progress) reporting periods. Data was obtained from the Ministry's CLIC system and the Gambling Helpline's database over two data collection periods.

The two data collection periods are:

- 1 July 2011 – 30 June 2012 (2011/12 Baseline Report data period)
- 1 July 2012 – 30 June 2013 (2012/13 Progress Report data period).

*Referrals **from** life skills and resiliency programmes*

Data was sorted to only include unique clients (i.e. clients were only counted once regardless of the number of times they attended services). Nearly one in four (24.1% or 2,990) unique service-users had a referral source recorded for 2012/13. The list of referral sources was reviewed and an assessment was made as to whether the source could be considered to be a 'life skills and resiliency programme'. The assessment as to whether referrals were from life skills and resiliency programmes was subjective and based on the detail included within the referral data. The data was collected from CLIC and the Gambling Helpline's database.

*Referrals **to** life skills and resiliency programmes*

For the year ended 30 June 2013, 3,402 facilitated referral sessions were held with service-users. The data was collected from CLIC.

Facilitation sessions assist service-users to access relevant services that assist them to reduce the gambling related and associated harms occurring to them and their family. A facilitated session includes the service-user, their service provider representative and a person from the life skills and resiliency programme.

Current state of the indicator

Refer to analysis on the next page.

Analysis of Ministry service-user data for referral from and referral to life skills and resiliency programmes (cont.)

*Referrals **from** life skills and resiliency programmes*

In 2011/12 49 service-users were recorded as being referred from a life skills and resiliency programme, this increased to 123 for 2012/13. Figure 7.4a (opposite) shows the sources of referrals for both periods. The key findings are:

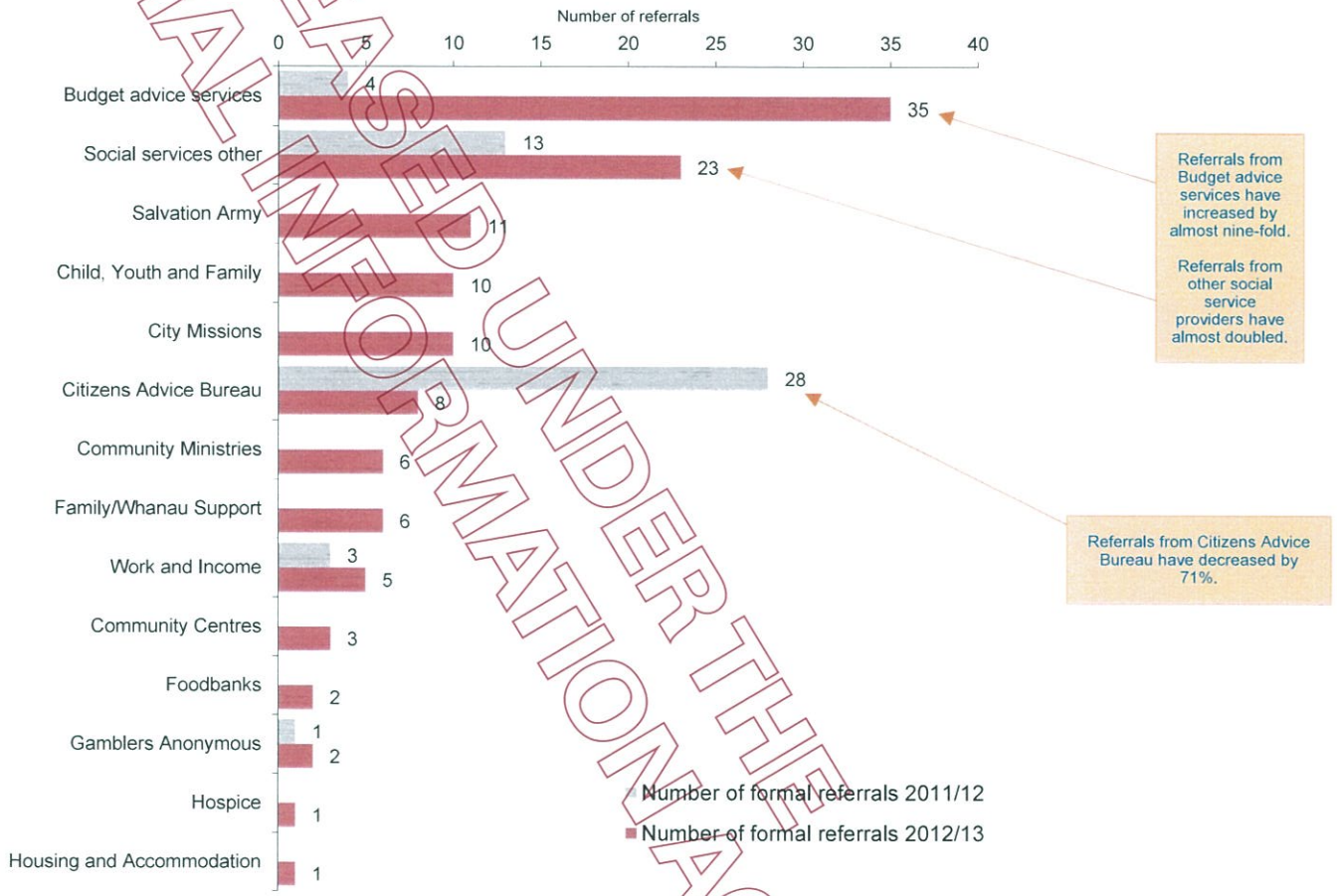
a. There was a 151% increase in the number of service-users recorded as referred from a life skills and resiliency programme between the reporting periods

b. Budget advice services were the most common referrer

c. Referrals from budget advice services increased by almost nine times between the reporting periods

d. Referrals from the Citizens Advice Bureau have decreased by 71%.

*Figure 7.4a: Number of **referrals from** life skills and resiliency programmes, 2011/12 (n=49) and 2012/13 (n=123)*



Analysis of Ministry service-user data for referral from and referral to life skills and resiliency programmes (cont.)

*Referrals **to** life skills and resiliency programmes (facilitations)*

Figures 7.4b and 7.4c (opposite) show referrals to resiliency programmes that met the definition of facilitation sessions (refer definitions section for this outcome indicator). The key findings are:

a. Facilitated referrals almost doubled between periods. In 2011/12 903 formal facilitated referrals were made to life skills and resiliency programmes. In the 2012/13 facilitated referrals increased to 1,782.

b. The most common facilitated referrals in 2012/13 were to venue exclusion and financial advice and support services, refer Figure 7.4c. Financial advice and support was the most common facilitated referral type, and venue exclusions were the sixth most common referral in the 2011/12 period, refer Figure 7.4b (opposite).

c. Facilitated referrals are also commonly made to other health sector organisations, including mental health, alcohol and other drug and tobacco cessation services.

Note: Facilitated referrals may occur between problem gambling service providers when an alternative service is more appropriate. For example if a service-user moves cities during treatment.

Note: The 'Other' category included in Figures 7.4b and 7.4c includes other similar services not classified under one of the categories specifically defined in CLIC.

*Figure 7.4b: Number of facilitated **referrals to** life skills and resiliency programmes, 2011/12 (n=903)*

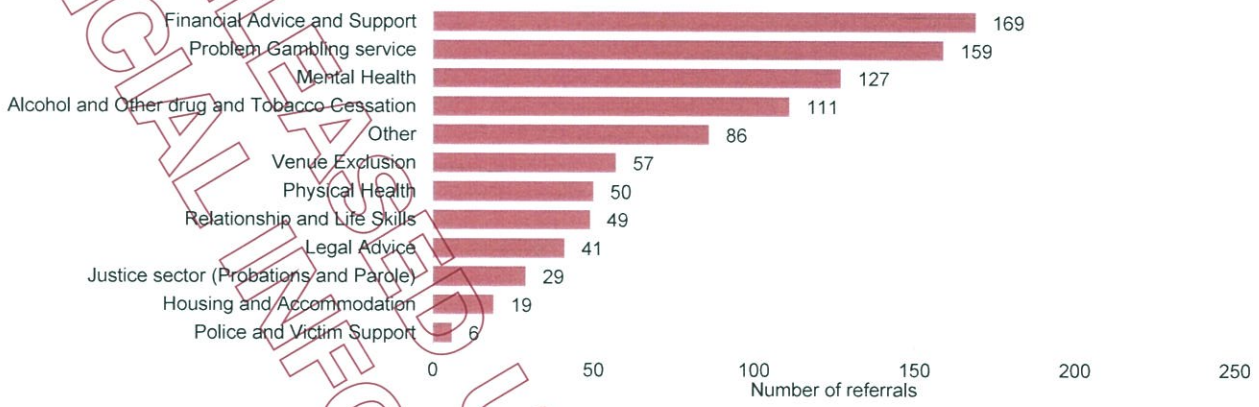
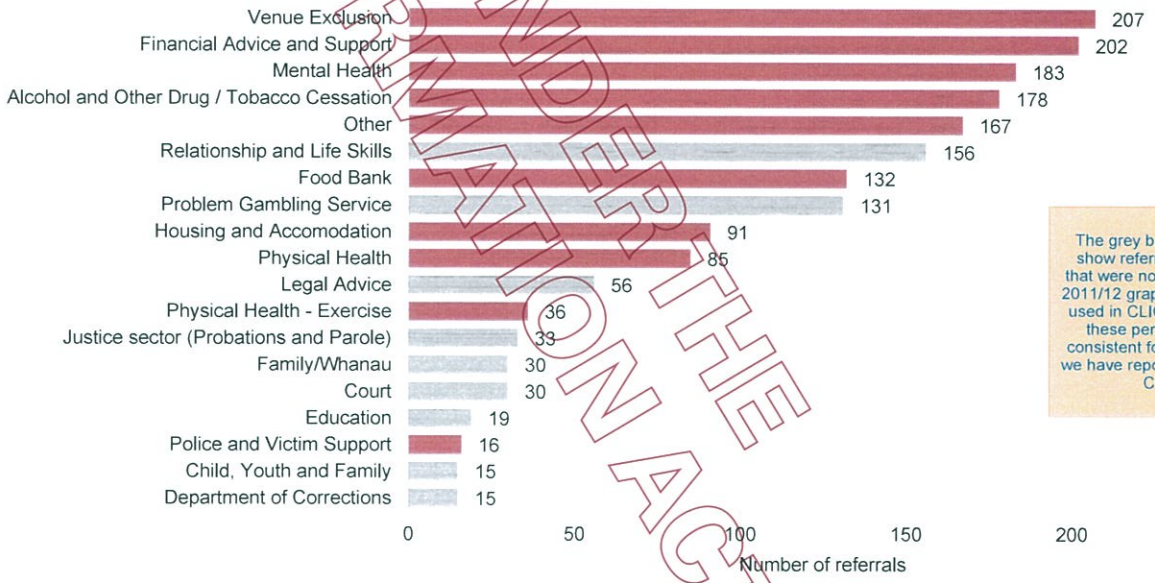


*Figure 7.4c: Number of facilitated **referrals to** life skills and resiliency programmes, 2012/13 (n=1,782)*



The grey bars in the 2012/13 graph show referrals recorded in 2012/13 that were not specifically shown in the 2011/12 graph. Some of the categories used in CLIC have changed between these periods. To ensure data is consistent for future progress reports, we have reported information using the CLIC categories.

Analysis of Ministry service-user data for referral from and referral to life skills and resiliency programmes (cont.)

Limitations and areas for improvement

This analysis only includes service-users where the referral source was recorded within the appropriate database. Informal referrals not made within the database are not recorded. Service providers are reliant on service-users reporting (when asked) who referred them to seek help.

It would be beneficial to develop a specific definition for life skills and resiliency programmes to determine whether certain referrals such as those from Work and Income New Zealand and related to exclusion from gambling venues should be included.

Facilitation sessions are used to measure referrals to life skills and resiliency programmes. Facilitations are tightly defined and require service providers to actively support people experiencing harm to access specialist services. Less formal referrals may be made to life skills and resiliency programmes that are not captured within referrals or reported on for this outcome indicator.

An increase in the number of referrals between reporting periods may be the result of improved data capture, rather than more referrals occurring.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

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Objective 8

Gambling environments are designed to prevent and minimise gambling harm

Analysis and presentation of outcome indicators for Objective 8		Previous measurement point
8.1	A summary of progress made by the joint Ministry of Health and Department of Internal Affairs relationships with the gambling industry	2011/12 Baseline Report
8.2	Analysis of a periodic stakeholder satisfaction survey of the joint Ministry of Health and Department of Internal Affairs relationships with the gambling industry	2011/12 Baseline Report
8.3	Analysis of industry data on training and programmes that assist gambling providers to be responsible hosts (i.e. host responsibility programmes)	2011/12 Baseline Report
8.4	Analysis of Department of Internal Affairs data on gambling venue compliance (and breaches) of relevant legislative requirements	2011/12 Baseline Report
8.5	Analysis of client data for referrals from gambling venues	This Report
8.6	Review of the effectiveness of industry mechanisms for identifying problem gamblers and gamblers at risk of problem gambling	2011/12 Baseline Report
8.7	Review of the number of venues, or societies, that have policies specific to key risk groups and behaviours (i.e. table games for Asian gamblers, self-exclusion for non-English-speaking gamblers)	2011/12 Baseline Report

Analysis of client data for referrals from gambling venues

Summary findings

- The number of referrals and proportion of referrals from the different types of gambling venues have not changed substantially for 2011/12 and 2012/13. Approximately 65% of all referrals were from the casino sector, and 32% were from pub/club venues.

→	Neutral trend	The number of referrals and proportion of referrals from different gambling venues has not changed substantially.
H	Confidence in the data	No change since the Baseline Report.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 8.5 analyses the referrals from gambling venues across the 2011/12 (Baseline) and 2012/13 (Progress) reporting periods. Data was obtained from the Ministry's CLIC system and the Gambling Helpline's database over the two data collections periods.

The two data collection periods are:

- 1 July 2011 – 30 June 2012 (2011/12 Baseline Report data period)
- 1 July 2012 – 30 June 2013 (2012/13 Progress Report data period).

The data was sorted to only include unique clients (i.e. clients were only counted once regardless of the number of times they attended services).

Nearly one in four (24.1% or 2,990) unique service-users had a referral source recorded for 2012/13. The list of referral sources was reviewed and an assessment was made as to whether the source could be considered to be a gambling venue.

Current state of the indicator

Figure 8.5a (below) shows the proportion of referrals from each type of venue, the Lotteries NZ referrals are very small (0.3%) in both 2011/12 and 2012/13 and cannot be easily seen on the graph. Figure 8.5b (below) shows the number of referrals from each venue type. The key findings are:

a. The number and proportion of referrals from the different types of gambling venues have not changed substantially.

b. In 2012/13 304 service-users were recorded as referred from gambling venues, with the largest sources of referrals being the Casino sector (64.8%) and the pub/club sector (31.9%).

For the purposes of this analysis, the pub/club sector is grouped together. This is because the Gambling Helpline database does not differentiate between these two sources.

Figure 8.5a: Proportion of referrals from gambling venues, 2011/12 (n=298) and 2012/13 (n=304)

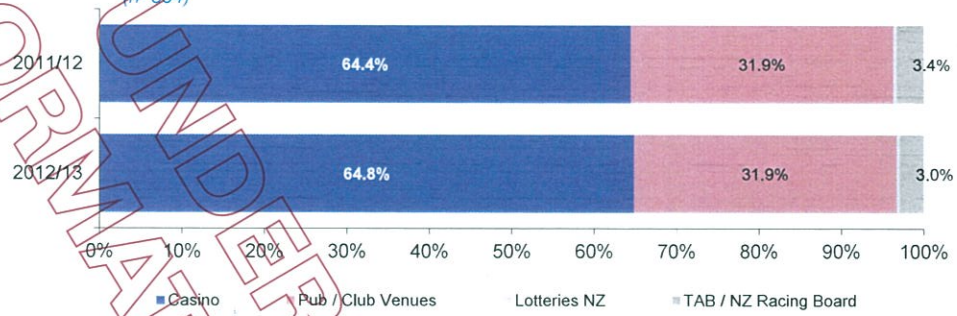
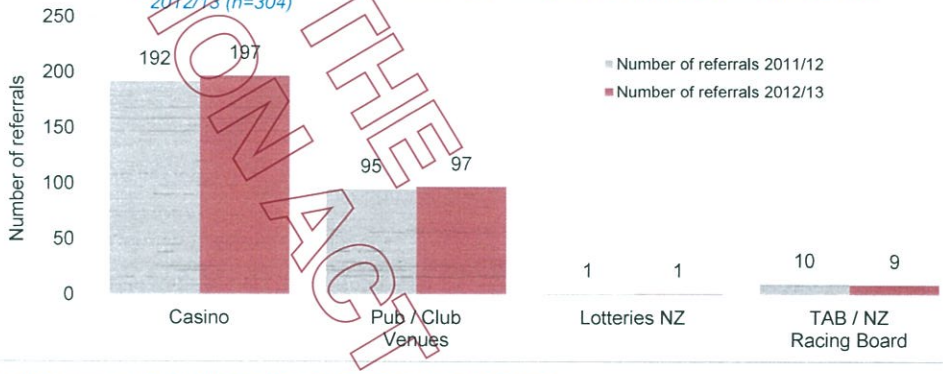


Figure 8.5b: Number of referrals from gambling venues by type, 2011/12 (n=298) and 2012/13 (n=304)



Analysis of client data for referrals from gambling venues (cont.)

The spread of referrals across New Zealand has not changed substantially from 2011/12. Figure 8.5c (opposite) shows where referrals from gambling venues were recorded. The data excludes the referrals recorded by the Gambling Helpline included in the graphs on the previous page as geographical data was unavailable.

Of the total gambling venue referrals recorded in CLIC for 2012/13, 83% of referrals were from three cities, Auckland (72 referrals), Christchurch (26 referrals) and Dunedin (16 referrals). This is similar to 2011/12 where 85% of gambling venue referrals were from Auckland, Christchurch and Dunedin.

Almost half of the gambling venue referrals reported in Figures 8.5a-c were from CLIC. The proportionality of venues recorded in CLIC differed to the Gambling Helpline data. For example, 89% of gambling venue referrals in CLIC were from casinos, whereas the Gambling Helpline data recorded 45% of total referrals from casinos.

Limitations and areas for improvement

This analysis only includes service-users where the referral source was recorded within the appropriate database. Informal referrals not made within the database are not recorded. Service providers are reliant on service-users reporting, when asked, who referred them to seek help.

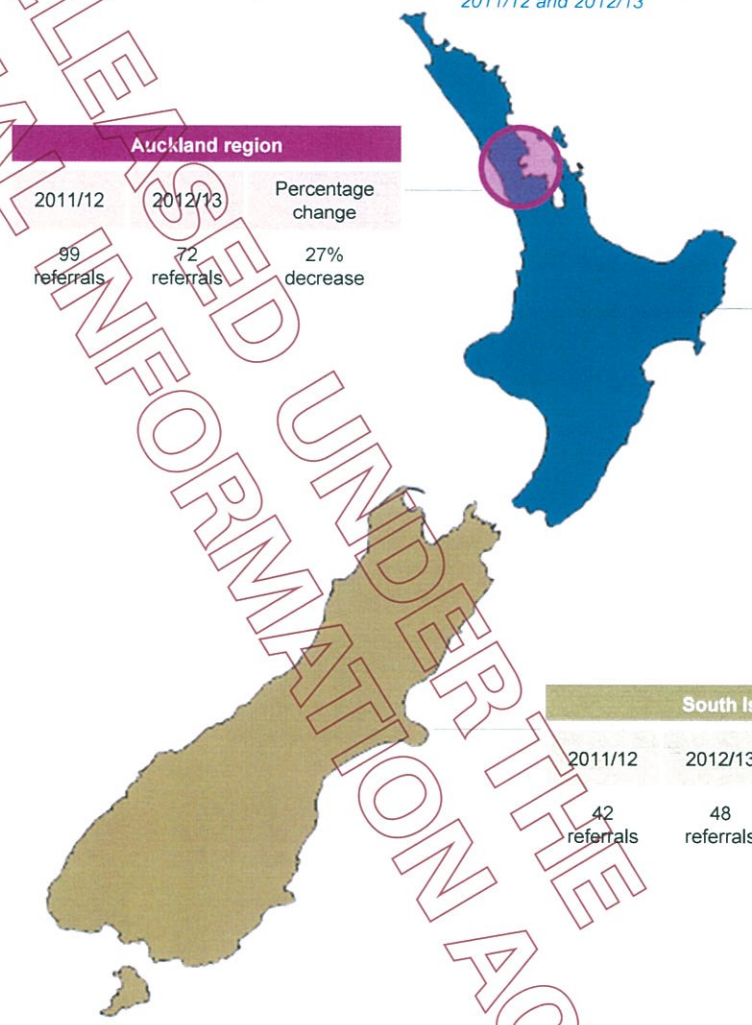
Referrals from the Casino sector are likely to be higher because SkyCity have a policy of requiring gamblers that have previously requested exclusion from the Casino to provide evidence of having attended six treatment sessions from an accredited provider before they are able to re-enter the Casino.

This analysis could be improved if data was reported on the geographical location of referrals to the Gambling Helpline.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

Figure 8.5c: Location of referrals from the gambling industry within CLIC, 2011/12 and 2012/13



Auckland region		
2011/12	2012/13	Percentage change
99 referrals	72 referrals	27% decrease

North Island - other		
2011/12	2012/13	Percentage change
16 referrals	17 referrals	6% increase

South Island		
2011/12	2012/13	Percentage change
42 referrals	48 referrals	14% increase

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Objective 9

Problem gambling services effectively raise awareness about the range of harms from gambling that affect individuals, families/whānau and communities for people who are directly and indirectly affected

	Analysis and presentation of outcome indicators for Objective 9	Previous measurement point
9.1	Analysis of client data for referrals from health sector and community services	This Report
9.2	Analysis of New Zealand Health Survey and problem gambling service presentation data for trends in presentation and a reduction in barriers to presentation	2011/12 Baseline Report
9.3	Analysis of Ministry-funded social marketing impact data	2011/12 Baseline Report
9.4	Analysis of the periodic service-user satisfaction survey and barriers to service usage survey	2011/12 Baseline Report
9.5	Assessment of the percentage of social marketing activities delivered specifically to at-risk groups	This Report

Analysis of client data for referrals from health sector and community services

Summary findings

- The total number of referrals from the health sector and community services has increased by 30% since the prior period, and represents 16.7% of all referrals recorded.
- The number and proportion of referrals from each service does not show a consistent increase or decrease between 2011/12 and 2012/13.

→	Neutral trend	The number of referrals has increased overall by 30% since 2011/12. However the change in the number of referrals from individual service providers between 2011/12 and 2012/13 is mixed. Referrals from some sources have increased, for example the Asian Family Hotline and Oasis, while referrals from other sources have decreased, for example the Gambling Helpline.
H	Confidence in the data	No change since the Baseline Report.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 9.1 analyses the referrals from health sector and community services across the 2011/12 (Baseline) and 2012/13 (Progress) reporting periods. Data was obtained from the Ministry's CLIC system and the Gambling Helpline's database over the two data collections periods described below.

The two data collection periods are:

- 1 July 2011 – 30 June 2012 (2011/12 Baseline Report data period)
- 1 July 2012 – 30 June 2013 (2012/13 Progress Report data period).

The data was sorted to only include unique clients (i.e. clients were only counted once regardless of the number of times they attended services).

Nearly one in four (24% or 2,990) unique service-users had a referral source recorded for the 2012/13 period. The list of referral sources was reviewed and an assessment was made as to whether the source could be considered to be a health sector and community service.

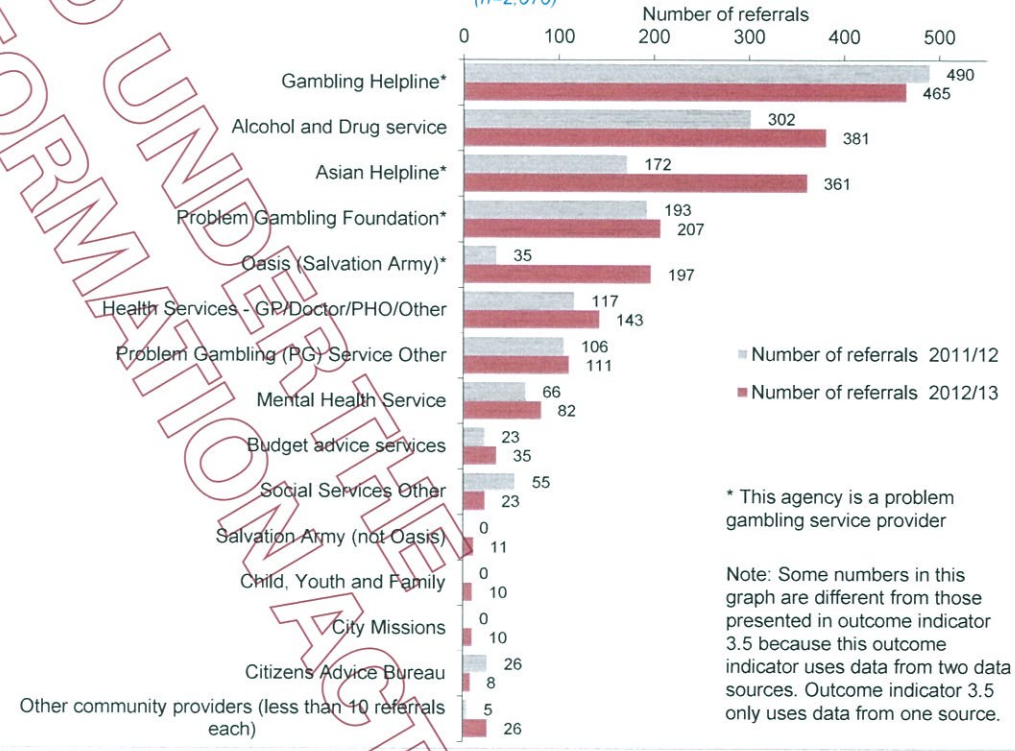
Referrals from health sector and community services made up 16.7% (2,070) of the referrals sources recorded in 2012/13.

Current state of the indicator

Figure 9.1a (below) shows the number of referrals from health sector and community services. The key findings are:

- The number of referrals increased by 30% from the 2011/12 period.
- The most common sources of referral were from problem gambling service providers (* next to the name in the graph below).
- Health sector organisations such as Alcohol and Drug services, primary care providers (GP, doctor or PHO), and mental health services also recorded high levels of referrals, and the number of referrals recorded was similar to 2011/12.

Figure 9.1a Number of referrals from health sector and community services, 2011/12 (n=1,590) and 2012/13 (n=2,070)



* This agency is a problem gambling service provider

Note: Some numbers in this graph are different from those presented in outcome indicator 3.5 because this outcome indicator uses data from two data sources. Outcome indicator 3.5 only uses data from one source.

Analysis of client data for referrals from health sector and community services (cont.)

Limitations and areas for improvement

This analysis only includes agencies that have referred a service-user to a problem gambling service in the 2011/12 and 2012/13 periods where the referral source was recorded. Service providers are reliant on service-users reporting who referred them to seek help. There may be duplication in referrals between the problem gambling service providers in that a referral source may be recorded both when a call is made to the gambling helpline and if a service-user visits a problem gambling service.

This outcome indicator could be improved in future years if referrals between problem gambling service providers were excluded.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

Assessment of the percentage of social marketing activities delivered specifically to at-risk groups

Summary findings

Social marketing activities have increasingly been delivered to at-risk groups since 2011/12:

- *Kiwi Lives 1* was less targeted, but its key messages delivered to two at-risk groups (Māori and Pacific people).
- *Kiwi Lives 2* was more targeted, though it was delivered more specifically to age-related at-risk groups (25-54 year olds).
- *Kiwi Lives 3* was the most targeted social marketing activity, and was targeted to both age-related at-risk groups (25-54 year olds), and ethnicity-related at risk groups (Māori and Pacific).

↑	Improving trend	The *Kiwi Lives 3* social marketing campaign is more targeted than *Kiwi Lives 1* and *Kiwi Lives 2* and is specifically delivered to ethnicity and age related at-risk groups.
H	Confidence in the data	No change since the Baseline Report.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 9.5 assesses the percentage of social marketing activities, conducted by the Health Promotion Agency (HPA, formerly HSC), that are delivered specifically to at risk groups.

In this study, social marketing activities are considered to be activities that use:

- *"Marketing principles and techniques to improve the health and welfare of people and of their physical, social and economic environment. It is a carefully planned, long-term approach to influencing human behaviour. Social marketing is different from commercial marketing because it aims to benefit the target group and society as a whole rather than make a financial profit (HPA, 2012)".*

This study assumes that random samples captured by Campaign Evaluation Surveys used to assess HPA's social marketing campaigns, is representative of the New Zealand population. The definitions of unprompted and prompted awareness were not included within the study.

Three social marketing campaigns conducted by the Health Promotion Authority (HPA, formerly HSC), have been analysed as part of outcome indicator 9.5. These include:

- *Kiwi Lives 1 (HPA, 2007-2009) – analysed in the 2011/12 Baseline Report*
- *Kiwi Lives 2 (HPA, 2009-2010) – analysed in the 2011/12 Baseline Report*
- *Kiwi Lives 3 (HPA, 2011-2012) – analysed in this report (2012/13 Progress Report).*

The Post Campaign and Campaign Evaluation surveys listed below were used to help analyse HPA's social marketing campaigns:

- *Report prepared by Research New Zealand (2013). Kiwi Lives 3 2013 Campaign Evaluation. Wellington: Health Promotion Agency.*
- *Report prepared by Synovate (2009). Kiwi Lives Advertising Stage Two Campaign Effectiveness Measure and Review. Wellington: Health Sponsorship Council.*

Current state of the indicator

At-risk Groups

At-risk groups identified by the NZHS

At-risk groups were identified within the 2006/07 *NZHS* as being:

1. Māori or Pacific ethnicity
2. Between 25-54 years of age
3. Alone
4. Less qualified.

At-risk groups identified by HPA

After the commencement of the *Kiwi Lives 2* campaign, HPA endeavoured to deliver more social marketing campaigns specifically to at-risk groups. As HPA states, measures were being developed concurrently to *Kiwi Lives 2* in order to target "*those groups in the population that are disproportionately affected by gambling harm*" (Statement of Intent, 2009, p. 45).

As a result, in 2011 HPA published a technical report to assess *Groups at Risk of At-Risk Gambling*. The report based its findings on the results of the Health Lifestyles Survey 2010. Its conclusions were intended to be used to guide the delivery of the *Kiwi Lives 3* campaign towards at-risk groups. Table 9.5a, overleaf summarises at-risk groups identified by the NZHS and HPA.

Assessment of the percentage of social marketing activities delivered specifically to at-risk groups (cont.)

Table 9.5a: At-risk groups

Study	At-risk groups identified
HPA (2011)	▪ Adults aged 35 years and over ▪ Those who live in smaller households ▪ Smokers ▪ Māori, Pacific and Asian people ▪ Smokers ▪ People who live in well-populated areas
NZHS (2007)	▪ Māori or Pacific ethnicity ▪ Between 25-54 years of age ▪ Alone ▪ Less qualified
KPMG interpretation of at-risk groups identified in both studies	▪ Māori or Pacific ethnicity ▪ Between 25-54 years of age

This report uses at-risk groups identified by both the NZHS 2006/07 and HPA (2011) as a basis for analysis, these are:

- Adults between the ages of 25 and 54
- People of Māori or Pacific ethnicity.

Degree to which the Kiwi Lives 1 campaign targets at-risk groups

According to HPA's SOI 2011-14, the *Kiwi Lives 1* campaign showed that:

"*Evaluation of public response to the first stage of Kiwi Lives showed that, even after a relatively short time, the messages were recalled by a substantial proportion of the target audience - between a sixth and a third of respondents in the four groups surveyed said they discussed problem gambling with others after viewing Kiwi Lives. In addition, Māori and Pacific peoples were particularly receptive to the message that problem gambling is a community, not just an individual, issue*" (Statement of Intent, 2011-14).

A high proportion of Māori and Pacific people recalled key messages from the *Kiwi Lives 1* campaign (Statement of Intent, 2011-14). This suggests that key messages were delivered to at least two at-risk groups, Māori and Pacific. However, there was little evidence to suggest that the campaign was targeted to the at-risk age groups. Hence *Kiwi Lives 1* was assessed as being partially delivered to at-risk groups (refer table 9.5d, overleaf).

Degree to which the Kiwi Lives 2 campaign targets at-risk groups

HPA's Statement of Intent 2009-2012 states that:

"*The [Kiwi Lives 2] campaign is aimed at New Zealanders from all backgrounds, aged between 25 and 54 years*" (HPA, 2009).

The aim outlined above suggests that *Kiwi Lives 2* was targeted to at least one at-risk group (25-54 year olds). However, little data was found to suggest that the campaign was targeted to at-risk ethnicities, hence the *Kiwi Lives 2* campaign, was assessed as partially delivered to at-risk groups.

Degree to which the Kiwi Lives 3 campaign targets at-risk groups

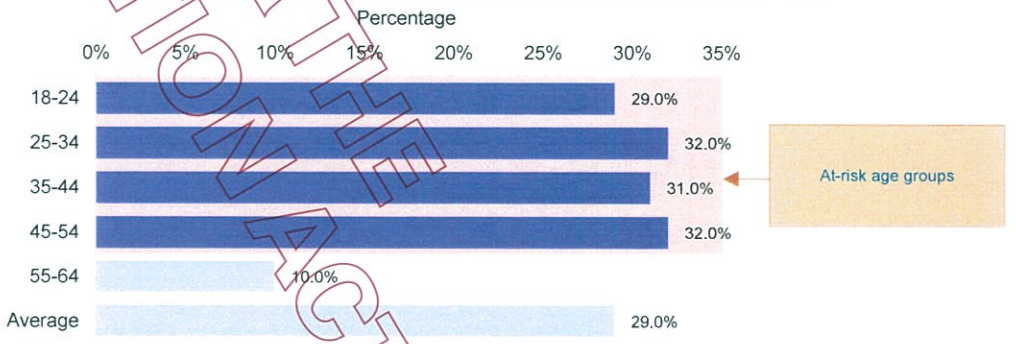
The *Kiwi Lives 3* campaign aired on television and radio nationally, accompanied by billboard advertising during the period between 2011 and 2012.

According to HPA, *Kiwi Lives 3*, the third phase of their social marketing campaign, was aimed at "*those groups of people who are at higher risk of developing gambling problems, as well as at the people in their lives who have the opportunity to intervene before gambling becomes harmful*" (Research New Zealand, 2013, page 3).

A review of the *Kiwi Lives 3 2013 Campaign Evaluation* survey, conducted after the *Kiwi Lives 3* campaign, highlights the extent to which the campaign was delivered to the at-risk groups - as highlighted above and in table 9.5b. For instance:

- Unprompted awareness of *Kiwi Lives 3*, for people affected by or exposed to gambling by age group suggests that the campaign was effectively reaching the at-risk age groups it was intended to 25 – 54 year olds (refer Figure 9.5b, below). There were no significant differences by ethnicity

Figure 9.5b: Unprompted recall of the Kiwi Lives 3 campaign by age group (n=350)



Assessment of the percentage of social marketing activities delivered specifically to at-risk groups (cont.)

Degree to which the Kiwi Lives 3 campaign targets at-risk groups (cont.)

- Similarly, prompted awareness of *Kiwi Lives 3* suggests that the campaign moderately to effectively reached its ethnic target groups of Māori and Pacific (refer Figure 9.5c, opposite top).

Overall assessment of the extent to which social marketing activities are delivered specifically to at-risk groups

A review of relevant documents suggests that from *Kiwi Lives 1* to *Kiwi Lives 3*, there has been a general trend towards the targeting of social marketing campaigns towards at-risk groups, particularly at-risk groups relating to age and ethnicity (Māori and Pacific) (refer table 9.5d).

Limitations and areas for improvement

This indicator represents a qualitative assessment of whether social marketing campaigns are delivered specifically to at-risk groups, based on documented and readily available information on targeting to at-risk groups.

The definitions of unprompted and prompted awareness were not included within the study.

Other at-risk groups, such as smokers, were not analysed in this report. Evidence of these groups being 'mutually exclusive', would need to be confirmed before they can be included as at-risk groups in future analysis.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for previous analysis and reporting of this outcome indicator.

Figure 9.5c: Prompted recall of Kiwi Lives 3 by ethnicity (n=350)

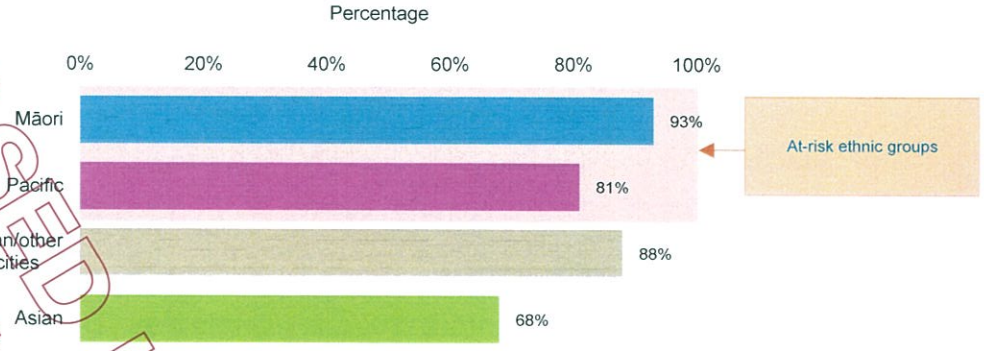


Table 9.5d: Delivery of social marketing campaigns to at-risk groups

	At-risk groups		
	25-54 year olds	Māori	Pacific
Kiwi Lives 1		✓	✓
Kiwi Lives 2	✓		
Kiwi Lives 3	✓	✓	✓

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Objective 10

Accessible, responsive and effective interventions are developed and maintained

Analysis and presentation of outcome indicators for Objective 10		Previous measurement point
10.1	Analysis of periodic clinical audits of intervention services	2011/12 Baseline Report
10.2	Analysis of periodic cultural audits for intervention and public health services	2011/12 Baseline Report
10.3	Analysis of client data for trends in comprehensive assessment and identification of multiple needs	This report
10.4	Analysis of independent moderation service data (resource demand, etc) against New Zealand Health Survey prevalence data	2011/12 Baseline Report
10.5	Analysis of client data for trends in culturally specific presentation, compared to New Zealand Health Survey prevalence data	2011/12 Baseline Report
10.6	Analysis of periodic service-user satisfaction and barriers to service survey specific to dedicated services	2011/12 Baseline Report
10.7	Analysis of the diversity of client characteristics (ethnicity, age, and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services)	This report

Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs

Summary findings

- The number of service-users with more than one problem (co-existing need), did not substantially change from 2011/12. As well as showing indicators of risky gambling behaviours, 'Alcohol and depression' and 'alcohol, depression and suicide' continue to be the most common co-existing needs.
- Females reporting risky alcohol behaviour decreased slightly from 2011/12 (31% to 28%). This increased slightly for males.
- **Risky drug taking behaviour** has increased since 2011/12 for females (10.7%) and Māori (10.2%).
- Overall **depression** scores have not changed substantially from 2011/12. No substantial differences were identified between males and females. However, both Māori and Non-Māori recorded a slight increase in depression screen results, for both initial and subsequent screens, from 2011/12.
- For initial **suicide** screening sessions there was an increase in those disclosing 'just thoughts' about suicide for males (8.5%), females (4.8%), Māori (6.8%) and Non-Māori (6.5%).
- Initial assessments highlighted that those seeking help for their gambling are spending slightly more on gambling compared to 2011/12, as there was a slight increase in initial median dollars spent in the month prior to an initial assessment.
- Users of problem gambling services reported spending less on gambling after treatment (no change from 2011/12), with the exception of the >$501,000 bracket.

↓	Deteriorating trend	There have been slight increases in risky alcohol behaviour, risky drug taking behaviour, increases in initial depression screening results and increased thoughts about suicide.
M	Confidence in the data	The data presented is only for the service users who were screened for other problems. Not all clients are screened for all problems reported in this outcome indicator therefore the information reported may not be representative of all clients attending services.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 10.3 analyses trends in comprehensive assessment and identification of multiple needs, by comparing 2012/13 Progress Report data with 2011/12 Baseline Report data. Data for outcome indicator 10.3 was obtained from the CLIC database and measures the periods:

- 1 July 2011 to 30 June 2012 (Baseline report period)
- 1 July 2012 to 30 June 2013 (Progress report period).

Note: there was a small sample size adjustment made to figures reported in the Baseline Report. In that report the sample size for service-users, used in the dollars spent on gambling screen, was reported as n=3,060. The Progress Report has corrected this amount to n=3,630.

Note: 'Other' includes New Zealand Europeans.

Types of screens analysed

Problem gambling service providers complete a series of screens (measures of effectiveness on co-existing issues) as part of the comprehensive assessment of service-user needs. This outcome indicator reports on the results of those screens, and where available movements in the results between initial and subsequent treatment sessions.

The following screens were analysed:

1. Problem Gambling Severity Index (PGSI)
2. Gambler outcome-control score
3. Dollars spent on gambling and annual household income
4. Multiple co-existing needs
5. Alcohol use
6. Drug use
7. Depression
8. Suicidality.

Data was analysed by gender and ethnicity for each measure. Ethnicity analysis was not completed for Pacific or Asian groups because the screens were applied to insufficient service-users (i.e. typically n<50).

Current state of the indicator

1. PGSI

Analysis of the PGSI is completed in outcome indicators 1.2 and 2.2. Refer to these outcome indicators for full analysis.

2. Gambler outcome-control score

Analysis of the gambler outcome-control score is completed in outcome indicators 1.2 and 2.2. Refer to these outcome indicators for full analysis.

Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

3. Dollars spent on gambling screen and annual household income

Figure 10.3a (opposite top) shows the dollars spent on gambling (in the previous month) reported by service-users in their first session with a clinician, for 2011/12 and 2012/13.

Service-users (n=2,881 in 2013 vs. n=3,630 in 2011/12) were asked:

'In the last month when you were gambling, roughly what amount of money did you spend on gambling?'

Key findings:

a. Decreased spending across all spending brackets, with the exception of the $1 - $100 bracket that had a slight increase (5%) in 2012/13.

b. Most changes in dollars spent can be explained by the smaller sample size used in 2012/13 (n=2,881, vs. n=3,630 in 2011/12). However, when assessing the general spread of spending, it is clear that there has been substantial decreases in the number of service-users reporting spending nothing, $501 - $1,000 and $1,001 - $2,000 brackets.

This analysis only includes gamblers. Family members and affected others are excluded.

Dollars spent by income

The CLIC database includes 921 service-users that were screened for both their dollars spent and income on more than one occasion (3,061 in 2011/12). Where these service-users also attended services in years prior to 2012/13, data from their first session was used to determine their initial score. Figures 10.3b and 10.3c (opposite middle and opposite bottom) present the median and mean dollars spent in the previous month with results grouped by the service-user's reported annual income band, across 2011/12 and 2012/13. Key findings:

a. There is a link between dollars spent and income, i.e. those on higher incomes tended to report a higher amount of dollars spent.

b. In general the variance between the median and mean for all income bands indicates that high losses experienced by some service-users increased the mean dollars spent.

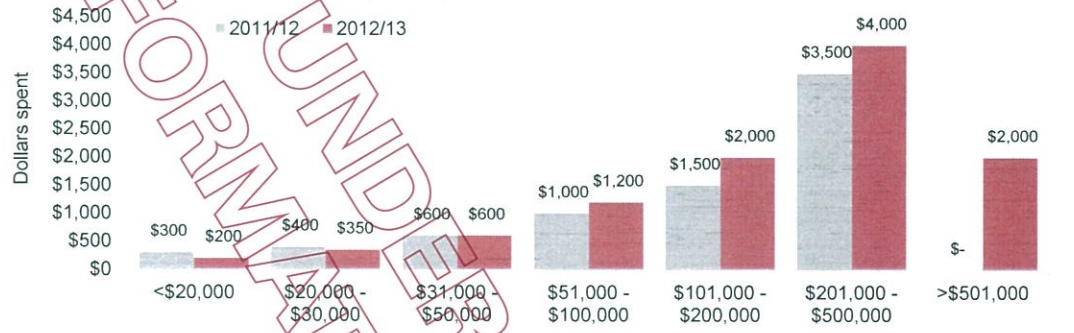
c. A general increase in median dollars spent across all income bands with the exception of the two lowest income bands, <$20,000 and $20,000 - $30,000.

d. An increase in mean dollars spent in the lowest and highest income brackets.

e. A decrease in mean dollars spent in the $31,000 - $50,000, and $201,000 - $500,000 income brackets.

Figure 10.3a: Dollars spent on gambling by service-users, 2011/12 and 2012/13

10.3b: Median dollars spent compared with annual income, 2011/12 and 2012/13



10.3c: Mean dollars spent compared with annual income, 2011/12 and 2012/13

Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

Figure 10.3d (opposite top) compares 2011/12 and 2012/13 using the median rather than mean (as the mean is easily skewed by individual large losses). Key finding:

a. Dollars spent between the initial and subsequent sessions reduced across all income brackets, with the exception of the >$501,000 bracket.

4. Multiple co-existing needs

The following pages analyse the results of screens completed and recorded in the CLIC database for service-users presenting at problem gambling services for other co-existing needs. These include screening for alcohol, drugs, depression and suicide. The analysis in this section only includes service-users where:

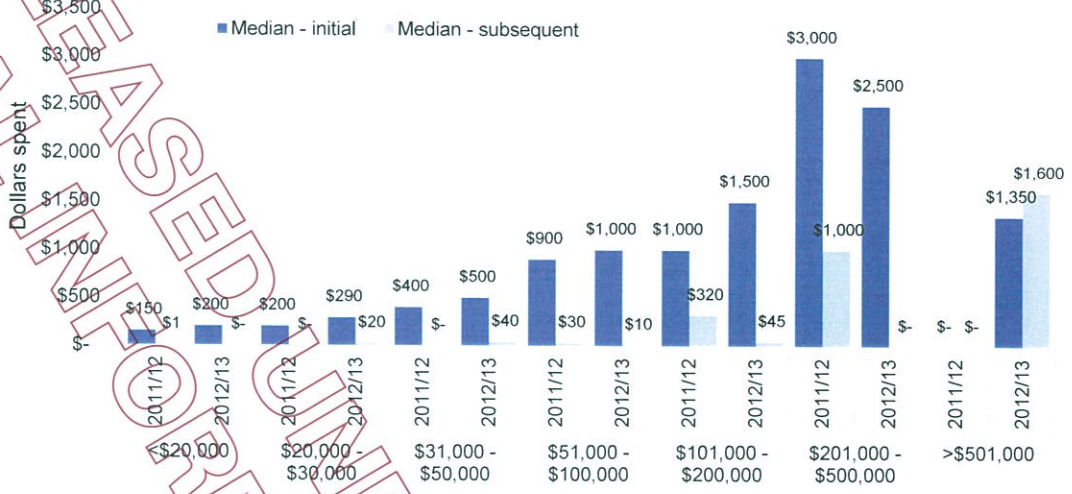
1. The relevant screen was applied; and
2. The results of the screen were entered into the CLIC database.

Figure 10.3e (opposite bottom) compares the proportion of service-users reporting these co-existing needs for 2011/12 with 2012/13. This shows that of those screened:

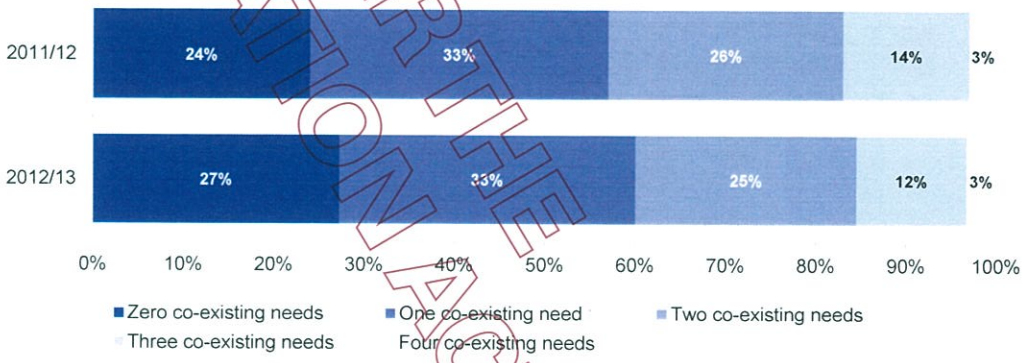
a. There was a slight increase (3%) for service-users experiencing **zero** co-existing needs
b. The was no change in the percentage of service-users reporting **one** co-existing need
c. There was a slight decrease (1%) in the percentage of service-users reporting **two** co-existing needs
d. There was a slight decrease (2%) in the percentage of service-users reporting **three** co-existing needs
e. There was no change in the percentage of service-users reporting all **four** co-existing needs (alcohol, drug, depression and suicide).

Note: Many service-users had results recorded in CLIC for fewer than four screens and accordingly could not have four co-existing needs reported.

10.3d: Median dollars spent compared with income for initial and subsequent sessions, 2011/12 and 2012/13



10.3e Proportion of service-users screened with between zero and four co-existing service needs, 2011/12 (n=2,402) and 2012/13 (n=3,449)



Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

4. Multiple co-existing needs (cont.)

Overall, the number of service-users reporting multiple co-existing needs increased from 1,035 in 2011/12 to 1,380 in 2012/13 (an increase of 33%). Because of the difference in sample size, percentages have been used instead of counts in multiple needs analysis.

Figure 10.3f (opposite top) compares the most common combinations of multiple co-existing needs reported by service-users in 2011/12 and 2012/13. Key findings:

a. The combinations of *alcohol and depression*, and *alcohol, depression & suicide* were the most common co-existing needs across periods.

b. The combinations of *depression & suicide* and *drugs, depression & suicide* have declined substantially from 2011/12.

c. The combinations of *drugs & depression*, and *alcohol, drugs, depression & suicide* have increased substantially from 2011/12.

d. Depression features as a co-existing need in the top seven needs categories.

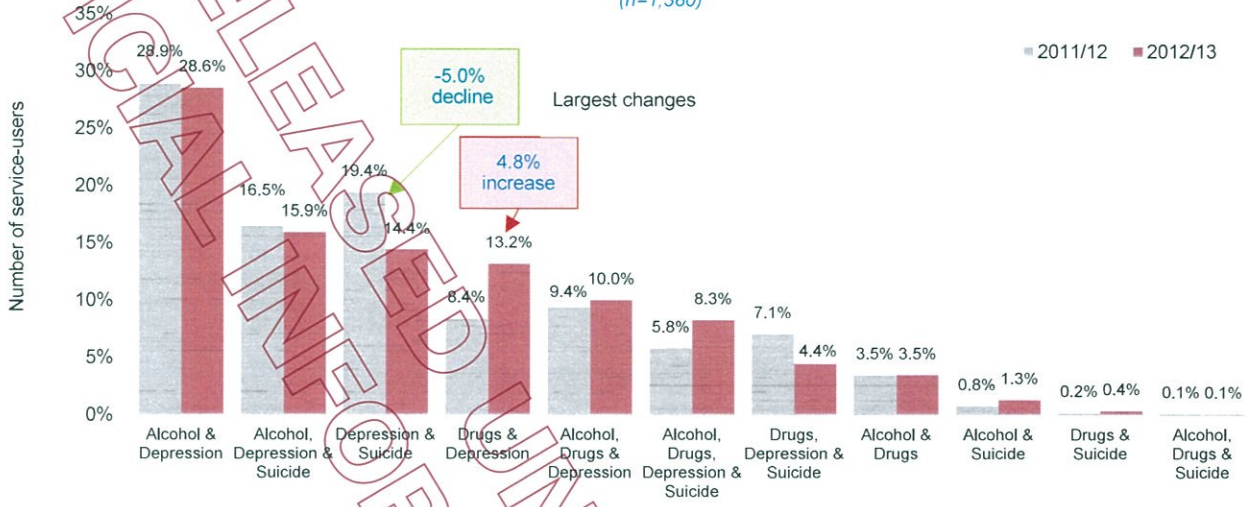
5. Alcohol use

The AUDIT-C alcohol use disorders screen was applied and recorded in the CLIC database for 2,758 service-users in 2012/13. This screen asks service-users three questions:

1. How often did you have a drink containing alcohol in the past year?
2. How many drinks did you have on a typical day when you were drinking in the past year?
3. How often did you have six or more drinks on one occasion in the past year?

A response of between 1 and 4 is provided to each question, with higher scores representing a higher level of risk. The highest possible score for the screen is 12.

10.3f Number of service-users with multiple co-existing needs (most common combinations), 2011/12 (n=1,035) and 2012/13 (n=1,380)



Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

5. Alcohol use (cont.)

Overall, the number of service-users screened for alcohol-use disorders increased from 2,171 in 2011/12 to 2,758 in 2012/13 (an increase of 27%). Percentages have therefore been used in analysis. Note: In Figures 10.3g and h, only the client's first recorded score is used.

Alcohol-use by males

Figure 10.3g (opposite top) presents the results of the alcohol use disorders screen for males for 2011/12 and 2012/13. A score of five or higher for males is considered an indicator of risky alcohol behaviour.

Key findings:

a. Almost half (43.5%) of males screened, and with a score recorded in the CLIC database, showed indicators of risky alcohol behaviour.

b. An increase since 2011/12 for males with a screen score of 0, 7, 9, 10, and 12; the most substantial increase being males that scored 0 (3.9% increase).

c. A decrease since 2011/12 for males that scored 1, 2, 3, 5, 6, and 8 in the alcohol-use screen.

Alcohol-use by females

Figure 10.3h (opposite bottom) presents the results of the alcohol use disorders screen for females. A score of four or higher for females is considered an indicator of risky alcohol behaviour.

Key findings:

a. More than a quarter (28.4%) of females screened and recorded in the CLIC database showed indicators of risky alcohol behaviour.

b. A decrease since 2011/12 for females across most scores, with the exception of 0, and 9. Scores of 1, 3, and 6 exhibited the most substantial decline amongst females.

c. An increase since 2011/12 for females that scored 0, 5 and 9; with the most substantial increase being females that scored 0 (8.1% increase).

Figure 10.3g: Results of alcohol-use disorders screen for males, by percentage, 2011/12 (n=1,137) and 2012/13 (n=1,464)

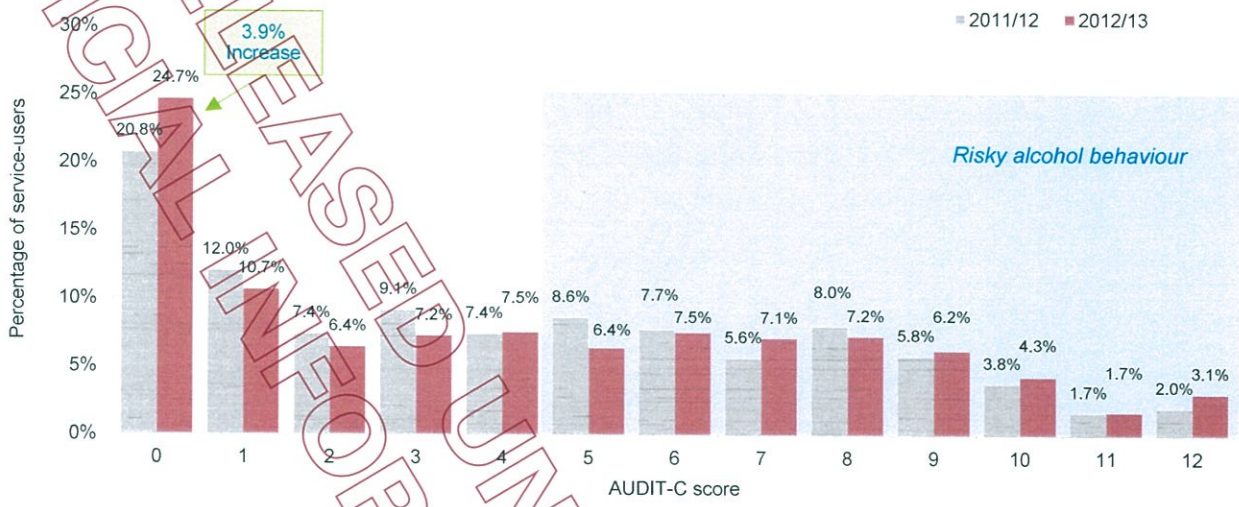
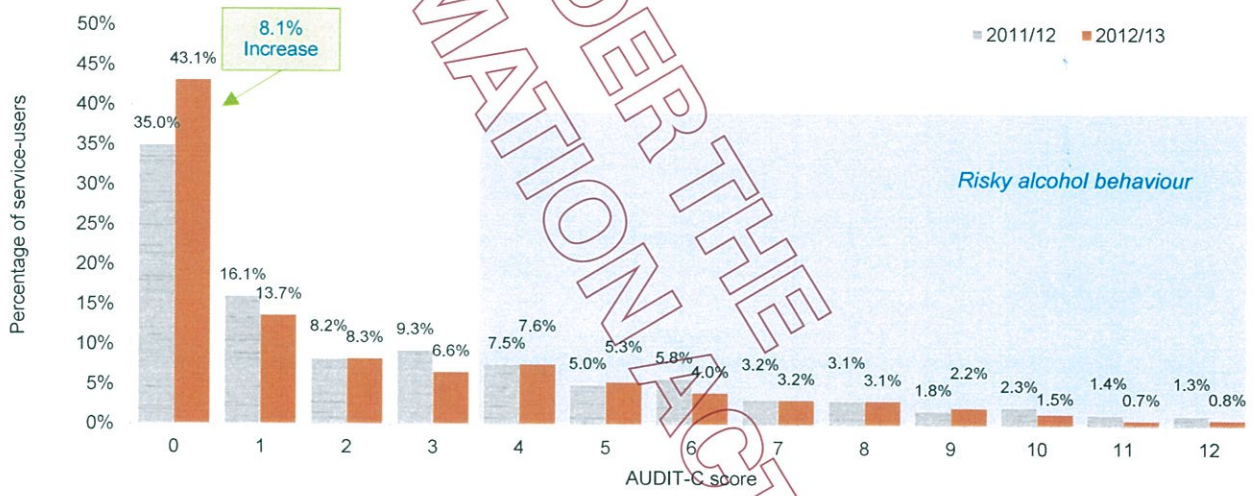


Figure 10.3h: Results of alcohol-use disorders screen for females, by percentage, 2011/12 (n=1,034) and 2012/13 (n=1,294)



Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

5. Alcohol use (cont.)

Initial and subsequent alcohol scores

Figure 10.3i (opposite top) presents the average AUDIT-C scores for service-users recorded in the CLIC database at initial sessions compared with subsequent sessions. This analysis includes 790 service-users who had an alcohol use screen completed on more than one occasion and recorded in the CLIC database. The latest session for all service-users was 2012/13, however data from previous years was used to determine the initial score (where available).

Key findings:

a. The average initial scores reported for males are higher than those for females at 3.49 compared with 2.19.

b. Initial scores for males were substantially lower in 2012/13 compared to 2011/12.

c. The scores for both genders reduced between their initial and subsequent screens.

Comparison of alcohol usage between Māori (average initial = 2.69, average subsequent = 2.14) and Non-Māori (average initial = 2.88, average subsequent = 2.57) showed no substantial differences. Data was available on 320 Māori service-users who received an alcohol use screen on more than one occasion and had the score recorded in the CLIC database. This was comparable to 346 other ethnicity clients having one or more scores recorded. Insufficient data was available to analyse Asian ethnicities separately.

6. Drug use

The drug use screen was applied and recorded in the CLIC database for 2,670 service-users in 2012/13. The drug use screen is based on a single 'yes' or 'no' response to the question:

'In the past 12 months, have you ever felt the need to cut down on your use of prescription or other drugs?'

Answers to this question were compared across 2011/12 and 2012/13. Key findings:

a. A small increase (4.2%) in the percentage of service-users answering 'yes' to the drug screen question and a concurrent decrease (4.2%) in those responding with 'no'.

Note: In Figure 10.3j (opposite bottom), only the client's first recorded score is used.

Figure 10.3i: Initial and subsequent alcohol use scores by gender, 2011/12 (n=444) and 2012/13 (n=790)

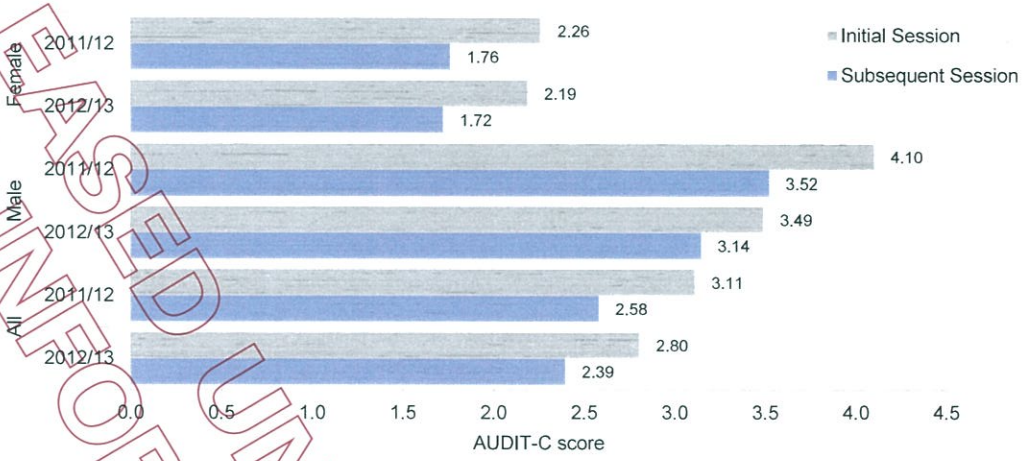
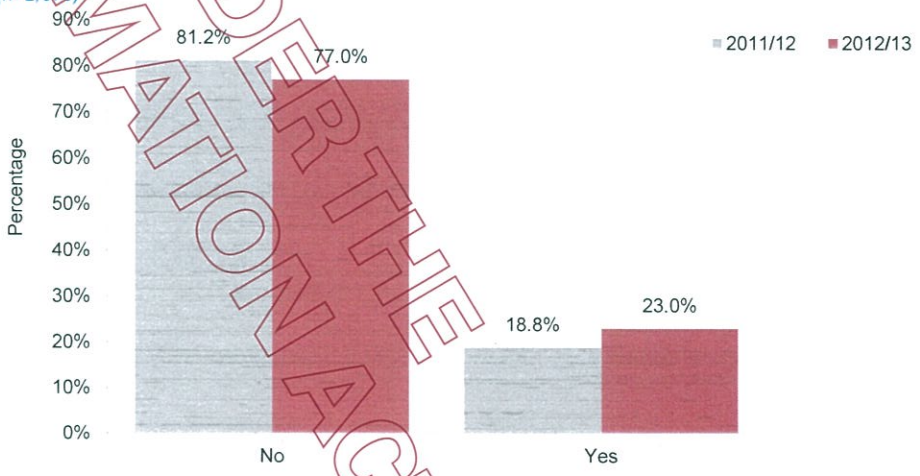


Figure 10.3j: Service-users with positive responses to drug screen, 2011/12 (n=2,087) and 2012/13 (n=2,670)



Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

6. Drug use (cont.)

Drug use by gender

Figure 10.3k (opposite top), compares by gender, the initial and subsequent drug use score for service-users that were screened on more than one occasion (answering 'yes') and had the results of the screen recorded in the CLIC database. The 2011/12 and 2012/13 results were also compared. This includes 764 clients that received an initial and subsequent drug score.

Key findings:

a. Across all categories, the percentage of service-users answering 'yes' to drug screen questions reduced in subsequent sessions, though this reduction was insignificant for males in 2012/13.

b. **Males** that answer 'Yes' exhibit <u>smaller declines</u> across periods and across initial and subsequent sessions compared to females:
   - 2011/12: 2.7% decline between initial and subsequent sessions
   - 2012/13: 1.1% decline between initial and subsequent sessions.

c. **Females** that answer 'Yes' exhibit <u>larger declines</u> across periods and across initial and subsequent sessions compared to males:
   - 2011/12: 4.1% decline between initial and subsequent sessions
   - 2012/13: 4.9% decline between initial and subsequent sessions.

Drug use by Māori

Figure 10.3l (opposite bottom) compares the initial and subsequent drug use screens for Māori compared with Non-Māori as recorded in the CLIC database, for 2011/12 and 2012/13. Data was available for 312 Māori that received an initial and subsequent drug score.

Key findings:

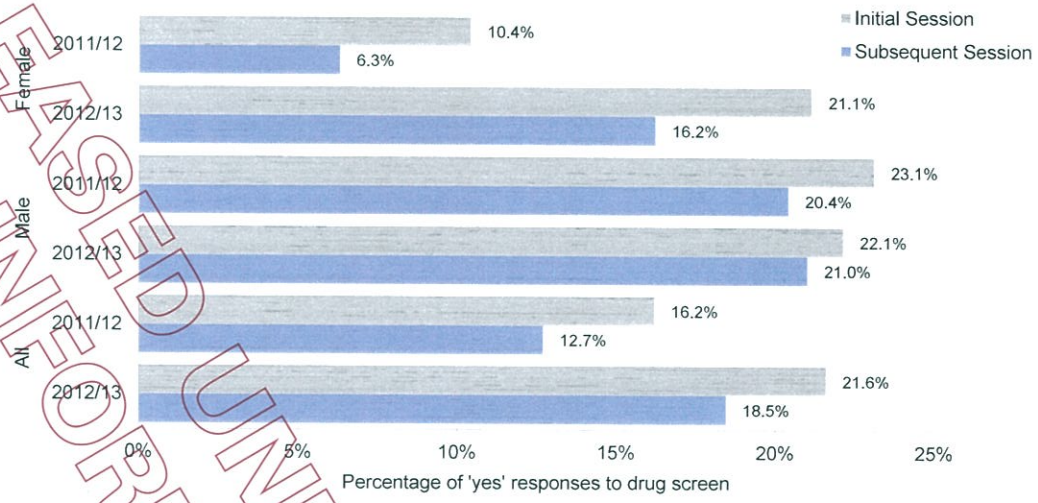
a. Risky drug taking behaviour has increased since 2011/12, for Māori and Non-Māori.

b. A greater percentage of Māori indicate risky drug-taking behaviour than Non-Māori in 2011/12 and in 2012/13.

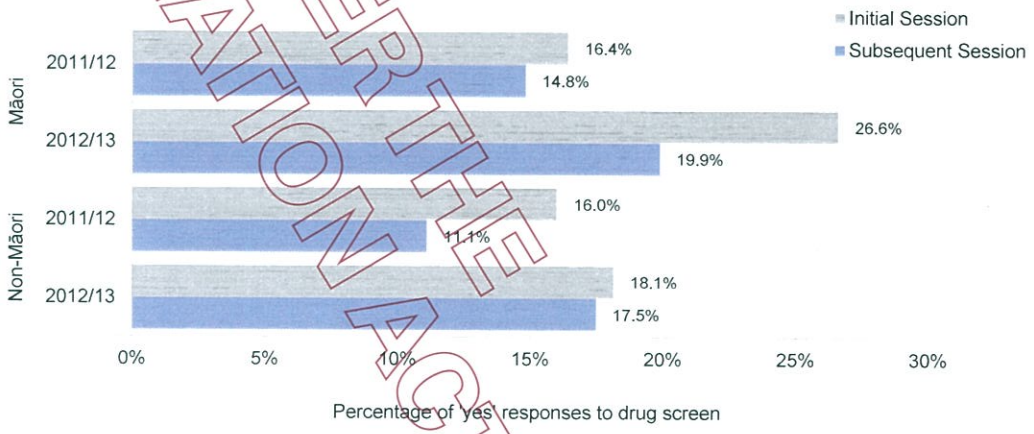
c. 2012/13 data suggests that Māori service-users indicating risky drug-taking behaviour were more responsive in subsequent sessions compared to Non-Māori (-6.7% vs. 0.6%).

d. Māori service-users were also more responsive compared to 2011/12 (-6.7% vs. 1.6%).

10.3k initial and subsequent drug use screens by gender, 2011/12 (n=349) and 2012/13 (n=764)



10.3l: Initial and subsequent drug use screens for Māori compared with Non-Māori (non-standardised), 2011/12 (n=349) and 2012/13 (n=764)



Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

7. Depression

Service-users are also screened for indicators of depression based on 'yes' or 'no' responses to two questions:

1. *'In the past 12 months, have you often felt down, depressed or hopeless?'*
2. *'In the past 12 months, have you often had little interest or pleasure in doing things?'*

A 'yes' response to either question is considered a positive response and an indication that the service-user may be affected by depression. In 2012/13, the CLIC database included 2,880 service-users that were screened for depression, of which 1,895 (66%) responded with a 'yes' to either one question or both questions.

Responses to depression screen

Figure 10.3m (opposite top) shows a slight increase in zero depression scores (3%) and a slight decrease in depression scores of 1 (-3%), however, this change is not significant. Note: in Figure 10.3m only the client's first recorded score is used.

Initial and subsequent depression screen by gender

Data was available within the CLIC database to compare the initial and subsequent sessions for 821 service-users. Figure 10.3n (opposite bottom) presents the results of the depression screen for these service-users.

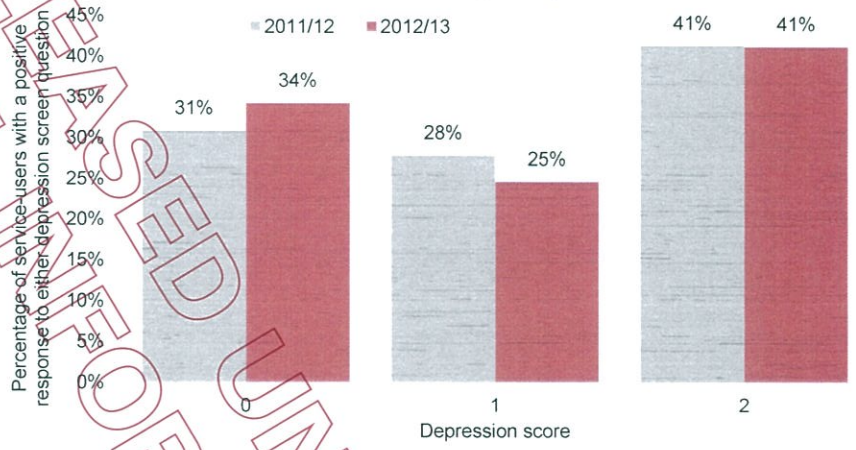
Key findings:

a. Overall, 69.4% of service-users responded positively to either question at the initial sessions, reducing to 54.7% in the most recent session. No substantial differences were identified between males and females.

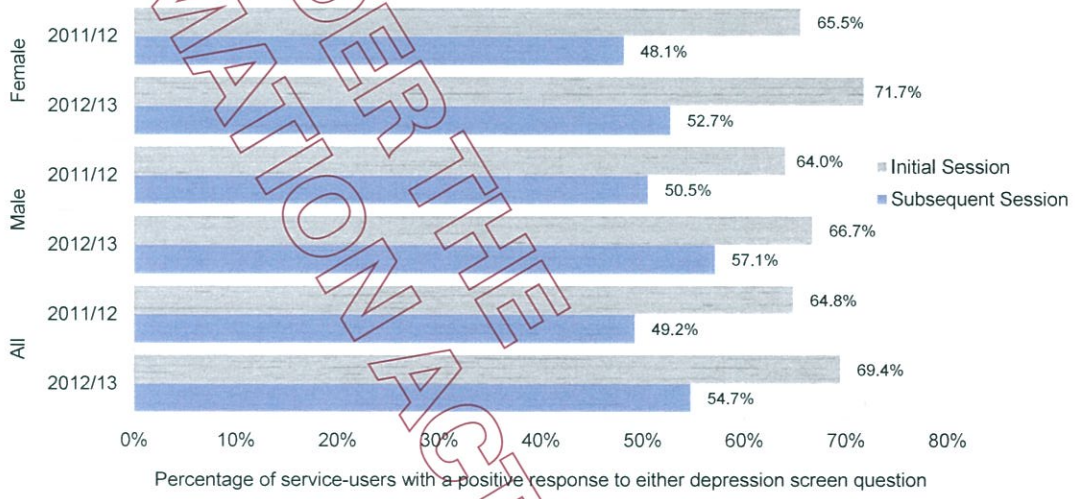
b. The percentage of females with initial positive depression screen results has increased slightly (6.2%) since 2011/12.

c. Overall, positive responses in initial and subsequent sessions increased slightly between 2011/12 and 2012/13, however this is not significant.

10.3m: Responses to Depression Screen, by percentage of service-users, 2011/12 (n=2,260) and 2012/13 (n=2,880)



10.3n: Initial and subsequent depression screen results by gender, 2011/12 (n=472) and 2012/13 (n=821)



Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

7. Depression (cont.)

Initial and subsequent sessions for Māori and Non-Māori

Figure 10.3o (opposite) compares the initial and subsequent sessions for Māori compared with Non-Māori recorded in the CLIC database, for 2011/12 and 2012/13.

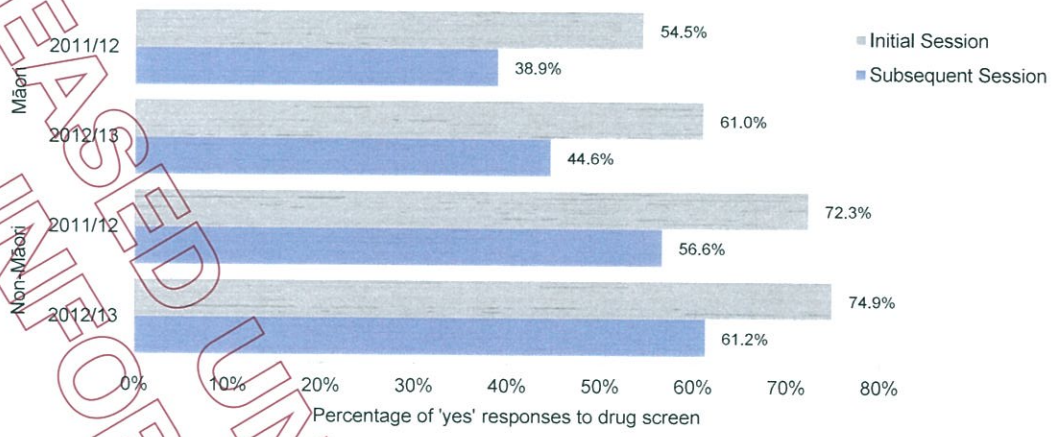
Key findings:

a. Both Māori and Non-Māori recorded a slight increase in depression screen results, for both initial and subsequent screens, between 2011/12 and 2012/13.

b. The percentage of Māori service-users exhibiting indicators of depression is lower than Non-Māori in 2011/12 and 2012/13.

c. A clear improvement across both groups after treatment for problem gambling.

10.3o: Initial and subsequent depression screen results for Māori compared with Non-Māori, 2011/12 (n=472) and 2012/13 (n=821)



Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

8. Suicide

Problem gambling service providers use a suicidality screen to establish whether there are any concerns about suicidal ideation amongst service-users.

Service-users are asked:

'Within the last 12 months, have you had thoughts of self-harm or suicide?'

Responses are allocated to one of the categories listed below based on the response.

- (0) No thoughts in the past 12 months
- (1) Just thoughts
- (2) Not only thoughts, I have also had a plan
- (3) I have tried to harm myself in the past 12 months.

Note: only categories 1, 2, and 3 are reported here.

Key findings:

a. In total 24.6% of service-users responded with indicators of suicidal ideation and this is presented in Figure 10.3p (opposite top)

b. No significant differences since 2011/12.

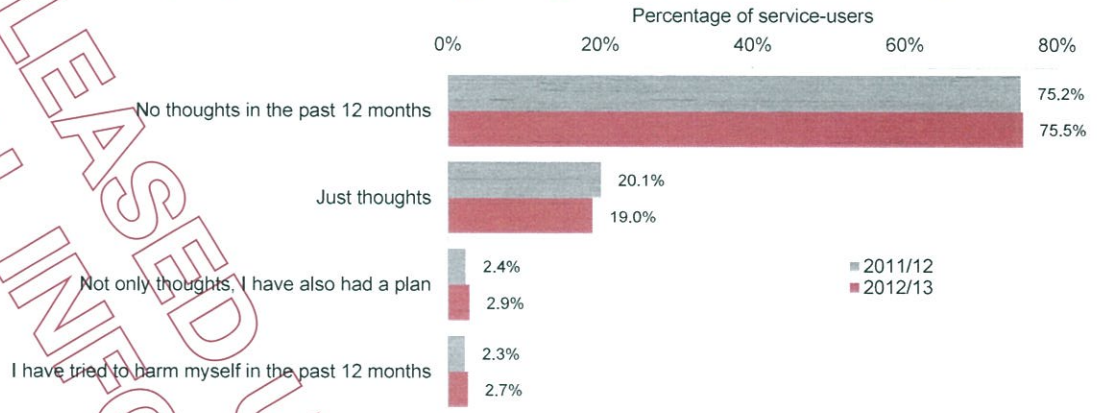
Initial and subsequent suicide screen by gender

Figure 10.3q (opposite bottom) compares the initial and subsequent suicide screen scores recorded in the CLIC database for males and females across the 2011/12 and 2012/13 periods.

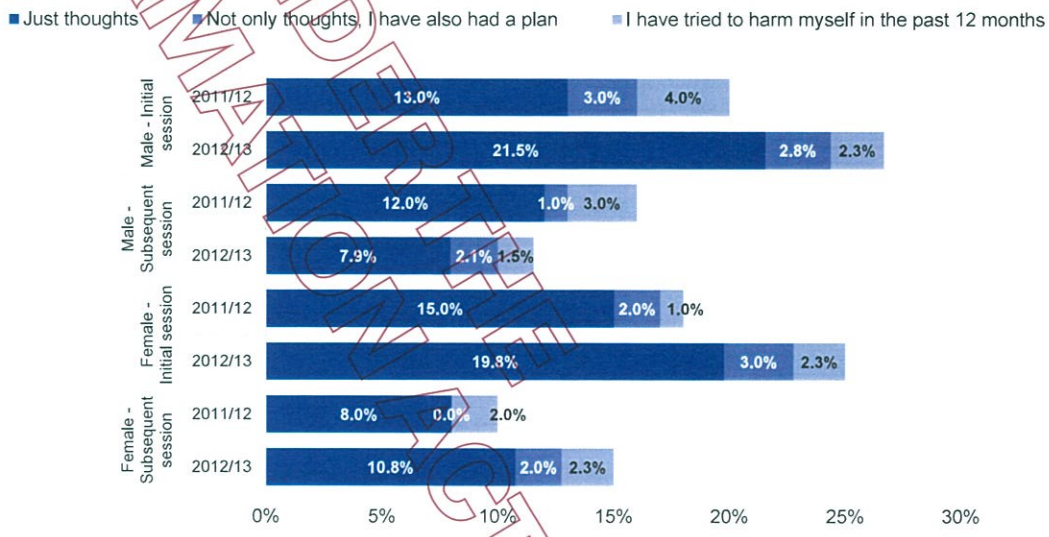
Key findings:

a. For initial sessions there was an increase in males and females reporting 'just thoughts' about suicide, and a concurrent decrease in males and females reporting 'no thoughts in the past 12 months' about suicide.

10.3p: Responses to suicide screen, by percentage, 2011/12 (n=2,178) and 2012/13 (n=2,785)



10.3q: Initial and subsequent suicide screen results by gender, 2011/12 (n=405) and 2012/13 (n=790)



Analysis of service-user data for trends in comprehensive assessment and identification of multiple needs (cont.)

Figure 10.3r (below) compares the initial and subsequent suicide screens recorded in the CLIC database for Māori compared with Non-Māori.

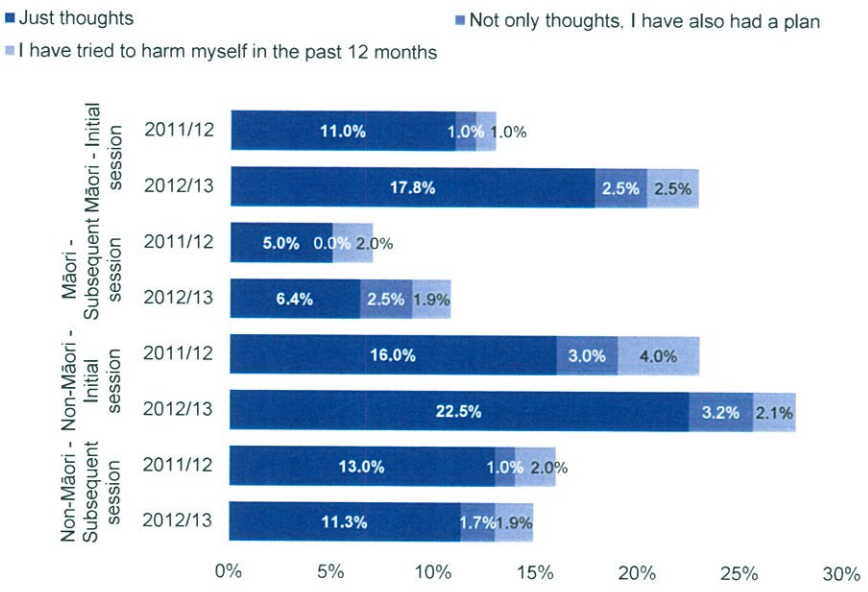
Key findings:

a. Like males and females, Māori and Non-Māori exhibit an increase in having 'just thoughts' about suicide since 2011/12.

b. A higher proportion of Non-Māori responded with indicators of suicidal ideation.

c. Both groups showed improvement in the proportion of service-users reporting 'no thoughts in the past 12 months' after treatment (not shown), in particular Māori comprised 89% of those who were screened reported 'no thoughts of suicide in the past 12 months'. The difference was larger in 2011/12.

10.3r: Initial and subsequent suicide screen results for Māori and Non-Māori, 2011/12 (n=405) and 2012/13 (n=790)



Limitations and areas for improvement

It is currently not compulsory for service providers to enter the results of individual screens in the CLIC database when completed. This outcome indicator could be improved if more screens were completed and recorded in the CLIC database.

Data within the CLIC database only relates to people that have been assisted by problem gambling services. People that do not seek help are not included and therefore it is not possible to analyse the results of their comprehensive assessment or co-existing needs.

The analysis of the results of the co-existing needs screens may be biased in that a clinical decision is made when applying screens. For example, if a service-user has other indicators of alcohol harm, the clinician may be more likely to apply the alcohol-harm screen. This would over-report the numbers of service-users presenting with each co-existing need. Hence, results should be treated with caution.

The measures of dollars spent on gambling are in response to the question:

'In the last month when you were gambling, roughly what amount of money did you spend on gambling?'.

Clinicians are encouraged to ensure that this only includes dollars lost on gambling (i.e. money taken to gamble with plus any additional money obtained, and ignoring any money won). Responses are subjective and therefore the analysis should be treated with caution.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services)

Summary findings

There was little to no change in the diversity of those presenting to different problem gambling service providers across all areas analysed when compared to 2011/12. The key messages are:

- **Dedicated Māori service providers –** The majority of presentations were Māori and 22% of attendance was from 'Other' ethnicities.
- **Dedicated Pacific service providers –** The majority of presentations were of Pacific ethnicity. There was also more than 15% attendance from Māori. Service-users are younger than at general service providers.
- **General service providers –** 'Other' was the most prevalent ethnicity with lesser proportions of Māori and Pacific people attending than at Māori and Pacific service providers.
- **Dedicated Asian service providers –** Analysis was not possible as service-users attending dedicated Asian services cannot be identified separately within the CLIC database.

→	No trend	There is little to no change in the diversity of those presenting to different service types.
H	Confidence in the data	No change since the Baseline Report.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 10.7 analyses the diversity of client characteristics (ethnicity, age and gender) presenting to difference service types (general, dedicated Māori, pacific or Asian services) and compares 2011/12 (Baseline Report) data with 201213 (Progress Report) data to understand if there has been any change in the diversity.

Data for outcome indicator 10.7 was obtained from the CLIC database and measures the period 1 July 2012 to 30 June 2013 (2012/13 Progress Report period). All service-users that attend Ministry of Health-funded problem gambling service providers are recorded in this database.

The database was filtered to include each service-user once. Each problem gambling provider was classified as either 'general' or 'dedicated' as defined in their contract.

The diversity of service-users was analysed by ethnicity, gender and age. For this outcome indicator, ethnicity was determined by the Ministry's prioritisation criteria whereby each service-user is categorised with a single ethnicity.

Note: 'Other' includes New Zealand Europeans.

Definitions

The diversity of service-users presenting is measured by the number of unique service-users (i.e. only counting each service-user once) receiving a brief or full session at a problem gambling provider.

General service providers are service-providers that are not contracted to provide services to specific ethnic groups.

Dedicated Māori, Pacific or Asian service providers are contracted to provide services to specific ethnic groups. Dedicated service providers are not exclusive and people from other ethnic groups are able to attend.

East Asian: The CLIC database categorises ethnicities as either Māori, Pacific, East Asian or Other. The East Asian category includes Burmese, Filipino, Indonesian, Cambodian, Laotian, Malay, Thai, Vietnamese and Chinese (including Chinese from outside Mainland China). Other Asian ethnicities such as Korean and Japanese are classified as Other.

Current state of the indicator

Dedicated Māori service providers - ethnicity

Figures 10.7a and 10.7b (overleaf) compare the ethnicity of gamblers presenting to Māori service providers with the ethnicity of those attending Non-Māori service providers. Presentations by family members or affected others are analysed separately in Figures 10.7c to 10.7d.

Key findings are:

a. The majority of those gamblers attending Māori service providers are Māori (62%) compared with Non-Māori service providers where 22% of service-users are Māori. This is less than 2011/12 where Māori attendance to Māori service providers was 66% and Māori attending Non-Māori service providers was 22%.

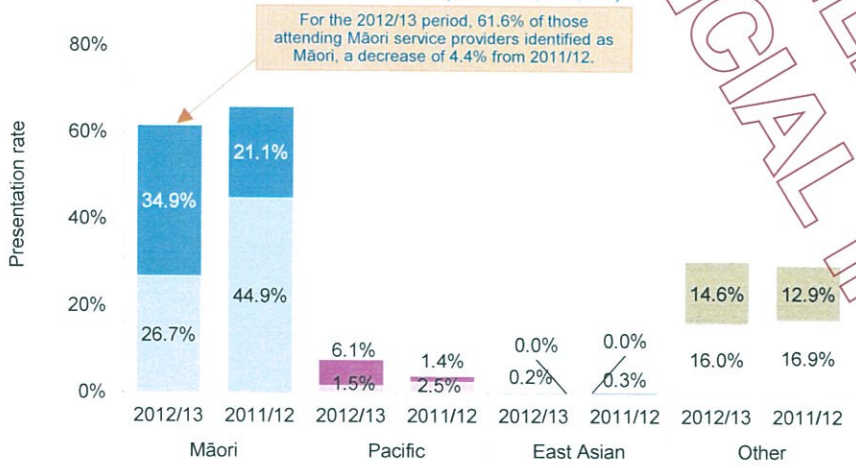
b. Of those attending Māori service providers, 31% identified as 'Other'.

Figures 10.7c and 10.7d (overleaf) provide similar analysis, but with a focus on family members/affected others presenting to service providers. This shows similar results with 62% of those presenting to Māori service providers identifying as Māori ethnicity, followed by 'Other' at 28%. This is similar to 2011/12 figures with Māori family members/affected others people attendance previously sitting at 68%.

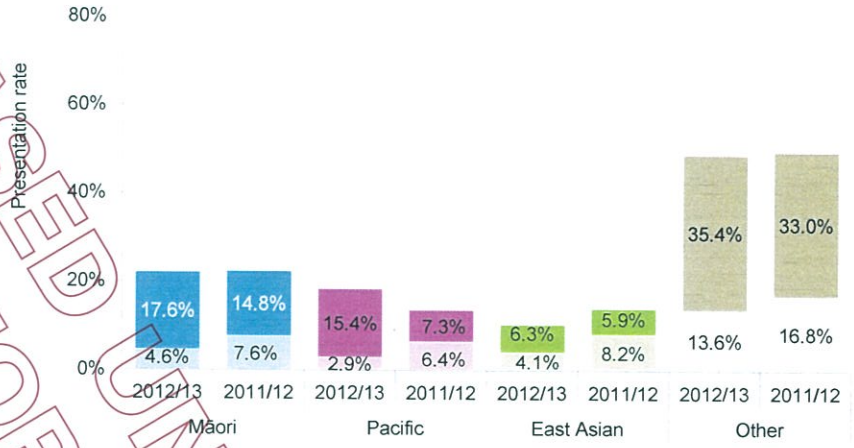
Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

Presentations to dedicated Māori service providers, 2011/12 and 2012/13

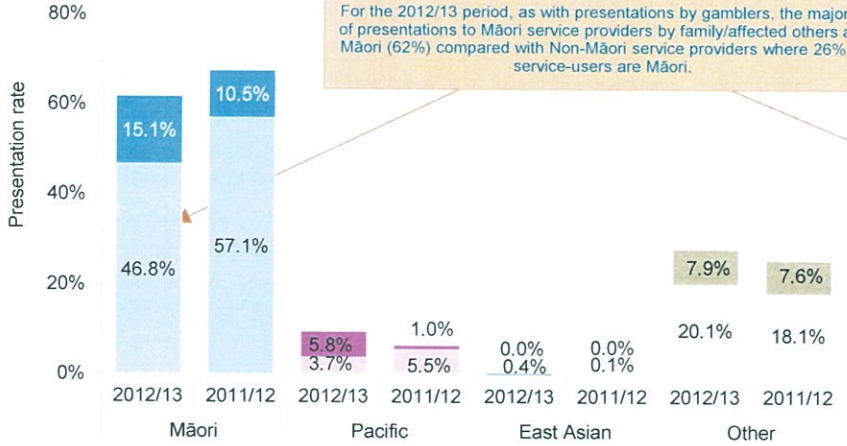
10.7a: Gambler presentations by ethnicity to Māori service providers (2011/12, n=1,418), 2012/13, n=1,552)



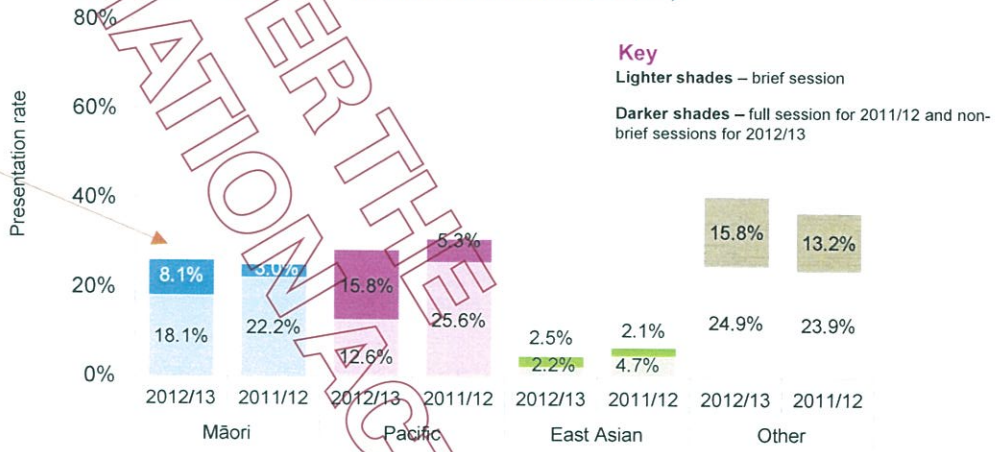
10.7b: Gambler Presentations by ethnicity to non-Māori service providers (2011/12, n=4,701, 2012/13, n=5,367)



10.7c: Family/affected other presentations by ethnicity to Māori service providers (2011/12, n=1,444, 2012/13, n=2,164)



10.7d: Family/affected other presentations by ethnicity to non-Māori service providers (2011/12, n=3,142, 2012/13, n=3,478)



Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

Dedicated Māori service providers - gender

Figure 10.7e (opposite) compares the gender of service-users presenting to Māori service providers with those presenting to Non-Māori and analyses both gambler and family members/affected others. This shows that more females than males are presenting to service providers with the exception of gamblers presenting to Non-Māori service providers where a higher proportion of males are attending (58%). This is very similar to data reported in 2011/12.

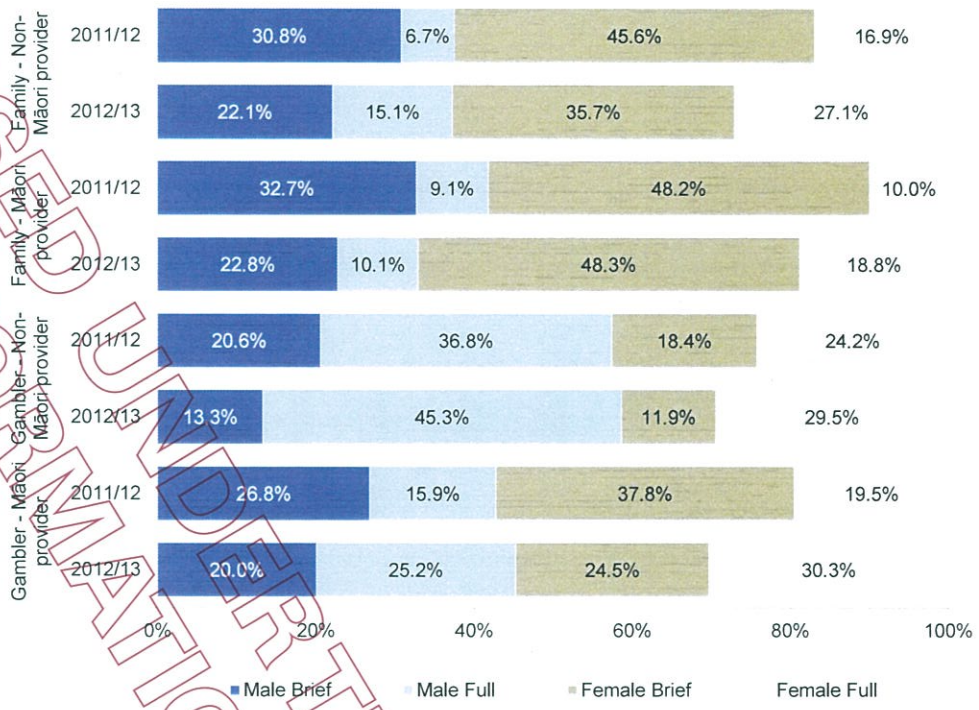
Aside from this, there were no notable differences in the gender of presentations by family members/affected others compared with gamblers.

Key findings:

a The proportion of family/affected others Male brief presentations and Female brief presentations for Non-Māori providers decreased.

b The proportion of Female brief gambler presentations at Māori providers decreased while the female full presentations increased for the 2012/13 period.

10.7e Presentation by gender to Māori service providers (2011/12, n=2,862, 2012/13, n=3,716) compared with Non-Māori service providers (2011/12/12, n=7,845, 2012/13, n=8,846)



Note: Due to rounding, some figures may not sum to 100% in Figure 10.7e above.

Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

Dedicated Māori service providers - age

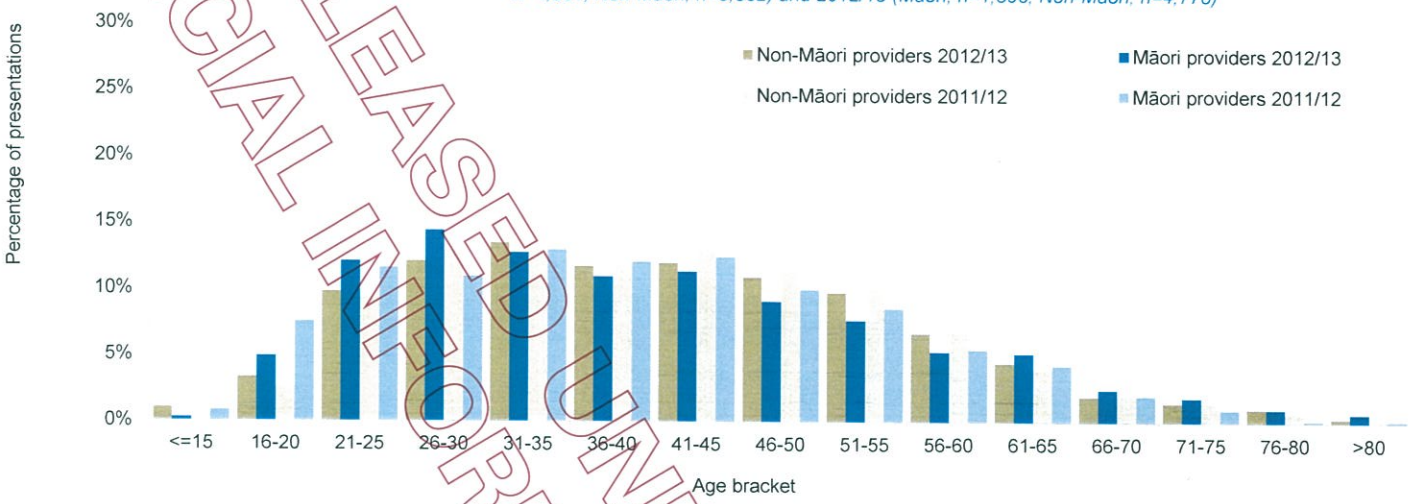
Figure 10.7f (opposite top) compares the presentations by gamblers at Māori service providers to Non-Māori service providers by age. This shows that presentations to Māori service providers are in younger age brackets than Non-Māori service providers. This is not unexpected and similar to the results in 2011/12.

Figure 10.7g (opposite bottom) compares the presentations by family/affected others at Māori service providers to Non-Māori service providers by age. This shows a similar message to the analysis for gamblers in that presentations to Māori service providers are in younger age brackets than Non-Māori service providers. This is again similar to the results of 2011/12.

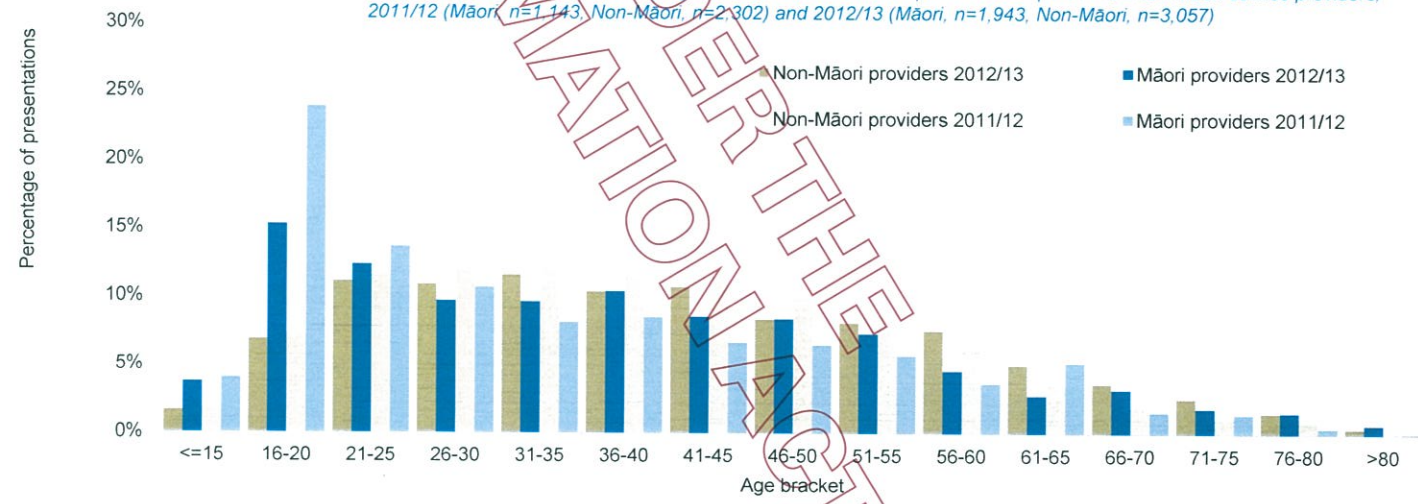
To simplify analysis, presentations by age are not separately identified as brief and full presentations.

Note: some minor corrections have been made to 10.7g.

10.7f Gambler presentations by age bracket to Māori service providers, compared with non-Māori service providers 2011/12 (Māori, n=1,351, Non-Māori, n=3,882) and 2012/13 (Māori, n=1,506, Non-Māori, n=4,778)



10.7g Family member/affected other presentations by age bracket to Māori service providers compared with Non-Māori service providers, 2011/12 (Māori, n=1,143, Non-Māori, n=2,302) and 2012/13 (Māori, n=1,943, Non-Māori, n=3,057)



Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

Dedicated Pacific service providers – ethnicity

Figures 10.7h and 10.7i (opposite top) analyse presentations by gamblers to Pacific service providers by ethnicity. Key findings:

a. Pacific ethnicities using Pacific service providers moved from using brief sessions to full or non-brief sessions.

b. The majority (78%) of presentations are of Pacific ethnicity, whereas 15% of presentations were Māori and 6% 'Other'.

c. Overall presentations balanced out with an increase in Māori (3.8%) presentations to Pacific services.

Figures 10.7j and 10.7k (opposite bottom) provide similar analysis but focused on family/affected other presentations. Key findings:

a. Presentations to non-Pacific service providers are highest for Māori and Other ethnicities.

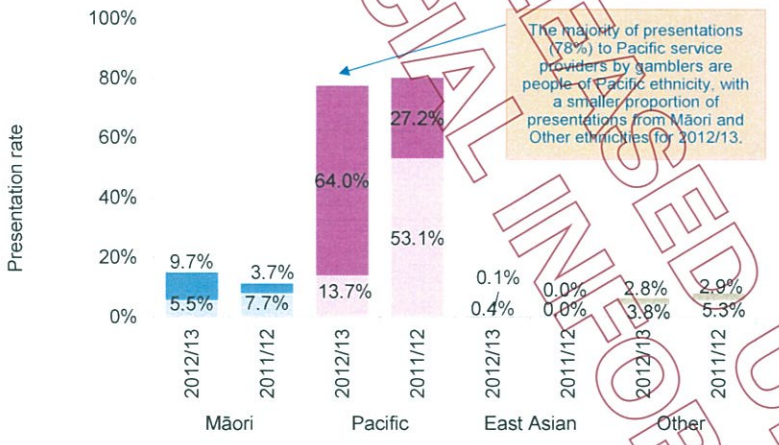
Key

Lighter shades – brief session

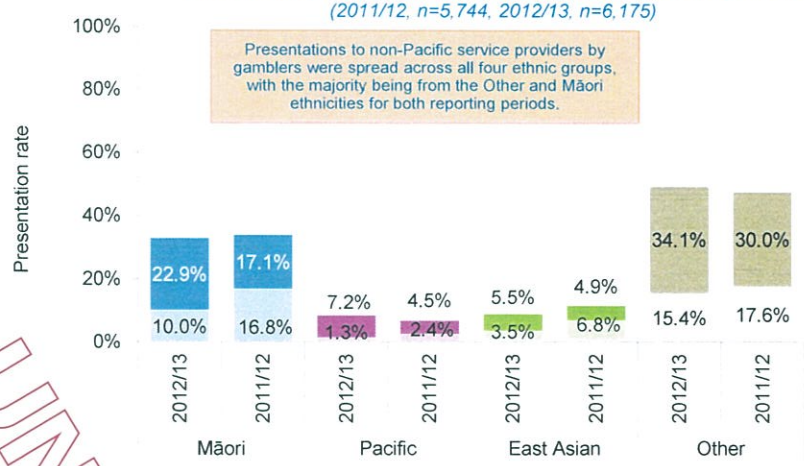
Darker shades – full session for 2011/12 and non-brief sessions for 2012/13 data

Presentations to dedicated Pacific service providers, 2011/12 and 2012/13

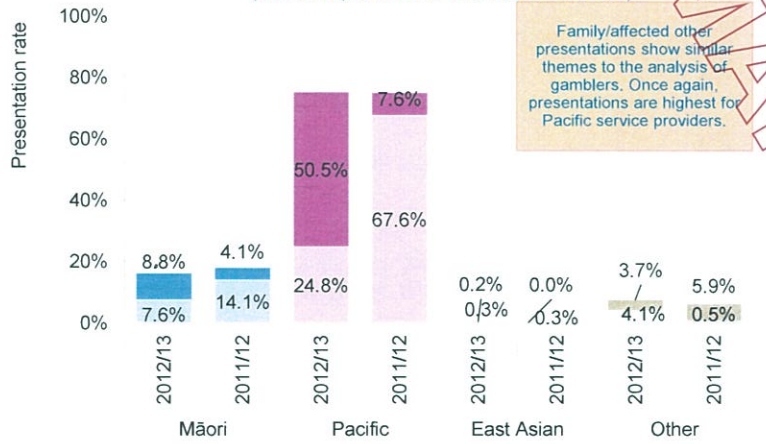
10.7h: Gambler presentations by ethnicity to Pacific service providers (2011/12, n=375, 2012/13, n=744)



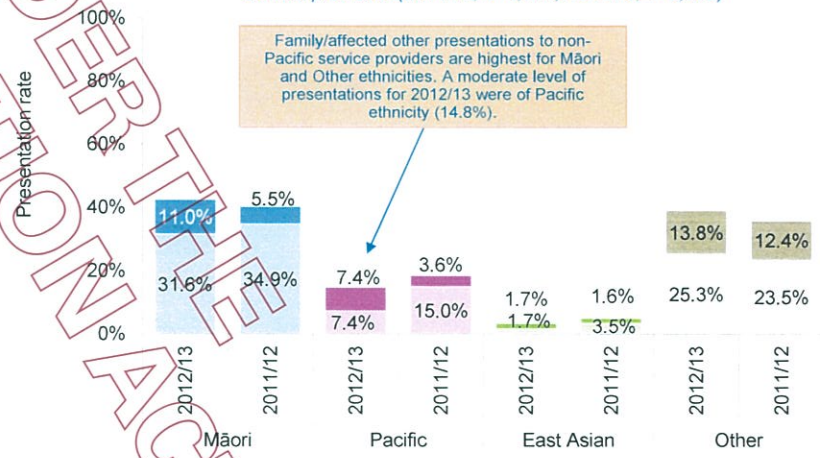
10.7i: Gambler presentations by ethnicity to non-Pacific service providers (2011/12, n=5,744, 2012/13, n=6,175)



10.7j: Family/affected other presentations by ethnicity to Pacific service providers (2011/12, n=370, 2012/13, n=592)



10.7k: Family/affected other presentations by ethnicity to non-Pacific service providers (2011/12, n=4,216, 2012/13, n=5,050)



Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

Pacific service providers – gender

Figure 10.7l (opposite) compares the gender of service-users presenting to Pacific service providers with those presenting to non-Pacific service providers and analyses both gambler and family members/affected others.

Key findings:

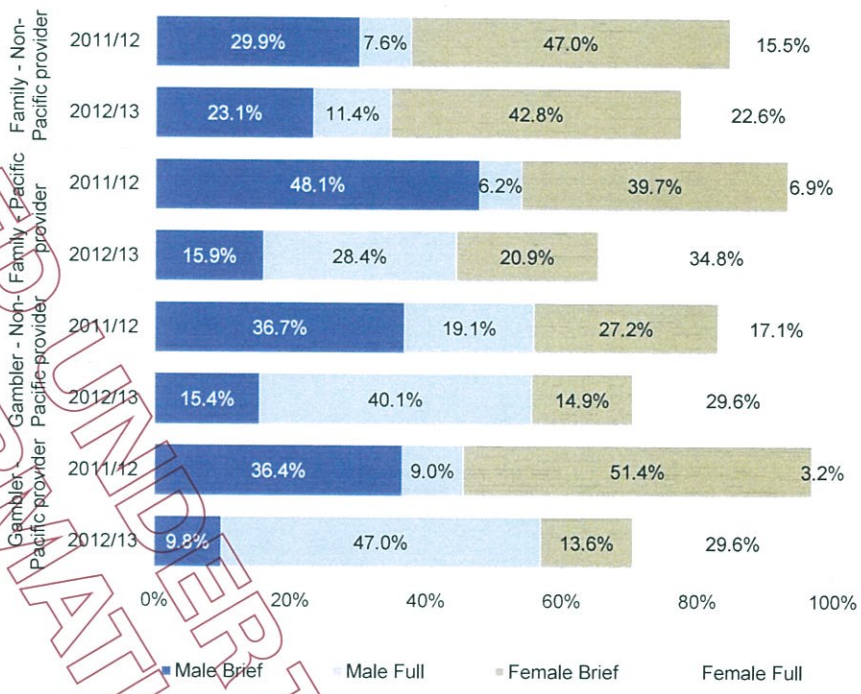
a. More male than female gamblers present to both Pacific service providers and non-Pacific service providers.

b. More female than male family/affected others present to both Pacific service providers and non-Pacific service providers.

c. The proportion of male gamblers presenting to Pacific service providers is almost the same as those presenting to non-Pacific services.

d. A greater proportion of family members/affected others presentations to non-Pacific service providers are female (65%), this is similar to 2011/12. This was the only subgroup that had more brief presentations than full presentations.

10.7l Presentation by gender to Pacific service providers compared with Non-Pacific service providers, 2011/12 (Pacific, n=1,413, Non-Pacific, n=9,294) and 2012/13 (Pacific, n=1,336, Non-Pacific, n=11,226)



Note: Due to rounding, some figures may not sum to 100% in Figure 10.7i above.

Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

Dedicated Pacific service providers – age

Figure 10.7m (opposite top) compares presentations by gamblers to Pacific service providers with non-Pacific service providers by age. Key findings:

a. A higher proportion of presentations in the under 20 years of age bracket are to Pacific service providers.

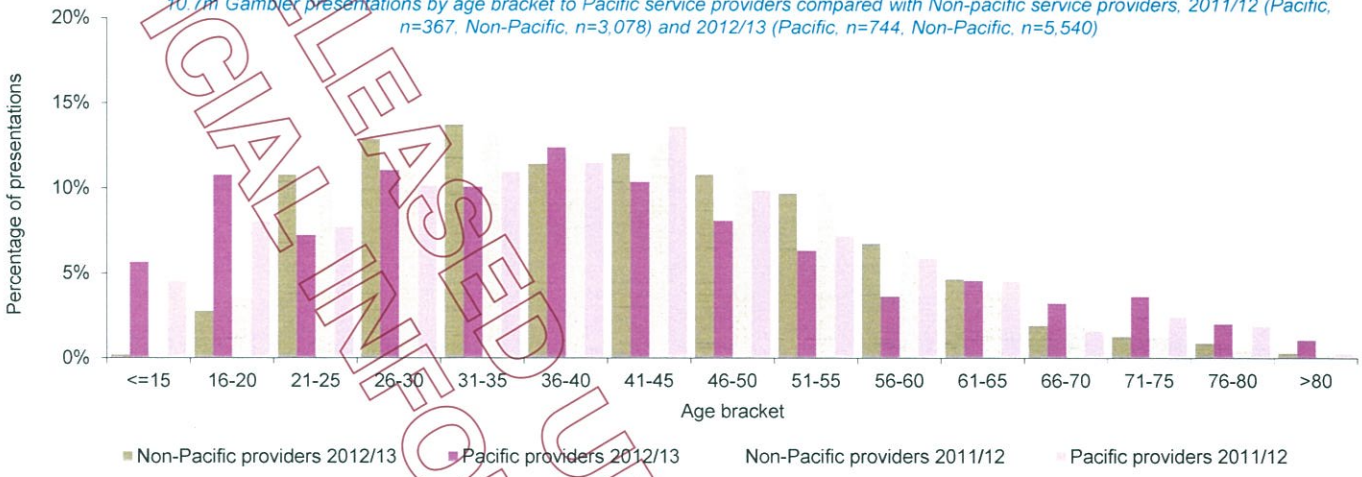
b. In the age brackets between 46 and 60, a lower proportion of presentations were to Pacific service providers.

Figure 10.7n (opposite bottom) compares presentations by family members/affected others to Pacific service providers with non-Pacific service providers by age. Key findings:

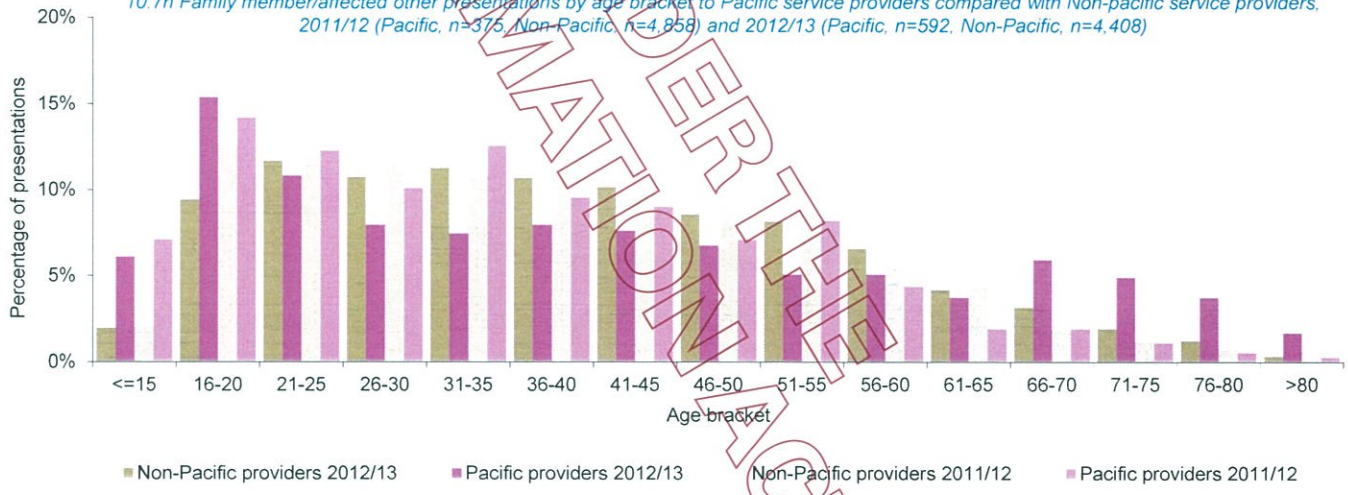
a. Across the age brackets, a younger cohort of family members/affected others present to Pacific service providers. This is similar to the 2011/12 results.

Note: To simplify analysis, presentations by age are not separately identified as brief and full presentations.

10.7m Gambler presentations by age bracket to Pacific service providers compared with Non-pacific service providers, 2011/12 (Pacific, n=367, Non-Pacific, n=3,078) and 2012/13 (Pacific, n=744, Non-Pacific, n=5,540)



10.7n Family member/affected other presentations by age bracket to Pacific service providers compared with Non-pacific service providers, 2011/12 (Pacific, n=375, Non-Pacific, n=4,858) and 2012/13 (Pacific, n=592, Non-Pacific, n=4,408)



Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

Presentations to General service providers, 2011/12 and 2012/13

General service providers – ethnicity

Figure 10.7o and Figure 10.7p, opposite top), illustrate gambler presentation to general service providers. Key findings:

a. Over half (56%) of gambler presentations to general service providers were of 'Other' ethnicity.

b. Māori and Pacific presented to Māori and Pacific service providers less for brief sessions and more to full or non-brief sessions.

c. Overall, across all four ethnicities, the percentage of presentation split has not changed substantially since 2011/12.

Figures 10.7q and 10.7r (opposite bottom) compare family/affected other presentations by ethnicity to general service providers compared with Māori and Pacific service providers. Key findings:

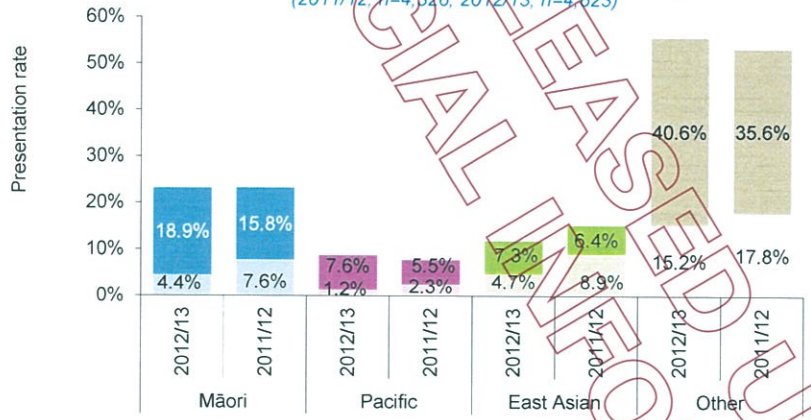
a. A high proportion of presentations by family/affected others of 'Other' ethnicities attend general service providers rather than Māori and Pacific providers.

Key

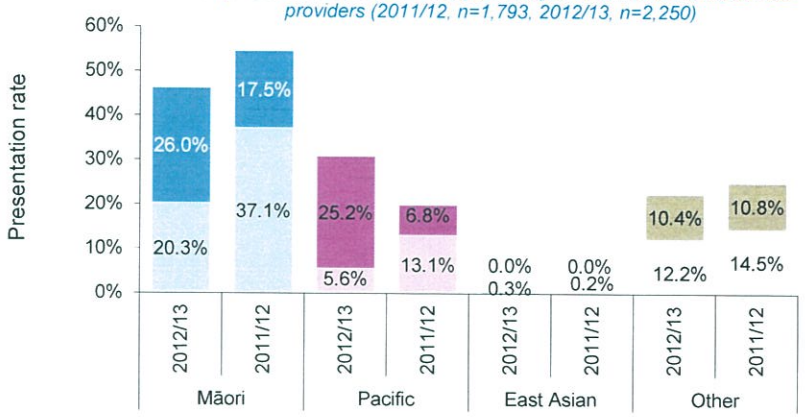
Lighter shades – brief session

Darker shades – full session for 2011/12 and non-brief sessions for 2012/13 data

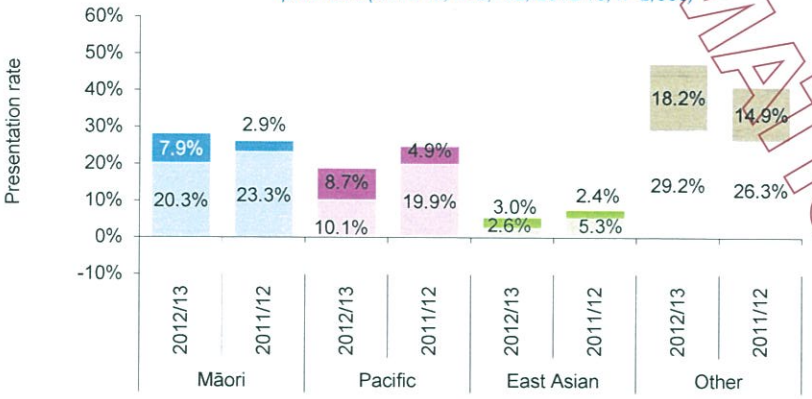
10.7o: Gambler presentations by ethnicity to General service providers (2011/12, n=4,326, 2012/13, n=4,623)



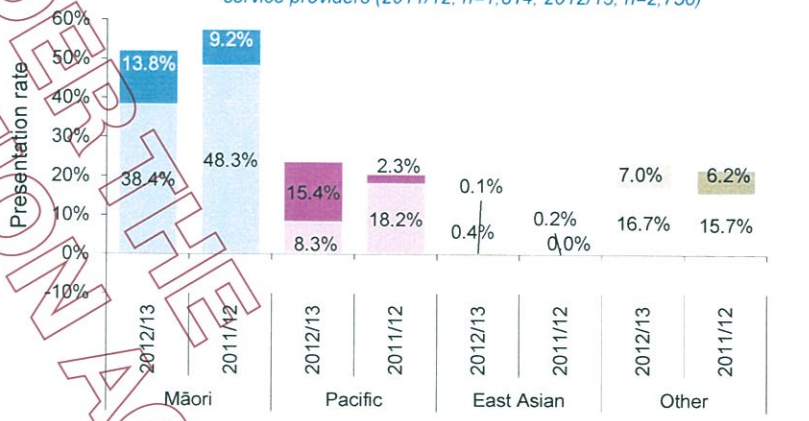
10.7p: Gambler Presentations by ethnicity to Māori and Pacific service providers (2011/12, n=1,793, 2012/13, n=2,250)



10.7q: Family/affected other presentations by ethnicity to General service providers (2011/12, n=2,772, 2012/13, n=2,886)



10.7r: Family/affected other presentations by ethnicity to Māori and Pacific service providers (2011/12, n=1,814, 2012/13, n=2,756)



Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

Dedicated Māori service providers - gender

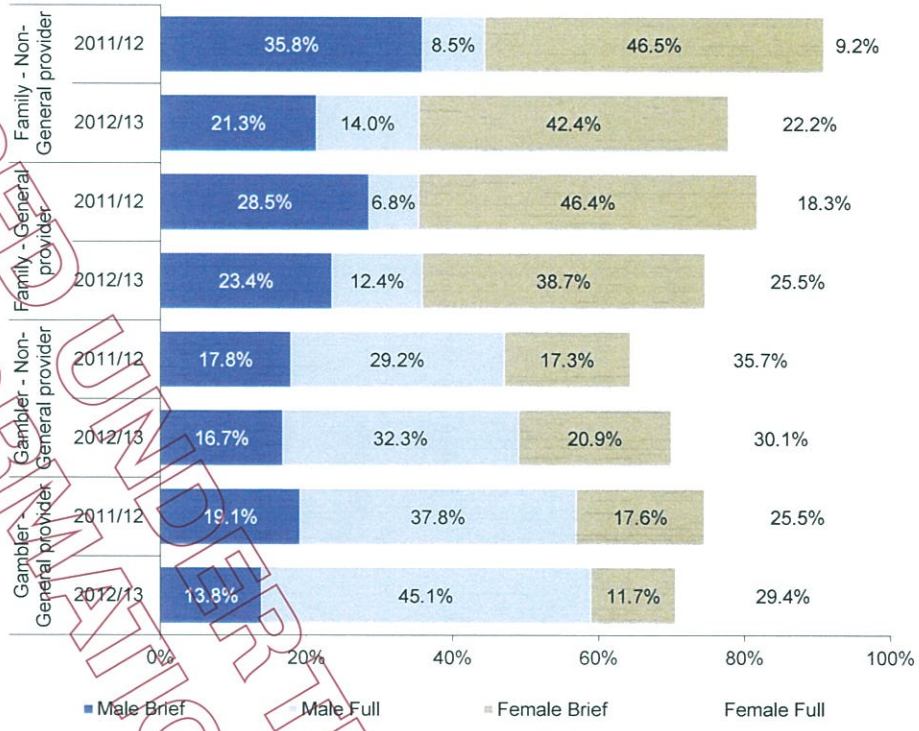
Figure 10.7s (opposite) shows presentations by gamblers and family/affected others to general services compared with Māori and Pacific service providers. Key findings:

a. A greater proportion of male gamblers attending general service providers (59%) than Māori and Pacific (49%).

b. The same proportion of male family/affected others attending general services (36%) as Māori and Pacific (35%).

c. The proportion of general presentations across all categories are similar between 2011/12 and 2012/13 except for presentations of family to non-general providers.

10.7s: Presentations by gender to General service providers compared with Dedicated service providers, 2011/12 (General, n=7,100, Dedicated, n=3,607) and 2012/13 (General, n=7,510, Dedicated, n=5,052)*



Note: Due to rounding, some figures may not sum to 100% in Figure 10.7i above.
**Dedicated service providers excludes Asian service providers (Asian service providers are included within General)*

Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

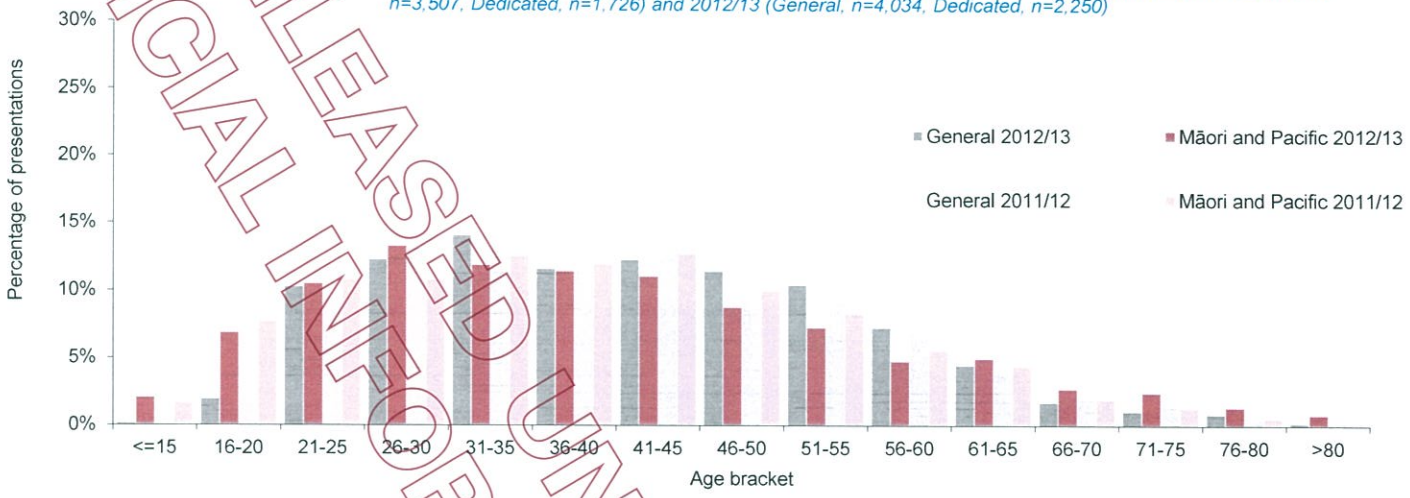
General service providers – age

Figure 10.7t (opposite top) compares gambler presentations to general service providers with presentations to Māori and Pacific service providers by age. This analysis shows there are more presentations to dedicated service providers rather than general service providers for gamblers in younger age brackets. This is consistent with the 2011/12 figures.

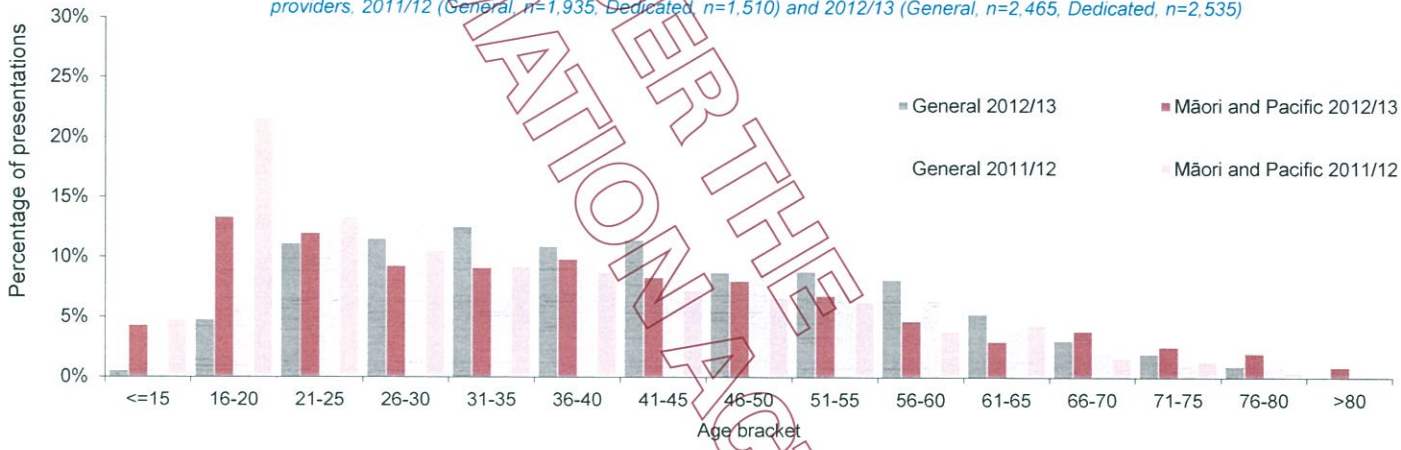
Figure 10.7u (opposite bottom) compares family/affected other presentations by age to general service providers with presentations to Māori and Pacific service providers. This analysis shows there are more presentations to dedicated service providers rather than general servicer providers for family member/affected other in younger age brackets. This is consistent with the 2011/12 figures.

To simplify analysis, presentations by age are not separately identified as brief and full presentations.

10.7t Gambler presentation by age bracket to General service providers compared with Dedicated service providers, 2011/12 (General, n=3,507, Dedicated, n=1,726) and 2012/13 (General, n=4,034, Dedicated, n=2,250)*



10.7u Family member/affected other presentations by age bracket to General service providers compared with Dedicated service providers, 2011/12 (General, n=1,935, Dedicated, n=1,510) and 2012/13 (General, n=2,465, Dedicated, n=2,535)*



**Dedicated service providers excludes Asian service providers (Asian service providers are included within General)*

Analysis of the diversity of client characteristics (ethnicity, age and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services) (cont.)

Limitations and areas for improvement

This analysis only includes those that present to Ministry-funded problem gambling service providers. Self-help or presentations to other service providers are excluded from this analysis.

Due to limitations with the CLIC database, it was not possible to analyse presentations to dedicated Asian service providers.

Results may be influenced by service-users choosing a service because of location rather than need or preference.

Future iterations of this outcome indicator could be improved by developing confidence intervals for the presentation rate analysis. This would provide greater confidence in the analysis.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

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Objective 11

A programme of research and evaluation establishes an evidence base, which underpins all problem gambling activities

Analysis and presentation of outcome indicators for Objective 11		Previous Measurement point
11.1	Analysis of a periodic stakeholder satisfaction survey of the Ministry's management of the problem gambling research programme	2011/12 Baseline Report
11.2	Summary of progress made in managing processes to provide agreed outcome and monitoring data	2011/12 Baseline Report
11.3	Summary of research infrastructure project delivery (scholarship and provider/research-initiated projects) for Māori, Pacific and Asian capacity to participate in research	2011/12 Baseline Report
11.4	Summary of research programme delivery	2011/12 Baseline Report
11.5	Review of the number of research reports finalised within Ministry of Health timeframes	2011/12 Baseline Report
11.6	The number of research projects completed that successfully involve all target groups, based on cultural identity (Pākehā, Māori, Pacific, Asian) age and gender	2011/12 Baseline Report
11.7	Analysis of the diversity of applications and successful awards for Ministry of Health-funded gambling scholarships	This Report

Analysis of the diversity of applications and successful awards for Ministry of Health-funded gambling scholarships

Summary findings

- Successful scholarship applications have decreased by 50%. The approval rate for scholarships has also decreased from 91% to 65%. Note: the population is small (2012 – 26 and 2013 – 17). One Post-Graduate Scholarship was awarded in 2013.
- More applicants for scholarships were female (82%); this is similar to 2012 (92%).
- There was ethnic diversity in the scholarship recipients. Three Māori, two Pacific, two Asian and four Other (including NZ European) received scholarships in 2013.

↓	Deteriorating trend	Overall the diversity of applications and successful awards decreased. There are less applicants and a lower success rate. More females received scholarships. Geographic diversity and the diversity of learning institutions reduced. Ethnic diversity is similar, however approval rates decreased for all ethnic groups except Pacific.
H	Confidence in the data	No change since the Baseline Report.
NA	Performance	Not reported.

Data source and approach to measurement

Outcome indicator 11.7 measures the diversity of applications and awards for gambling scholarships across the 2012 and 2013 calendar years. Data for the 2012 calendar year was obtained from Te Rau Matatini. Te Rau Matatini are contracted by the Ministry of Health to administer problem gambling scholarships. Data for the 2013 calendar year was obtained directly from the Ministry of Health using the 2012 data request template to ensure data consistency.

Scholarship data from the 2012 and 2013 calendar years has been analysed in order to assess the diversity of applications and successful awards for the 2012 and 2013 periods. This analysis has aimed to determine a trend of the diversity and successful awards for Ministry of Health funded gambling scholarships.

Definitions

Diversity includes analysis by age, gender, ethnicity, region and chosen institution of study.

For the purpose of measuring this outcome indicator, withdrawn applications have been treated as approved because withdrawal from the scholarship process is the decision of the applicant, and is outside the control of those who administer the scholarships. In some cases, an applicant's withdrawal from the process will allow for the administrator to offer the scholarship to another applicant. However, this is dependant on the timing of the withdrawal and is not always possible.

Current state of the indicator

During the 2012 calendar year 26 applications for scholarships were received. Of the 26 applications received, 22 were approved, four were declined and two applicants later withdrew their approved application. For the 2013 calendar year, 17 applications were received. Of the 17 applications received, 11 were approved, two were subsequently withdrawn and six were declined.

To summarise the 2013 calendar year compared to 2012, total applications fell by nine, approvals fell by 11, there was no change in the number of withdrawals, and total applications declined rose by two. Overall, there has been a decline in both the number of applications received and the number of successful applications. One Post-Doctoral Scholarship was awarded in 2013.

Note: 'Other' includes New Zealand Europeans.

Age and gender diversity

Key findings about the age and gender of applicants:

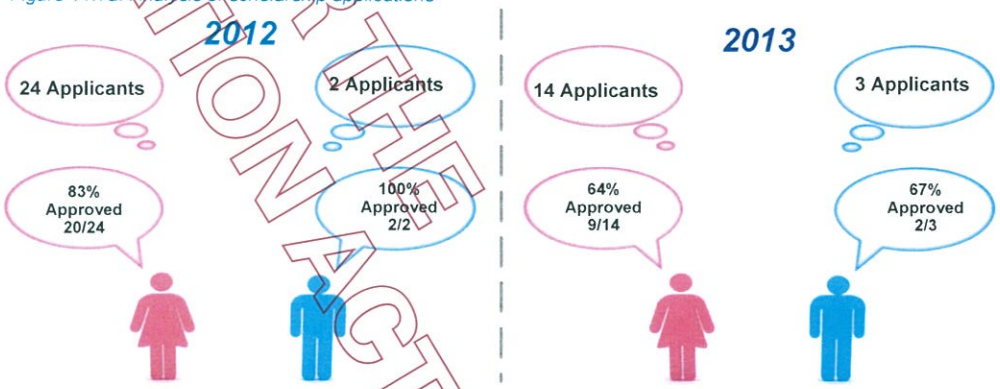
a. In 2012, of the total 26 applicants, 24 were female and two were male. In 2013, 14 applicants were female and three were male (as shown in Figure 11.7a, below).

b. Males had more success in 2012 than females, 100% of scholarships applied for were approved, compared to 67% in 2013 (as shown in Figure 11.7a).

c. In 2012, two female applicants withdrew from study and the scholarship programme for the year, whereas in 2013 one male and one female withdrew from study.

d. The average age of scholarship applicants increased by 1 year to 42 years in 2013. The average age of scholarship recipients for 2013 is the same as 2012 (40 years).

Figure 11.7a: Analysis of scholarship applications



Analysis of the diversity of applications and successful awards for Ministry of Health-funded gambling scholarships (cont.)

Diversity of applicants and recipients by region

In 2013 the majority of applications for scholarships were from the Auckland region, with seven of the 11 Auckland applicants successful in gaining a scholarship. In 2012 scholarships were awarded in eight regions, however in 2013 the geographic spread of scholarships reduced and scholarships were only awarded in five regions. Scholarship applications were not received from any new regions in 2013.

The number of applications per region, and the corresponding number of scholarships approved are shown in Figure 11.7c (opposite).

Diversity of applicants and recipients by chosen institution of study

In 2012 scholarships for study were approved for applicants from nine different institutions. In 2013 applicants from seven different institutions received approved scholarships for study. The learning institution with the highest number of approved scholarships for study is the same for both years; Auckland University of Technology (AUT).

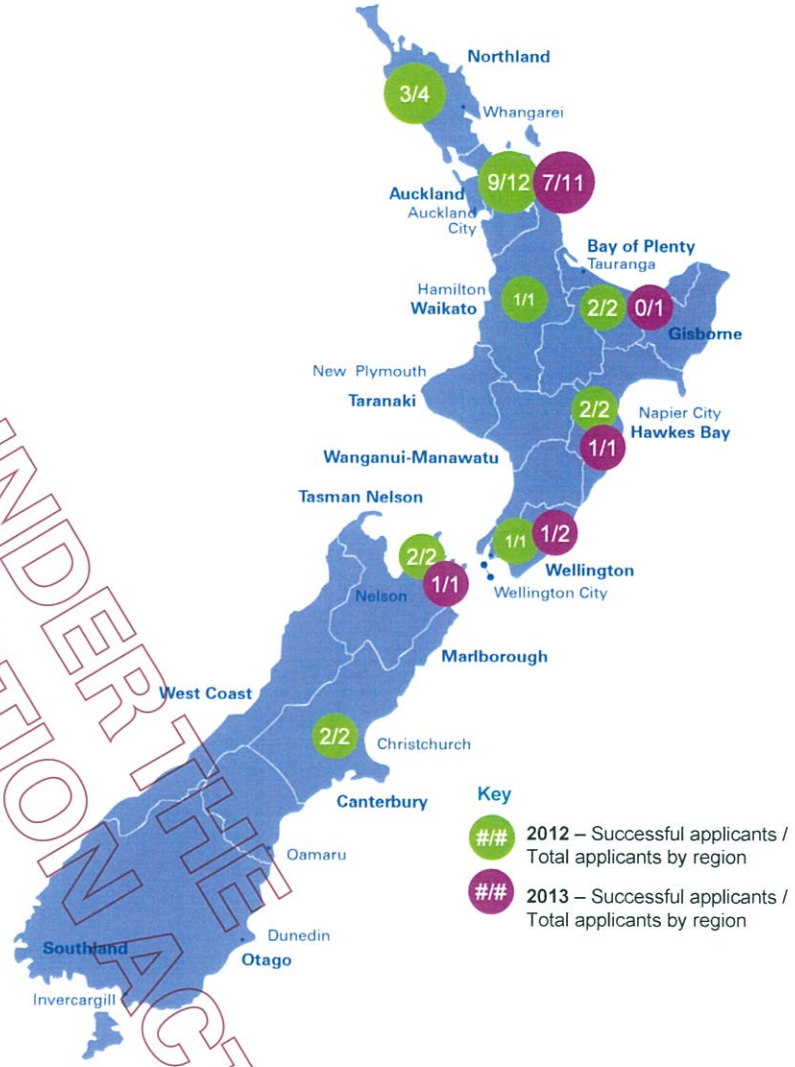
Of the 17 applications submitted in 2013, two applicants were from learning institutions which did not submit any applications in 2012 (shaded in blue in the table below). Four of the 2012 learning institutions did not have any Ministry of Health-funded gambling scholarship applicants in 2013 (shaded in grey in the table above).

For 2013, Wellington Institute of Technology (WELTEC) had the most applications declined. WELTEC had a total of six applicants in 2012 and 2013 with a 100% approval rate in 2012, this decreased to a 16% approval rate in 2013.

Table 11.7b Scholarships approved and declined by learning institution

Learning Institution	2012 Approved	2012 Declined	2012 Total	2013 Approved	2013 Declined	2013 Total	Change in the total number of applications
Auckland University of Technology (AUT)	7	1	8	5		5	-3
Massey University	2		2	1		1	-1
University of Otago	1		1	1		1	No change
Quality Plus Training Ltd	1		1				-1
Te Puna Wananga o Anamata	1		1				-1
University of Auckland	1	3	4	1	1	2	-2
Vision College	1		1				-1
Waikato University	2		2				-2
Victoria University				1		1	+1
Wellington Institute of Technology (WELTEC)	6		6	1	5	6	No change
Manukau Institute of Technology				1		1	+1
Total	**22**	**4**	**26**	**11**	**6**	**17**	**-9**

Figure 11.7c: successful scholarship applications by region



Analysis of the diversity of applications and successful awards for Ministry of Health-funded gambling scholarships (cont.)

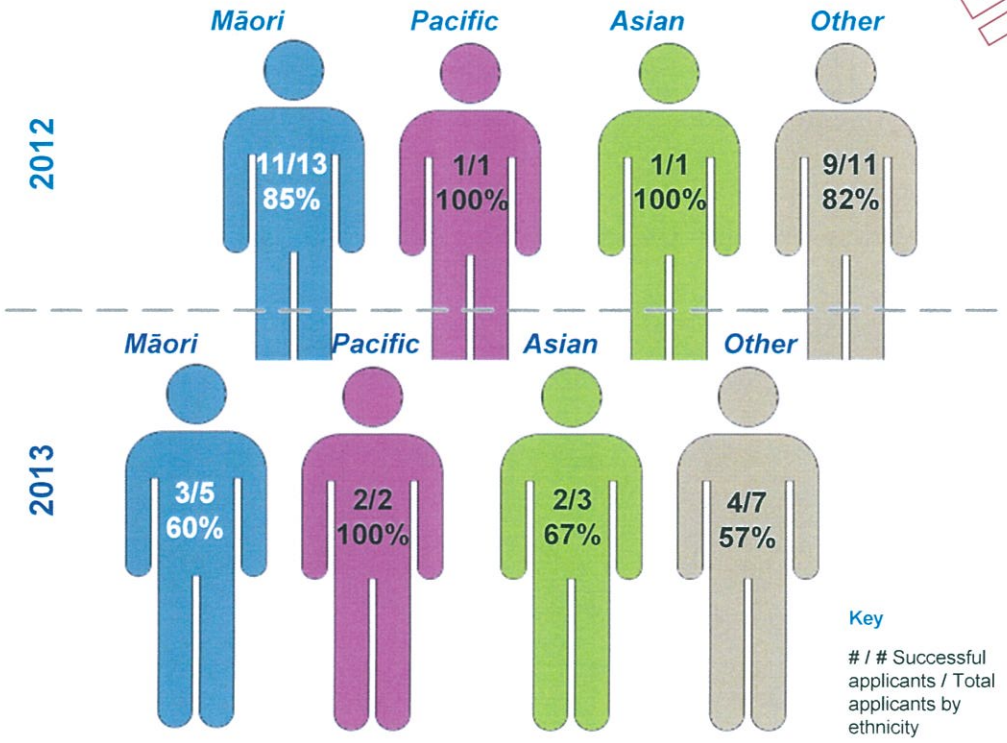
Cultural diversity of applicants

Figure 11.7d (below) shows:

a. For 2012, of the total applicants there were 13 Māori, one Pacific, one Asian, nine other (which included seven NZ European). The most common ethnicity of scholarship applicants was Māori, who represented 50% of applicants.

b. For 2013, the total number of applicants dropped from 26 to 17. Total Māori applicants declined from 13 to five and the number of successful Māori applications decreased from 85% (2012) to 60% (2013). Total Asian applicants increased from one in 2012 to three in 2013. One Asian applicant was approved in 2012 and two of the three applicants were approved in 2013.

Figure 11.7d: diversity of scholarship recipients 2012 and 2013 calendar year comparison



Limitations

This analysis is based on data provided by Te Rau Matatini - the scholarship administrator for the 2012 calendar year. The 2013 calendar year data was provided by the Ministry of Health using the same date request template for consistency purposes.

There are no additional limitations for this outcome indicator.

For further information

Refer the Outcomes framework for preventing and minimising gambling harm – Baseline Report, for more information about this outcome indicator.

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Appendix A

Glossary

Glossary

Term	Definition
Addiction Practitioners' Association, Aotearoa-New Zealand (DAPAANZ)	A professional body for anyone interested in addiction treatment (DAPAANZ, 2013).
At-risk gamblers	Refer PGSI.
Awareness campaign	Refer to social marketing.
Barriers to service usage	Barriers to service usage are considered as being equivalent to barriers to help-seeking within this document. Barriers to help seeking are defined as intrinsic and extrinsic barriers to accessing healthcare (Bellringer et al, 2008).
Baseline report	A report that provides a 'snapshot' of the current state of the objectives and outcome indicators included within the Preventing and Minimising Gambling Harm: Six-Year Strategic Plan.
Brief intervention session	Brief intervention sessions are for people early in the course of developing gambling problems. The services aim to encourage individuals experiencing harm from gambling to recognise and acknowledge the consequences of their gambling and to change their gambling behaviour or seek specialist support where necessary (Ministry of Health, 2012).
Buffer	A buffer is a zone around a map feature measured in units of distance or time. A buffer is useful for GIS analysis (Sommer, 2006).
Casino	Gambling: (a) that satisfies relevant game rules; and (b) to which both a casino venue licence and casino operator's licence apply; but (c) that does not include the gambling conducted by the New Zealand Racing Board (Gambling Act 2003).
Census Area Unit (CAU)	A census area unit is one of the 1,770 geographic areas (commonly suburbs) defined within the Census and NZDep2006 index.
Class 4 gambling	Class 4 gambling refers to operating Electronic Gambling Machines outside a Casino.
Class 4 gambling policy	A policy set by a territorial authority that must consider the social impact of gambling within the territorial authority's district and specify whether or not Class 4 venues may be established in the district and, if so, where they may be located (Department of Internal Affairs, 2013a).
Client Information Collection Database (CLIC)	A database administered by the Ministry of Health to collect data on the usage of Ministry-funded problem gambling services.
Clinical audits	An assessment of a problem gambling service provider's compliance with clauses within their contract related to clinical practice.
Club	A voluntary association of persons combined for a purpose other than personal gain that offers Class 4 gambling.
Confidence in the outcome indicator	An assessment of the effectiveness of the data at measuring the indicator and the reliability and robustness of the data.
Confidence	The probability estimate of how much reliance can be placed on the findings (Cavana, 2001).
Councillor	An elected representative of members of the community involved in the decision-making and Governance of a territorial authority.

Glossary (cont.)

Term	Definition
Counsellor	Refer to Intervention Practitioner.
Cultural audits	An assessment of a problem gambling service provider's compliance with clauses within their contract related to cultural practice.
Dedicated provider	An organisation where the purpose of the service is to minimise problem gambling-related harm to and for Māori, Asian and Pacific problem gamblers and/or their affected others.
Department of Internal Affairs (DIA)	The Government agency responsible for the regulation, auditing and investigation of casino and non-casino gambling.
Deprivation index	Refer to New Zealand Deprivation Index.
East Asian ethnicity	A grouping of Asian ethnicities that includes Burmese, Filipino, Indonesian, Cambodian, Laotian, Malay, Thai, Vietnamese and Chinese (including Chinese from outside Mainland China).
Effectiveness (of treatment)	Measured by movements in a service-user's PGSI, for example, dollars lost and control over gambling measures as assessed in an intervention session compared with the original scores recorded.
Electronic Gaming Machine (EGM)	A slot machine (American English), informally fruit machine (British English), the slots (Canadian English), poker machine or "pokies" (slang) (Australian English and New Zealand English) or simply slot (American English), is a casino gambling machine (Wikipedia, 2013).
Electronic Monitoring System (EMS)	EMS collects information on the non-casino gambling machine expenditure at all Class 4 club and pub venues throughout New Zealand. This database also retains information on the number of venues, the number of electronic gambling machines and their locations (Department of Internal Affairs, 2013b).
Facilitation intervention session	Facilitation services involve minimising gambling-related harm to individuals, their families/whānau and affected others by facilitating people's access to health and social services. Facilitation services recognise that merely referring someone to another service is not usually effective. Active effort and support are often required to help clients to receive the support they need for other problems in their life (Ministry of Health, 2012).
Follow-up intervention session	Follow-up services provide follow-up and motivational support to clients for 12 months after their last full intervention session with a problem gambling intervention service. (Ministry of Health, 2012).
Full intervention session	Full intervention services are community-based assessment and intervention services for people with gambling-related problems. They aim to minimise problem gambling-related harm to the service-user and their family/whānau and affected others by providing a range of psychosocial interventions. Full intervention services make up the core clinical work that most face-to-face intervention staff engage in every day (Ministry of Health, 2012).
Gambling harm	Gambling harm has the meaning set out in the Gambling Act 2003. It means harm or distress of any kind arising from, or caused or exacerbated by, a person's gambling, and includes personal, social or economic harm suffered by the person, their spouse, partner, family, whānau and wider community, or in their workplace or society at large.
Gambling industry	A term used to collectively describe the operators of gambling in New Zealand.
Gaming machine	Refer to Electronic Gambling Machine (EGM).

Glossary (cont.)

Term	Definition
Gambling machine	Refer to Electronic Gambling Machine (EGM).
Gambling / Pokie Trusts	An operator of Class 4 gambling as defined in the Gambling Act 2003.
General provider	A provider whose services aim to minimise problem gambling-related harm for all members of the community, including delivering services to Māori, Pacific, Asian and other priority population subgroups.
Geographic Information System (GIS)	Geographic Information Systems are used to visualise, question, analyse, interpret, and understand data to reveal relationships, patterns, and trends (ESRI, 2013).
Health and Lifestyles Survey (HLS)	A survey that measures New Zealanders' behaviours, attitudes and knowledge on a range of health and lifestyles topics including food and drink, smoking, gambling and being out in the sun (Health Sponsorship Council, 2010).
High deprivation communities / Low socioeconomic community	Communities of decile 8, 9 and 10 on the NZDep2006 deprivation scale.
Inequality	Where one population group is over or under-represented compared to other population groups.
Inequity	Inequity and inequality typically have distinct definitions. However, for the purposes of this report the terms are used interchangeably. Refer to Inequality.
Intervention Practitioner	A trained individual who supports people experiencing gambling harm.
Intervention provider	A problem gambling service provider that provides treatment to people experiencing gambling harm.
KPMG	The authors of this report and one of New Zealand's leading providers of Audit, Tax and Advisory services.
Low deprivation communities / High socioeconomic community	Communities of decile 1 to 3 on the NZDep2006 deprivation scale.
Māori community	A Māori community is defined in two ways (dependent on the outcome indicator). Either: a. communities with a greater proportion of Māori than the census average, or b. communities that are identified as Māori by problem gambling providers.
Medium deprivation communities / Medium socioeconomic community	Communities of decile 4 to 7 on the NZDep2006 deprivation scale.
Ministry of Health (Ministry)	The Ministry allocated responsibility for the development and implementation of an integrated problem gambling strategy that must include: a. measures to promote public health by preventing and minimising the harm from gambling b. services to treat and assist problem gamblers, their families and whānau c. independent scientific research associated with gambling d. evaluation.

Glossary (cont.)

Term	Definition
National Gambling Study (NGS)	A survey that provides information about gambling in New Zealand.
New Zealand Deprivation Index (NZDep2006)	A scale of deprivation prepared by the University of Otago that divides New Zealand into tenths based on nine variables from the 2006 census. A score of 10 indicates that the community is in the most deprived 10 per cent of areas in New Zealand and a score of 1 indicates that the community is in the least deprived 10 per cent of areas.
New Zealand Health Survey (NZHS)	A survey that provides information about the health and well-being of New Zealanders with a specific and dedicated section covering the participation in gambling and prevalence of problem gambling.
Objective	A goal defined in the Preventing and Minimising Gambling Harm: Six-Year Strategic Plan.
Outcome Indicator	A measure of progress towards achieving one of the eleven objectives within the Preventing and Minimising Gambling Harm: Six-Year Strategic Plan.
Outcomes Framework Advisory Group	A group comprising representatives from across the gambling and problem gambling sectors to provide guidance and direction to the Outcomes Framework for Preventing and Minimising Gambling Harm project.
Outcomes Framework for Preventing and Minimising Gambling Harm	A project that measures and reports on progress towards the achievement of strategic objectives (or 'outcomes') and the overall goal set out in the Preventing and Minimising Gambling Harm: Six-Year Strategic Plan.
Participation	Participation in one or more gambling activities i.e. Lotto, Housie, gambling machines.
Performance	An assessment of the current state of an outcome indicator against the baseline report. This will occur in progress reports.
Problem Gambling Severity Index (PGSI)	The PGSI includes a nine-item problem gambling screen, which measures the continuum of gambling problems to identify the gambling status of individuals. The PGSI is used to derive the prevalence of non-problem gambling, low-risk gambling, moderate-risk gambling and problem gambling within the New Zealand population.
Pokie machine	Refer 'Electronic Gaming Machine'.
Presentation rate	Divides the number of presentations to problem gambling services in a year for a population group by the prevalence of problem gambling for the same population group. The presentation rate provides a measure of how many of those at risk of gambling harm engage with services.
Presentation	Measures the number of unique service-users (i.e. only counting each service-user once) receiving a brief or full session at a problem gambling service provider.
Prevalence	The number of cases in a population, often presented as a percentage or proportion.
Problem gambling audits	Independent audits commissioned by the Ministry of Health of problem gambling service providers.
Problem gambling outcome/overall goal	Government, gambling industry, communities and families/whanau working together to prevent harm caused by problem gambling and to reduce health inequalities associated with problem gambling. Refer to the Preventing and Minimising Gambling Harm Six-Year Strategic Plan 2010/2011 - 2015/16 for additional information.

Glossary (cont.)

Term	Definition
Problem gambling service provider	An organisation funded by the Ministry of Health to deliver either intervention or public health services, or both.
Progress report	A report to be prepared in the future, on an as required basis, to measure performance against previous reports.
Pub	A venue that operates Class 4 gambling. Pubs are open to members of the public.
Public health initiative	Any initiative that fits within the public health service specifications that form part of each problem gambling service provider's contract with the Ministry.
Public health practitioner	A trained individual who works on public health initiatives.
Public health provider	A provider in the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society (World Health Organisation, 2013).
Referral	An act of referring someone, or something, for consultation, review, or further action (Oxford Dictionaries Online, 2013).
Reliability	Consistently good in quality or performance; able to be trusted (Oxford Dictionaries Online, 2013).
Robustness	The characteristic of being strong enough to withstand intellectual challenge (Princeton University Wordnet, 2013).
Satisfaction	An evaluation of emotion (Oxford Dictionaries Online, 2013).
Service-user (Client)	A person that uses the services of a problem gambling service provider either for their own gambling harm, or that of an affected family member/other.
Service utilisation	Measures the number of sessions delivered by problem gambling service providers in a year for each population group.
Six-Year Strategic Plan	The Preventing and Minimising Gambling Harm: Six-Year Strategic Plan, being the document (prepared every six years) the Ministry of Health uses to guide the delivery of the integrated problem gambling strategy.
Social marketing	A process that uses marketing principles and techniques to improve the health and welfare of people and of their physical, social and economic environment. It is a carefully planned, long-term approach to influencing human behaviour. Social marketing is different from commercial marketing because it aims to benefit the target group and society as a whole rather than make a financial profit
Standardised	A method of adjusting the results for a particular population group to account for differences in that population group (typically age and gender).
Statement of Intent (SOI)	A document that sets out the key elements of how a Government agency will contribute to the delivery of the Government's priorities.
Strategic documents	For the purposes of the baseline report, this is defined as Government sector annual reports, statements of intent and other strategic documents.

Glossary (cont.)

Term	Definition
Submission	The action of presenting a proposal, application, or other document for consideration or judgment (Oxford Dictionaries Online, 2013).
Territorial authority (TA)	Territorial authorities are the second tier of local government in New Zealand, below Regional Councils (Wikipedia, 2013).
Three-year service plan	This document (prepared every three years) outlines the Ministry's forecast budget and intentions for the period and is a key input to the setting of the problem gambling levy.
Trend	An assessment of the current state of an outcome indicator against the previous year's report. This will occur in progress reports.
Venue	For the purpose of the Outcomes Framework for Preventing and Minimising Gambling Harm, a venue is a building where gambling is licensed to take place.

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Appendix B

Technical notes

Approaches to data collection

Approaches used to collect data are driven by the **type of data** needed to measure the indicators. The progress report consists of secondary data (i.e. data that already exists). The secondary data was collected from data holders.

Tools used to analyse quantitative data

Two main approaches were used to analyse quantitative data: statistical analysis and GIS analysis.

Statistical analysis

Number driven analysis (quantitative) within this report is supported by descriptive statistics only.

Descriptive statistics

Descriptive statistics provide 'descriptive information about a set of data' (Cavana et al, 2001), such as a specific group within the population, for example, users of problem gambling services. Descriptors include frequencies/counts, mean and standard deviation.

The key limitation of results based on descriptive statistics is that they do not represent the entire population, just the group they are describing. For instance, if results show that users of problem gambling services are made up of people with an average age of 40 years, it cannot be assumed that New Zealanders have an average age of 40 years, only those that use problem gambling services.

GIS analysis

GIS analysis was used to analyse outcome indicators 1.3. and 2.3. GIS analyses information through a process of layering i.e. one layer of geo-coded data is overlaid on top of another. Multiple layers were overlaid on top of one another to analyse outcome indicator 1.3 and 2.3 including:

- The number and location of gambling venues
- The number and location of EGMs
- The amount and location of gambling spend.

Further details on the GIS methodology can be found in outcome indicator 1.3.

Representation of data

Data represented in the Figures of the baseline report and this progress report is generally rounded to zero decimal places. However, when relevant or necessary it is rounded to one decimal place.

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Appendix C

Selected bibliography

Selected bibliography

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Appendix D

Outcome indicators reported in the 2012/13 Progress Report

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Outcome indicators reported in the 2012/13 Progress Report

Indicator reference	Indicator name	Measurement period	Included in Progress Report?
1.1	Analysis of New Zealand Health Survey data (three yearly) for trends indicating (in)equitable gambling and problem gambling prevalence	Six-yearly	No
1.2	Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends	Annually	Yes
1.3	Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable prevalence of gambling participation and opportunities in low socioeconomic communities	Annually	Yes
1.4	Analysis of the proportion of charitable trust gambling grants allocated to communities with New Zealand social deprivation scores between decile 7 and 10	Annually	No
1.5	Review of problem gambling provider reports for the range of low socioeconomic communities targeted by public health initiatives	Annually	Yes
2.1	Analysis of New Zealand Health Survey data (three yearly) for trends indicating (in)equitable gambling and problem gambling prevalence for Māori	Six-yearly	No
2.2	Analysis of Ministry of Health problem gambling intervention data for (in)equitable presentation, service utilisation and effectiveness trends for Māori	Annually	Yes
2.3	Analysis of Department of Internal Affairs electronic monitoring system data (Class 4 revenue) against the New Zealand deprivation index for trends indicating (in)equitable prevalence of gambling participation and opportunities in Māori and low socioeconomic communities with high Māori populations	Annually	Yes
2.4	Analysis of the proportion of charitable trust gambling grants allocated to Māori communities and organisations	Annually	No
2.5	Review of problem gambling provider reports for the range and number of Māori communities targeted by public health initiatives	Annually	Yes
2.6	Review of the number and quality of opportunities for Māori to provide advice into Ministry processes around problem gambling activities	Annually	No
2.7	Analysis of periodic cultural audits to identify levels of cultural responsiveness of general and Māori intervention and public health services	Six-yearly	No
2.8	Analysis of client data for trends in Māori specific presentations compared to New Zealand Health Survey prevalence data	Annually	No
3.1	Analysis of community awareness and concern indicators from the Ministry-funded Behaviour Change Survey	Six-yearly	No
3.2	Periodic review of public health provider reports to the Ministry to assess the state of local communities and progress against community readiness assessments for community action and community policy implementation	Six-yearly	No
3.3	Regional interest in and involvement with Ministry of Health Strategic Plan development, including the diversity of submissions	Six-yearly	No
3.4	The number and diversity of submissions received by a sample of local government bodies in relation to gambling decision-making, including assessment of the level of input from low socioeconomic communities or representatives	Six-yearly	No
3.5	The number of national agencies that actively screen and refer for problem gambling	Annually	Yes
3.6	Review of the number and quality of opportunities for Māori, Asian and Pacific representation in the Ministry of Health, National Problem Gambling Team and Department of Internal Affairs processes for decision-making in relation to problem gambling	Annually	No
4.1	The number of government departments actively participating and collaborating with the Ministry of Health and the Department of Internal Affairs to reduce gambling-related harm	Six-yearly	No
4.2	Analysis of government sector strategic documents (i.e., annual reports and statements of intent) for commitment to addressing gambling-related harm	Six-yearly	No

Outcome indicators reported in the 2012/13 Progress Report (cont.)

Indicator reference	Indicator name	Measurement period	Included in Progress Report?
4.4	Analysis of a Ministry-funded Behaviour Change Survey on the attitudes of participants employed in decision-making roles in relation to problem gambling and perceptions of gambling-related harm (i.e., policy makers, gambling industry leaders, church leaders, school principles, kuia and kaumātua)	Six-yearly	No
4.5	Review of the percentage of territorial local authority gambling venue policies that reflect an active awareness of the potential harms of gambling	Six-yearly	No
4.6	Analysis of industry marketing expenditure and sponsorship activities	Annually	Yes
5.1	Analysis of government sector annual reports and statements of intent for commitment to addressing gambling-related harm	Six-yearly	No
5.2	Analysis of the Department of Internal Affairs survey on community attitudes to gambling and problem gambling	Six-yearly	No
5.3	Analysis of Ministry-funded survey on community attitudes to gambling and problem gambling	Six-yearly	No
5.4	Analysis of Department of Internal Affairs annual reports of gambling industry host responsibility compliance	Annually	Yes
5.5	Analysis of the attitudes of national key decision-makers (i.e., Ministry of Health and Department of Internal Affairs officials, the Gambling Commission, industry leaders, local government councillors) compared to national Ministry-funded attitudes survey responses	Six-yearly	No
6.1	Analysis of problem gambling practitioners' (public health and intervention) employment patterns and conditions, such as duration of employment and pay ranges compared to other sectors	Six-yearly	No
6.2	Analysis of the number of problem gambling practitioners (public health and intervention) who have the relevant problem gambling competencies for the work they deliver	Six-yearly	No
6.3	Analysis of the number of problem gambling practitioners (public health and intervention) who have received relevant tertiary training	Six-yearly	No
6.4	Assessment of the availability of culturally specific training programmes for problem gambling practitioners	Annually	No
6.5	Analysis of the diversity of the problem gambling workforce, including: · ethnic diversity (Māori, Pacific and Asian), age and gender · the percentage of Māori, Pacific and Asian practitioners who are working in mainstream organisations · the range of languages spoken by the problem gambling workforce · the percentage of the workforce that speaks te reo Māori · the percentage of the problem gambling workforce who identify as recovering gamblers or who have used problem gambling intervention services in the past.	Six-yearly	No
7.1	Analysis of the prevalence of protective and resiliency factors demonstrated in the New Zealand Health Survey for different population groups	Six-yearly	No
7.2	Analysis of community involvement in the Ministry-funded Behaviour Change Survey	Six-yearly	No
7.3	Review and summary of the range of public health initiatives reported to the Ministry by public health providers that are community action-based and have community policy implementation	Annually	No
7.4	Analysis of Ministry service-user data for referral from and referral to life skills and resiliency programmes	Annually	Yes
8.1	A summary of progress made by the joint Ministry of Health and Department of Internal Affairs relationships with the gambling industry	Annually	No
8.2	Analysis of a periodic stakeholder satisfaction survey of the joint Ministry of Health and Department of Internal Affairs relationships with the gambling industry	Six-yearly	No
8.3	Analysis of industry data on training and programmes that assist gambling providers to be responsible hosts (i.e., host responsibility programmes)	Annually	No
8.4	Analysis of Department of Internal Affairs data on gambling venue compliance (and breaches) of relevant legislative requirements	Annually	No

Outcome indicators reported in the 2012/13 Progress Report (cont.)

Indicator reference	Indicator name	Measurement period	Included in Progress Report?
8.5	Analysis of client data for referrals from gambling venues	Annually	Yes
8.6	Review of the effectiveness of industry mechanisms for identifying problem gamblers and gamblers at risk of problem gambling	Annually	No
8.7	Review of the number of venues, or societies, that have policies specific to key risk groups and behaviours (i.e., table games for Asian gamblers, self exclusion for non-English-speaking gamblers)	Six-yearly	No
9.1	Analysis of client data for referrals from health sector and community services	Annually	Yes
9.2	Analysis of New Zealand Health Survey and problem gambling service presentation data for trends in presentation and a reduction in barriers to presentation	Six-yearly	No
9.3	Analysis of Ministry-funded social marketing impact data	Six-yearly	No
9.4	Analysis of the periodic service-user satisfaction survey and barriers to service usage survey	Six-yearly	No
9.5	Assessment of the percentage of social marketing activities delivered specifically to at-risk groups	Annually	Yes
10.1	Analysis of periodic clinical audits of intervention services	Six-yearly	No
10.2	Analysis of periodic cultural audits for intervention and public health services	Six-yearly	No
10.3	Analysis of client data for trends in comprehensive assessment and identification of multiple needs	Annually	Yes
10.4	Analysis of independent moderation service data (resource demand, etc.) against New Zealand Health Survey prevalence data	Six-yearly	No
10.5	Analysis of client data for trends in culturally specific presentations compared to New Zealand Health Survey prevalence data	Annually	No
10.6	Analysis of periodic service user satisfaction and barriers to service usage survey specific to dedicated services	Six-yearly	No
10.7	Analysis of the diversity of client characteristics (ethnicity, age, and gender) presenting to different service types (general, dedicated Māori, Pacific or Asian services)	Annually	Yes
11.1	Analysis of a periodic stakeholder satisfaction survey of the Ministry's management of the problem gambling research programme	Six-yearly	No
11.2	Summary of progress made in managing processes to provide agreed outcome and monitoring data	Annually	No
11.3	Summary of research infrastructure project delivery (scholarship and provider/research-initiated projects) for Māori, Pacific and Asian capacity to participate in research	Annually	No
11.4	Summary of research programme delivery	Annually	No
11.5	Review of the number of research reports finalised within Ministry of Health timeframes	Annually	No
11.6	The number of research projects completed that successfully involve all target groups, based on cultural identity (Pākehā, Māori, Pacific, Asian) age and gender	Six-yearly	No
11.7	Analysis of the diversity of applications and successful awards for Ministry of Health-funded gambling scholarships	Annually	Yes

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