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Migrant and Indigenous Gambling

Beyond Treatment and Intervention For the Asian Community In New Zealand

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THE ASIAN POPULATION IN NEW ZEALAND

In this article, Asians are studied from the point of view of ethnicity. The New Zealand census data provides information on over 30 Asian ethnic groups (Statistics New Zealand, 2001). The current paper focuses on the top five ethnic groups living in New Zealand: Chinese, Indian, Korean, Cambodian and Vietnamese. At times, the term "Asians" is used to refer to the collective set of Asian ethnic groups. The use of this term, however, is in no way meant to imply that these groups or communities are homogeneous in nature. In fact, they are very diverse with respect to language, migration experiences, and gambling problems and needs. Still, many Asian groups do share certain value orientations.

Asians make up the fastest-growing ethnic population in New Zealand today. In the decade between 1991 and 2006, the number of people identifying themselves with a cultural group linked to an Asian country more than doubled, to almost 354,552 or 9.1% of the total population. Chinese is the largest ethnic group within the Asian population, followed by Indian and Korean. Other ethnic groups are Thai, Filipino, Japanese, Sri Lankan, Malay, Cambodian, and Vietnamese.

Recent immigrants (people born overseas and resident in New Zealand for less than 10 years) comprise an increasing proportion of the ethnic groups within the Asian population. In the 2001 census, recent immigrants comprised 87% of the total Korean population and 52% of the total Chinese population.

A majority of the Chinese, Indian and Korean recent immigrants came to New Zealand following a fundamental change in New Zealand immigration policy in 1986. This policy was aimed at attracting immigrants with professional skills and capital for investment, irrespective of race and country of origin. Large numbers of Cambodians and Vietnamese came to New Zealand under the refugee category between 1977 and 1992. In recent years, however, Cambodians and Vietnamese have come to New Zealand instead as asylum seekers, or as immigrants sponsored by family members under the Family or Humanitarian category.

In 2001, nearly three quarters of Chinese and Indian recent immigrants lived in the Auckland Main Urban Area (MUA). The proportions of Koreans, Vietnamese and Cambodians living in the Auckland MUA were 70%, 69% and 50% respectively.

In addition to immigrants and refugees, there has been a substantial growth of Asian fee-paying students to New Zealand in recent years. In 2009 there were 141,812 foreign fee-paying students studying in New Zealand, of which 61% came from Asian countries such as China, Japan, South Korea, Taiwan and Thailand. Although Asian fee-paying students are not long-term residents in New Zealand, they experience a range of difficulties common to immigrants such as loneliness and insufficient cultural and linguistic skills.

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Other difficulties that migrants, refugees, asylum seekers and foreign fee-paying students face in New Zealand are: a drop in personal socio-economic status following migration; inability to speak the language of the host country; separation from family; lack of friendly reception by the surrounding host population; isolation from persons of similar cultural background; traumatic experience or prolonged stress prior to migration; and adolescent or senior age at time of migration (Ho, et al., 2002).

ASIAN MIGRANTS AND GAMBLING IN NEW ZEALAND

Several articles have pointed out that Chinese people's migrant status (in New Zealand) and their gambling behaviours are closely related, and that they tend to use gambling as a way to escape from problems (Wong, 2000; Wong, 2004; Wong & Tse, 2003; Tse, Wong & Kim, 2004; Tse, S., Wong, J., Kwok, V. & Li, Y. (2004); Tan & Tam, 2003).

Tse (2005) in his research found:

"Migration was also identified as a major reason why Chinese start gambling; many Chinese gamble in New Zealand because it is legal. Migration creates many difficulties for migrants: language barriers; issues around communications and relationships; and the absence of places to socialise and express themselves. Some members said New Zealand is boring and does not provide suitable entertainment for Asian people. In addition, friends invite people to gamble for entertainment and the casino is a good place to meet people. Gambling is also a problem for international/Chinese students studying in New Zealand who are without a proper role model" (Tse, et al., 2005).

In the 1999 New Zealand National Survey on Gambling, no Asians were identified as having current gambling problems (Abbot, 2001b). However, the researchers noted that this finding should be treated with caution because of the small sample size and other methodological factors (Abbot, 2001a). In another study, 30% of Chinese respondents and 50% of Korean respondents in New Zealand considered gambling to be a major problem in their communities (Ngai, et al., 2001). A survey of Christchurch restaurant employees, conducted by the Asian Services of the Problem Gambling Foundation of New Zealand found a disturbing trend of high numbers of Chinese workers being affected by problem gambling (Tan & Tam, 2003).

Despite the likelihood of higher levels of gambling problems, New Zealand research has indicated that Asian people may be less likely to seek help for their problems. Asian clients made up 6.9% of the total client population seeking face-to-face problem gambling treatment in 2009 (MOH, 2010). Asian people compose 9.1% of the New Zealand population (2006 census) it is apparent that Asian clients are under-represented in gambling counselling services. Furthermore, Asian clients stood out for their tendency towards very high losses. The mean loss for Asian clients was \$12,797, in comparison to the average loss of \$1,834 for all clients, and the

median loss was \$4,000 vs. \$800 for all clients (MOH, 2008). Paton-Simpson's interpretation is that the association with higher losses may reflect higher losses in Asian communities – possibly linked with a greater likelihood of gambling on casino tables, where higher stakes are often wagered in a continuous form of gambling: It may also indicate, the author wrote, that a higher level of losses is required before a person from an Asian community will seek help from a specialist gambling treatment agency (Paton Simpson et al, 2004).

Other articles demonstrate that Asians' help-seeking behaviours are also different: they tend not to seek help until they are in desperate situations. (Vong, 2002 & Wong, 2000)

DEVELOPMENT OF THE PUBLIC-HEALTH APPROACH TO GAMBLING IN NEW ZEALAND

Aotearoa-New Zealand appears to be both the first country in the world to adopt a serious public health approach to gambling and to be at the forefront of a public health approach to gambling. The 2003 international conference in Auckland entitled 'Gambling through a Public Health Lens' was the first such conference in the world. This conference focused on producing an international charter on gambling as a tool directed at governments to point out their duty of care towards communities regarding gambling. A post-conference version of the Charter has been written; further work from a cultural perspective is in progress

Public health practitioners aim to establish a broad framework for public health and health promotion practice on a national basis. Supported by the New Zealand Ministry of Health, the public health approach today consists of three main areas – promotion, prevention and protection. The Asian Family Services of Problem Gambling Foundation of New Zealand deals primarily with promotion and prevention. This is in accordance with the modern model for public health, known as "the New Public Health", based on the framework of the Ottawa Charter of Health Promotion. The blending of the public health and health promotion perspectives is referred to as public health/health promotion.

WHAT IS THE PUBLIC-HEALTH APPROACH TO GAMBLING?

The public health approach is about bearing in mind health and wellbeing issues in a broad framework and, as required, designing intervention strategies that suit this "broad" approach to gambling.

The scope of modern public health has moved beyond physical health to include mental health, wellbeing, and quality of life (Ellis & Collings, 1997; Ministry of Health 2002). The attempt to apply the public health concept to gambling is an extension of the trend and is quite recent (Korn & Schaffer, 1999). In New Zealand, 'public health' funding has only been available in the gambling arena for a few years, although some health promotion activities occurred before

that.

In general, it is agreed that the core of public health/health promotion practice has to be community-based and that a “community first” approach should be adopted. At the same time, there are other important dimensions of the ‘New Public Health’ – policy, healthy environments, individual knowledge and skills, and health services that reflect this kind of philosophy. Community is the centre of gravity, but the whole dimensionality of public health surrounds this centre (Raeburn & Herd, 2004).

RELATIONSHIP BETWEEN PUBLIC HEALTH AND HEALTH PROMOTION

Public health is more concerned with the patterns of health issues in society, and with the broad “causes” or determinants of these patterns, rather than dealing with individuals in clinics and hospitals, which usually has a treatment focus. It is concerned with the context of health (Raeburn & Herd, 2004) – the communities that people live in on a daily basis, their families, their cultural settings, their economic situations, their employment status, their ability to access services and so on.

Public health tends to have two broad dimensions. One is the “scientific” aspect associated with epidemiology, which looks at the patterns of disease in society. The other has to do with wide-scale intervention strategies for health and disease issues, as distinct from the individual-client and treatment approach of mainstream medicine and health (Raeburn & Herd, 2004).

In turn, the intervention aspect has three subdivisions: Health protection, which is concerned with legislated and regulatory aspects of safety, hygiene and environmental aspects of health; prevention, which involves measures to prevent specific diseases and problems from occurring; and health promotion, which is concerned with longer-term action to develop people’s capacity to enhance their own health and well-being (Raeburn & Herd, 2004).

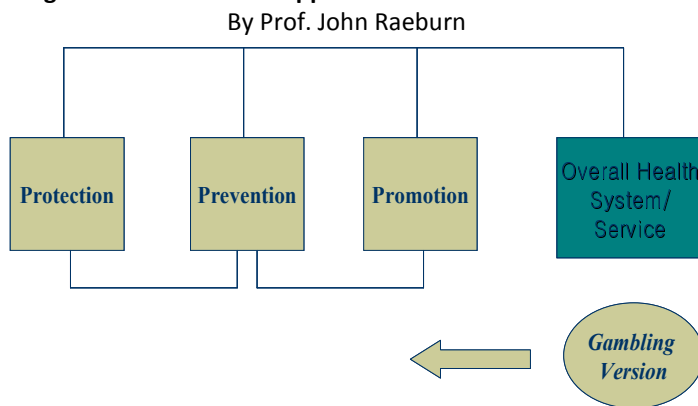
According to Brown and Raeburn (2001), public health as it relates to gambling has two main arms. One is health protection, or harm minimisation (a concept that comes from the addictions arena, with which gambling is also associated), and the other is health promotion. This binary concept of public health for gambling has been outlined elsewhere.

The harm minimisation aspect of public health from gambling refers mainly to the regulatory side (Raeburn & Herd, 2004) – the legislation and policies enacted by governments and others to protect the population from the perceived harms of gambling. Examples are warnings on gambling machines, host-responsibility programmes, and regulations to licence gambling operators and limit the proliferation of poker machines or casinos.

To some extent the distribution of treatment services in communities is also covered here. This role is also designed to limit harm, although by the time most clients

seek this type of help, the harm is well-established. But a valuable part of any good gambling treatment system is early intervention, along with services such as helplines, which fall into the harm-minimisation category to the extent that they pick up people at early stages of the disorder.

Figure 1: Public Health Approach



The health promotion aspect of public health for gambling is rather different. Whereas harm minimisation is a reaction by authorities to immediate and identified harms, health promotion is more of a developmental process involving people and communities. The aim is to develop attitudes, knowledge, strengths and capacities to deal with the demands and dangers of potentially damaging forces in society (Raeburn & Herd, 2004). Gambling is a powerful, prevalent and constantly marketed activity in its modern technological manifestation, and is becoming more so.

People need to be better informed about gambling – its dangers, and how to deal with it in an appropriate way. Like the harm-minimisation approach, health promotion accepts that gambling is a part of society. That being so, it is essential that both the regulators and the communities themselves become knowledgeable about gambling in its many aspects, and that they can work on their own towards appropriate strategies (Raeburn & Herd, 2004).

AN ASIAN APPROACH TO HEALTH PROMOTION

There is no ready-made health promotion that applies across all Asian cultures. Based on the ideas from their Chinese- and Korean-speaking staff, what the Asian Family Problem Gambling Services offers is simply a starting point. However, further discussion and development is still needed.

There are two main factors that have emerged as being particularly relevant to an Asian approach to health promotion. They are the *balance approach* and the *curiosity approach*.

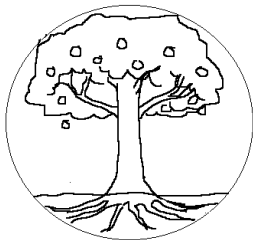
The balance approach to health promotion for Asian community

Deep in the mind of most Asians is the sense that good health and wellbeing are related to balance, such as the

idea of “Yin and Yang”. Concepts related to balance are harmony and holism. It is understood that health, wellbeing and happiness are present only when there is a balance between all the components – both internal and external – of peoples’ lives. Following this, the way to promote health is to look at all the components as a whole, rather than only focusing on one symptom or aspect.

New immigrants at risk for gambling problems on their arrival in a new country such as New Zealand can often be identified as displaying a condition of brokenness” (Raeburn & Herd, 2004). That is, most of them have had to uproot their lives and transplant them into a new and unfamiliar place they call their new home. Their lives turn upside down – they have left behind their family, friends, work, culture, and usually their entertainment and support systems. This leaves them feeling empty or broken. Such situations have the sense of an unresolved problem, and gambling, which starts as an attempted escape from this condition, becomes a problem. The way to change or prevent this is to restore balance and harmony in their lives. This requires looking into each part of each immigrant’s life and dealing with the “broken bits”.

Effective health promotion looks at the whole life situation of the person, acknowledges the difficult and demanding life situation of new immigrants in the new country, and studies the holistic inner and outer environments that can be changed to restore balance and harmony, in a way that avoids personalising the issue. That is, it externalises the gambling problem rather than focusing on the individual’s personal qualities.



Hence, the concept of empowerment is very acceptable to Asian people. The restoration of balance is treated as the person gains back their own power over the situation through education, life skills and supportive environments, restoring control and power in difficult and challenging life situations. This creates the best possible resilience with regard to an issue like gambling (Raeburn & Herd, 2004).

The curiosity approach to health promotion

Another strong characteristic of many Asian people is that they are full of “curiosity”. When something significant or bad happens, they wish to know the cause and to understand it. This trait is useful in the development of health, wellbeing and happiness.

Awareness-raising and education about all aspects of gambling and how these relate to other dimensions of life are likely to be very helpful in developing resilience and strength in the face of gambling and other pressure within Asian communities.

The Asian Family Problem Gambling Services considers a tree with strong roots, situated in a circle, a good symbol of Asian health promotion. Health is represented by the healthy fruit and leaves on the tree and by the robustness of the tree itself, all of which depend on the surrounding environment. This is symbolised by the circle. The health of the fruit and of the tree depends on the depth and food sources of the roots and on the weather, including sunshine, suitable air and temperature. A tree that is rootless, is poorly nourished, has insufficient sunlight or is in an unsuitable climate, will be unhealthy, and its fruit will not grow properly.

Providing strong roots, good nourishment and a suitable climate so that the whole tree benefits, is the way forward for Asian health promotion.

With the above two models of health promotion, there is much in this Asian perspective that has universal application and can be applied to all cultures.

THE ABCDE MODEL

The Asian Problem Gambling Services adopted the ABCDE model (Raeburn & Herd, 2004) from Professor John Raeburn, which is as follows.

- A = Awareness-raising**
- B = Building networks and coalitions**
- C = Community development**
- D = Developing policy and resources**
- E = Evaluation**

1. Awareness-raising

The awareness-raising stage of health promotion is not designed to scare communities about the “horrors” of gambling. It aims to show an accurate picture of the impact that gambling has on people at a grassroots level. This is done through discussions, workshops, forums, presentations and media interviews, which involve the culturally appropriate local perspective.

Media campaigns can be at a local or national level. These widespread campaigns provide information about gambling, which can reduce some of the need for intensive local awareness-raising activities. Some health promotion advisors may choose more locally focused campaigns, using community newspapers, posters, school programmes and public gatherings in order to develop community awareness.

2. Building networks and coalitions

Going to the community, networking, gathering people together, delivering presentations and creating discussions about a social issue of the scale and importance of gambling means that some people may become interested enough to take action. One of the aims of the health promotion advisors is to encourage people to form groups at a grassroots level, especially on a sustainable basis, so that the group becomes the focus for their community’s

action about gambling. Such a group is called an “action group”. At this stage, the group often needs assurance that the health promotion advisors will continue to provide support and guidance, even though the group understands that it needs to be in control of its own organisation and processes.

3. Community development

The aim of the community-development process is to help community-action groups set up ongoing community projects. They run these projects themselves to tackle gambling issues, such as providing a better gambling environment. Projects are based on a needs assessment of the community done by the community itself.

The community development process is quite complex and takes a high degree of skill by health promotion advisors. It is based on the **PEOPLE System (Planning and Evaluation of People-Led Endeavours)** and has been widely used in New Zealand as a systematic planning model for community-controlled health promotion and development projects. It appears to have wide inter-cultural acceptance. The PEOPLE System provides a strong basis for sustainable, self-determined community projects. The aim is for communities in New Zealand to become competent in community capacity and development, and to oversee their own affairs with regards to gambling in a way that is rewarding to them.

4. Developing policy and resource

Policy development can be interpreted as the community development process becoming mature. When local people know more about what ‘healthy gambling activities’ there are for their community, they will become a valuable source of knowledge for the development of a suitable gambling policy in their community. A skilled health promotion advisor will facilitate these processes in such a way that the local expertise is documented and directed to the appropriate channels. Therefore, a well-informed local community will be able to make submissions to create law changes about gambling that are beneficial and healthy for the community, and that put pressure on policy makers (local and central governments). A skilled health promotion advisor with an interest in this area could assist greatly in this process.

Developing resources at this stage aims at capitalising on the lessons learned from the early work of the health-promotion advisors. Manuals and resources can then be developed to record insights; these can be transformed into ‘resource kits’ for use by others. In this way the knowledge and skills can be passed on to other health-promotion advisors to operate in a similar way of disseminating effective ideas and skills. These could take the form of printed materials, videos, manuals, websites, workshops and training programmes.

5. Evaluation

The final step in the ABCDE model is evaluation, which is done in diverse ways but is based mainly on a goal-achievement approach. Not only is it necessary to want community action to work, but it also needs to be sustained. The evaluations are designed to ensure the most effective ways of operating in order to achieve the desired outcomes. Health promotion

work is complex and is likely to continue developing over a period of time. Evaluation is constantly required to improve what is being done because the gambling area is new, hidden and powerful. Evaluation provides health promotion advisors with a unique opportunity to get it right.

THE PEOPLE SYSTEM

The PEOPLE System approach is easy for health promotion advisors to follow in planning and evaluating community development projects. It is used when a public health advisor has reached the community development stage of the ABCDE framework. Since community processes are complicated, the PEOPLE System provides the capacity to go through the necessary process step by step.

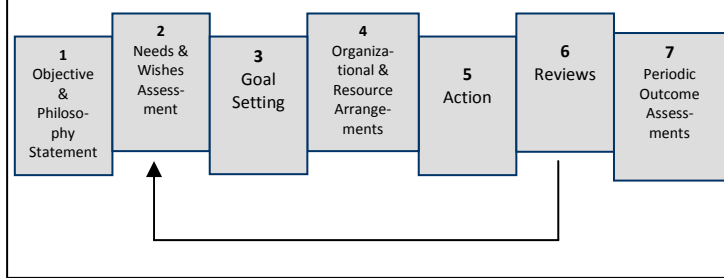
The important factor here is “people-led”. Although the health promotion advisors are assisting in the process of community development, the community itself is controlling the undertaking. The philosophies of community empowerment, control and self-determination are followed.

Raeburn & Herd (2004) also suggest following a seven-stage procedure to deliver the PEOPLE System. Each step in the procedure may not necessarily follow the previous one, but in general, one starts at the beginning and works through the order.

- All projects begin with an initial phase, which may sometimes take a lengthy period of time, about what the community wants to do, and how they want to do it.
- A more precise process then follows of assessing through surveys, focus groups and community meetings. What the community wants for itself is a clear specification and prioritisation of its own needs and wishes.
- Explicit goal-setting then takes place for what the community wants to achieve over the next phase.
- The goal-setting is accompanied by a consideration of what resources are available and what sort of organisational structure is required to make it happen.
- Action to meet these goals is then planned and undertaken; each goal area has a person responsible for it who in turn may work with a number of people on relevant tasks.
- As work proceeds, there are regular reviews where people responsible for various goals report their progress to the group. Thus, when difficulties occur, the group can participate in finding a solution.
- Finally, an overall assessment of progress is completed periodically to ensure that the whole enterprise is on track and that it is having its intended impact.

These seven steps can be condensed as shown in the diagram below. The ‘feedback loop’ illustrates that the ‘review’ process can adjust the ‘needs, goals and actions’ as new information becomes available, with the aim of having a constantly improving enterprise. The goals should remain unchanged, as it is a matter of stability to ensure that the system is not diverted by dissimilar trends.

The seven steps



The PEOPLE System allows flexibility for cultural and local interpretation, and for spontaneity and creativity. It is able to span a variety of cultures successfully, and has been used in both urban and rural settings in New Zealand. The system is most effective with a degree of training in its use. (For more information on the PEOPLE System, please refer to Raeburn, 1992, & Raeburn and Rootman, 1998).

LIMITATIONS

The public health approach can be described as building a fence in front of a drop-off and raising awareness of the consequences of going to the other side of the fence. This approach encourages communities and individuals to play and be happy within the safe zone. Therefore, it is only useful for communities that have not been affected by problem gambling and for individuals who are not participating in problem gambling activities. The reason is that problem gamblers usually do not attend any form of public health activities and that they have already gone beyond the fence and may be falling down the cliff or even lying injured at the bottom.

At these stages, they need intervention – i.e., an ambulance at the bottom of the cliff – but intervention is not part of public health. However, the public health approach would be useful for the family and friends of these problem gamblers. If they participate in public health activities, they may gather more information about the behaviours of problem gamblers and about where to seek help. They may learn how to prevent problem gamblers from going beyond the fence and, if the gambler has gone beyond or is at the edge of the fence, they can encourage the gambler to seek help earlier, rather than waiting at the bottom of the cliff.

Furthermore, since the majority of Asians in New Zealand are migrants, they may not have been able to settle down during their post-migration adjustment period, they may not have a sense of belonging, self-esteem and self-confidence as well as security. If that is the case, public health may not be of interest to them, since their focus is on how to get a job and survive. Public health practitioners may have difficulties drawing their interest to public health approach activities.

EFFECTIVENESS OF THE PUBLIC-HEALTH APPROACH

When public health practitioners carry out the ABCDE model, the PEOPLE system and the seven steps, there are

different assessment, review and evaluation processes they need to follow to see if the proposed strategies were effective. If the project was from the community, they need to evaluate whether their goal has been achieved. Public health practitioners can also set up a grassroots reference group to give them feedback. It may or may not work out smoothly at the beginning. It may take a lengthy time to develop a community where people are interested in making a difference, particularly among the Asian migrant population. The public health approach is an ongoing task. Community groups and public health practitioners need to keep working like gardeners planting seeds, who need to wait for suitable conditions – temperature, soil, rainfall, sunshine, and air – for seeds to grow.

CONCLUSION

The Asian population is growing in New Zealand. A large number of these people are migrants in the process of settling down. They are facing lots of difficulties during their post-migration adjustments, and some are using gambling as a way to escape their problems. On one hand, Asian population's involvement in gambling activities in New Zealand is an over-representation of their population. On the other hand, when seeking help from counselling services, they are an under-representation of their population.

Gambling is a powerful, prevalent and constantly marketed activity in our era, and it is going to become more so. People in the Asian and mainstream populations need to be better informed about gambling, its dangers, and how to deal with it in an effective way. The Asian Family Problem Gambling Services in New Zealand go beyond treatment and intervention by adopting the public health approach to help the Asian community in New Zealand.

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Migrant and Indigenous Gambling

This issue combines two topics, indigenous and migrant problem gambling. They are New Zealand articles, but we would encourage anyone wanting to submit from overseas to do so and it can be included in the next issue. In the following two articles some concepts are introduced that are unique to Māori (who are the indigenous people of New Zealand) and may need some clarification for our international readers.

The concept of *Whanu ora* discussed in the first article is well explained in Terry's article. The concepts of *kaupapa Māori* and *taha Māori* personify the Māori perspective and the conceptualisation of Māori knowledge which has been developed through oral tradition. This is a process by which Māori mind receives, internalizes, differentiates, and formulates ideas and knowledge exclusively through *te reo Māori* (the Māori language) The expression *tangata whenua* is a Māori term of the indigenous peoples of New Zealand and literally means "people of the land."

Whanau means family, or extended family, which could consist of up to three or four generations living together. To *korero* is to chat, or to speak in Māori and *whakaoho mauri* is an awakening of the spirit. *Te Tiriti o Waitangi* is mentioned in the second article, it is also known as the Treaty of Waitangi, the treaty was signed between representatives of the British Crown and some of the chiefs of northern North Island tribes in 1840. *Whānau Ora* provides practical, community-based support to whānau so they can be self-managing and determine their own economic, cultural and social development. The primary focus is on achieving best outcomes for whānau through the development of whānau leadership and integrated whānau-centred service delivery. The principle of *Ngā Kaupapa Tuku Iho* is about the ways in which Māori values, beliefs, obligations, and responsibilities are available to guide whānau in their day to day lives.

Problem Gambling and Whānau Ora

Whānau Ora

The prevalence of problem gambling amongst Māori and its impacts are well documented. Likewise problem gambling service utilisation by Māori is also well monitored by the Ministry of Health (who fund problem gambling services). Meaningful outcome data for both clinical interventions and for public health activity is still forthcoming in the problem gambling sector – including for Māori as individuals, whānau and communities. In the early days of Māori social service and health developments a number of 'kaupapa Māori' or 'taha Māori' initiatives came into being with the intent to engage Māori utilising Māori values, practises and experience to increase access, retention and outcomes for Māori (Cave et al, 2008). Many still believe there is a need for such choices to be available to our communities. What will or how will Whānau Ora potentially impact on the problem gambling sector?

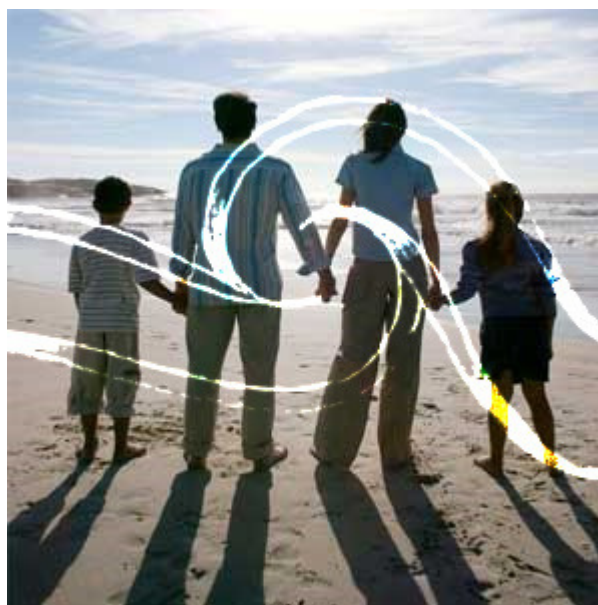
Whānau Ora has been a policy initiative for some years but now it presents potential opportunities and challenges to how Māori (and Pacific) providers might configure themselves and how they might practice. In many ways, Māori problem gambling services are well positioned to describe and articulate their practice in a Whānau Ora way.

One way to visualise Whānau Ora is the vertical and horizontal integration of service delivery across various sectors (e.g. health, justice, housing etc.). It incorporates programmes and packages of care, service delivery models and population approaches. But what is said to underpin this approach is Māori resources, language and culture – '*Ngā Kaupapa tuku iho*'. Essentially these are the ways in which Māori values, beliefs, obligations and responsibilities are available to guide whānau in their day-to-day lives. There is an assumption that utilisation of '*Ngā Kaupapa tuku iho*' will enhance access to relevant and effective services and thus effective outcomes. The horizontal integration is currently being made possible by a contracting and funding environment that includes multiple partners. To succeed services are being advised to consider the infrastructure needed to implement and monitor Whānau Ora practice and outcomes.

Problem gambling services with a public health approach are well suited to consider a range of interventions aimed at '*whakaoho mauri*'. However the challenge is to develop the capability of services and practitioners to be able to utilise '*Ngā Kaupapa tuku iho*' to develop the capacity of whānau to care for members and to plan and mobilise resources to achieve wellbeing. At the same time it is important that outcome frameworks are designed around whānau rather than the symptom relief of individuals or contract outputs. Capturing how Whānau Ora practice is being delivered and articulating outcomes clearly will be important.

Cultural Competence and Fluency

The complexity of many presentations to problem gambling services sees the opportunity for navigation of clients and or their whānau across a number of other providers and sectors in a coherent way. This obviously has some alignment with the 'facilitation' service specification (a purchase unit out of the Ministry of Health funding contract), however, the responsibilities and obligations involved for a Whānau Ora practitioner go beyond just facilitation, support work or case management. What it might mean is problem gambling services clustering with primary care or other health and social service providers to provide wrap around services.



Cultural competence is the integration of cultural and clinical components of care. In relation to the current discussion it means utilising Māori practices, values and experiences to enhance engagement and retention, enhance therapeutic alliance, inform assessment (cultural formulations) and negotiate outcomes. The concept of cultural fluency takes the idea of cultural competence one step further in that there is an expectation that service users and their whānau are able to understand information given and are able to act in an informed way on the information. Thus, outcome frameworks that are cognisant of cultural competency and cultural fluency aim to identify goals, pathways to get there and hold practitioners accountable for what they do.

Utilising '*Ngā Kaupapa tuku iho*' does not preclude use of other methodologies, e.g. cognitive behavioural approaches, motivational enhancement or even acupuncture, rather it is how these are blended and infused to achieve the negotiated outcomes of whānau. Māori practitioner competency frameworks, such as the Takarangi Competency Framework (Matua Rāji, 2009), Aka Matua (Te Hauora Rūnanga o Wairarapa, 2009) or even the values of Hapai te Hauora Tapui Ltd., provide clear descriptions of

not only what Māori values and experiences they expect to be utilised to be effective but also how these might be manifested in practice.

This level of accountability can be threatening for many practitioners and services who believe they have been delivering a Whānau Ora Service. Many practitioners have been unable to articulate the principles and practices that underpin their work as Māori practitioners other than in a generic way. So, this concept makes our ability to demonstrate how working in a whānau or even a Māori way makes a difference.

Conclusion

In many ways, Māori problem gambling services are well positioned to describe and articulate their practice in a Whānau Ora way. Because a service does not have a Whānau Ora contract does not mean they can't practice in a Whānau Ora way. Whānau Ora practice demands greater accountability for what is being done and this might mean services and practitioners need competency frameworks to guide service and workforce development. They will also need competent supervision as well as systems of quality improvement that ensure practice is being recorded and monitored.

A number of people are already asking of frameworks such as the Takarangi Competency Framework whether non-Māori can sign up. The answer is; Māori responsiveness is everyone's responsibility so these frameworks and even starter frameworks such as *Lets Get Real* (Te Pou, 2008) can be very useful. Unless practitioners (and managers) are able to articulate what they do and how they add value to a 'whakaoho mauri' outcome, Māori responsiveness will be vulnerable to the whims of policy and funding constraints.

While many Māori services and communities may well welcome Whānau Ora approaches, ultimately how the Ministry of Health problem gambling team make sense of this and other pressures to integrate (e.g., coexisting mental health and alcohol and other drug problems or assimilation into District Health Board operations), will be crucial.

Currently the sector would seem to be output driven and funded in a way that doesn't necessarily reflect the exciting potential that Whānau Ora presents. If we are to look to the future and maximise the opportunity currently being presented, Māori services and practitioners need to korero now amongst ourselves and with other health and social service agencies. E Oho! Maranga Mai!
Mauri Ora!

Terry Huriwai Chair of Te Rangihaeata Oranga Trust and Advisor, Matua Raki (National Addiction Workforce Development Centre)



Te Tiriti o Waitangi, Equity and Asian Public Health Practice

Problem gambling is a hidden problem among the Asian communities. How can we ensure we deliver an equitable service to vulnerable populations such as Asians in New Zealand within a Te Tiriti framework?

Contemporary New Zealand has been recognised as a multi-cultural society within a bi-cultural nation. Te Tiriti o Waitangi is an agreement between the Māori people as the indigenous people of New Zealand and the Crown; this defines our bi-cultural nation.

The Asian population recognises Māori as tangata whenua who hold a unique place in New Zealand. It further recognises Te Tiriti o Waitangi as the nation's founding document.

Because of the unique environment created by the signing of Te Tiriti, the way New Zealand deals with multi-culturalism can be different from other jurisdictions.

Article the first [Article 1, English translation of the Māori version]

"The chiefs of the Confederation and all the chiefs who have not joined that Confederation give absolutely to the Queen of England forever the complete government over their land".

This Article gives Asian people, along with other non-Māori people, the historical, constitutional and legal basis for being in New Zealand.

Article the third [English text]

"In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her royal protection and imparts to them all the Rights and Privileges of British Subjects."

This Article imparts to Asian migrants the same rights as other non-Māori, including the right to health.

(Source: CMDHB Integrated Asian Strategic Action Plan 2010)

Many service providers believe equity is “sameness” when it is not! It is about “fairness”. There are 180 ethnic groups in New Zealand and if we are to deliver “right to health”, enshrined in Article Three of Te Tiriti, then as public health practitioners we need to work towards determining how we can respond to them all to achieve health equity.

The principles of Te Tiriti are the foundation of a framework (the Asian Responsive Health Indicator Framework) currently in development, that will be used by practitioners to respond in a culturally appropriate way to the health needs of firstly the Asian population but also the many different peoples of New Zealand.

Cultural responsiveness needs to be part of a health organisation both vertically (from governance level down) and horizontally (across all divisions). Only when whole of the organisation aspire to this, can there be a chance of true equity in health among all groups of New Zealanders.

For example, consumers who occupy a minority ethnic group may find language a barrier to accessing a health service. Stakeholders, focused on health equity through cultural responsiveness, could interview the consumers to find out why they weren’t making better use of the service.

Having identified language as a barrier, the stakeholders would need to tell the funders, who would respond by paying for interpreters.

The Treaty gives us all equal rights to good health, but currently, the use of life expectancy and mortality data to determine inequalities in health gives a skewed picture of inequity because many Asian migrants haven’t lived in New Zealand long enough to provide those data.

Considering utilisation of health services, disability, disease prevalence, and quality of life measures may give a truer picture of inequity that exists in recent migrant populations living in the country.

So measures that we use to determine the problem gambling inequalities and what indicators should we consider is important to address inequalities. These indicators however, must also be culturally informed.

Dr Kawshi De Silva,
Chairperson of Asian Health Foundation.



Join the Gambling and Public Health Alliance International

Connect with Alliance members around the world dedicated to reducing and eliminating gambling related harm.

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Share knowledge and information about international developments in legislation, policy and programmes to utilise in the task of reducing gambling harm.

Benefit from the support and advice provided by Alliance members worldwide.

Receive regular electronic newsletters and keep up-to-date with news from other members around the world on developments and issues in their region or country.

Membership to the Alliance is free. The Alliance receives no funding or support from the gambling industry.

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