Int J Ment Health Addiction (2007) 5:320–330
DOI 10.1007/s11469-007-9085-5

Gambling, Social Disorganisation and Deprivation

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Received: 3 January 2007 / Accepted: 24 April 2007 /
Published online: 26 September 2007

Abstract The harms associated with the proliferation of gambling opportunities is increasingly being researched and documented as part of a public health approach to reduce gambling related harm in many countries. New Zealand has had a history of gambling for just under 200 years with the behaviour introduced by new settlers to New Zealand and the indigenous population around 1840. This paper proposes that gambling contributes to the social disorganisation and social deprivation of many communities and especially, those which are low income and are the residence of indigenous and ethnic minority populations. New Zealand has adopted a public health approach to addressing gambling related harm and this is supported through legislation. As part of a public health approach to reduce gambling related harm new questions are proposed to challenge those who have power in the licensing and regulation of gambling and the authority as where public health resources should be directed to remove gambling related harm. Maori the indigenous population of New Zealand is the focus this paper, but the questions proposed can be used by different groups in communities where gambling creates harm.

Keywords Social disorganisation · Social capital · Social deprivation · Indigenous · Public health

Introduction

The purpose of this paper is to discuss the proposition that gambling contributes to social disorganisation in some communities. Further, that those involved in gambling depend upon the social disorganisation of specific communities so that certain groups such as Maori whanau (extended family) and ethnic minority populations are unable to object to the legalisation of gaming and the deliberate placement of gambling venues in their local areas where they live. The concept of social disorganisation is important, as it provides an opportunity to reframe who benefits from gambling, who are victims from gambling and

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what interventions are needed for different communities and specific population groups to reduce gambling related harm from a public health perspective.

This paper is written from an indigenous Maori perspective and has been submitted to support recognition of the socio economic and cultural effects of gambling in New Zealand. Gambling as an activity was introduced to Maori society by new settlers who came to New Zealand in the early nineteenth century. Since then, supported though government led policies, wagering has now become a normalised recreational activity (Grant 1994).

Gambling now plays an integral part of the cultural life of being Maori, for many Maori social institutions such as marae (meeting places) Kohanga Reo (language nests) and Maori sports groups in which all been established in some way of gambling funding. There existence is now dependent wholly or partially upon this form of funding to support their continued operation and or to develop new amenities. Gambling is also used to by some whanau to help off set the costs of tangihanga, (funeral) such as, covering the costs of hosting people from different whanau, hapu (sub tribe) and iwi (tribe) and community groups who attend, to pay respects for the death of a person. Tangihanga is an important custom for Maori, as it provides the opportunity for whanau, hapu and iwi bonds to be strengthened and for tribal histories and cultural values to be relived and pasted from one generation to the next.

The paper supports the development of a public health approach to remove gambling related harm in New Zealand and it supports the Gambling Act 2003, the Local Government Act 2002, and the Ministry of Health's purchasing intentions for 2007 to 2010, to address gambling related harm in New Zealand, (Ministry of Health 2006a, b, c, e, f; d). To support a public health approach, specific questions are proposed in this paper, to facilitate discussion as to the degree of support, information, resources and authority which is commonly available to socially disorganised communities to assist them to become organised and empowered to change the social, economic and cultural environments that they live in. The questions asked in New Zealand are likely to be applicable to other countries, which have supported the proliferation of gambling opportunities.

In New Zealand now gambling venues alone or alongside other socially engineered recreational activities, such as cheap liquor outlets, bars, prostitution, and fast food outlets now have the potential to create considerable harm, especially in low income communities which are often socially disorganised.

The paper will now discuss briefly the concepts of social disorganisation and social capital, the framing and victimisation of socially disorganised communities, the impact gambling and problem gambling has on Maori communities and the effects of the concentration of gambling venues in low income communities. The implications of gambling venues in communities where Maori live will also be briefly described as well as the flow on effects for the wellbeing of Maori tamariki (children) and mokopuna (grandchildren) who will be parents and community leaders in the future.

It is proposed that the wellbeing of children and young people should be at the heart of any public health approach to reduce gambling related harm in order that the next generation are able to live in healthy communities and are able to develop and achieve their full potential as healthy citizens.

Concept of Social Disorganisation

Kawachi and Kennedy suggest that crime provides a perfect window to look at the health status of a community and how it functions from a public health perspective (Kawachi et al.

1999a, b). The impact of crime on the health of communities and citizens is also increasingly receiving public health attention as the economic and psychological costs associated with crime is quantified as well as the impact on victims, such as effects of post traumatic stress disorder, (Robinson and Keithley 2000).

The concept of social disorganisation has arisen from the work of Shaw and Mckay who looked at crime, deprivation and how communities were organised along friendships, kinship and acquaintances in the1940s (Shaw and Mckay 1942). It was identified then that there was some communities which were unable to socialise their youth, to adopt locally held community values, beliefs and social norms. Instead youth from these communities, developed their own social structures, such as forming their own social gangs. As part of belonging to these social organisations, they then developed their own cultural identities, particularly in terms of their own values, social norms and behaviours which were often quite radically different from their parents. In contrast to youth, their parents' identity was often linked to belonging to a specific ethnic population and their identity was shaped by their traditional cultural values and beliefs and lifestyle.

Youth in being different from their elders, often joined a gang and became involved in activities which created havoc in the communities in which they and their parents lived. They for example, often became involved in such activities as crime, violence, alcohol abuse, legal and illegal drug abuse. Due to their behaviour, these youth were often at risk of criminal offending, and this led them to come in contact with the Police and or the Justice system, leading to some being sentenced either in the community or in prison. The youth were often defined and seen as juvenile delinquents.[1]

In looking further where youth were seen as problem, it has been identified that the communities in which they lived in, often had common features. Some of these features were as follows: there were a high percentage of solo mothers who often had several children from different male partners and who had little involvement in the care and parenting of their offspring. Mothers were often left responsible for the care of their children often on their own with little social, financial or cultural support and they were often reliant on Government for income support. Employment in these communities was generally limited and there was often a high level of unemployment. Schools in the area often achieved a low level of educational attainment. Those living in these communities at all stage of life generally experienced poor health. Violence, drug and alcohol abuse and criminal offending often leading to imprisonment, was often accepted as norm in these communities. These features in these communities often led families to live in state of chaos, where they experienced constant trauma, poverty, alienation, detachment from and between kin, there existed limited social trust between individuals, families and social groups and generally, there existed minimal "social capital."

Manukau is a major growing city in the Auckland metropolitan region and increasingly the media is reporting events which suggest that this urban area is showing many of the above features which would fit the profile described above, of a socially disorganised community. Ethnic specific gangs engaging in violence and homicide are now regularly seen and reported as well as domestic violence and child abuse. Many communities throughout New Zealand both urban and rural also now experience the effects of social disorganisation.

[1] At present in Auckland which is the largest city in New Zealand, which has a diverse ethnic population, there has been increasing concerns by the Police and local communities of the degree of violence and crime generated by youth in specific communities. Explanations of the factors which are creating youth violence mirror those which are described as characteristics of socially disorganised communities.

Concept of Social Capital

Social capital is defined as those social relationships which encourage trust and social bonds and which facilitates cooperation between citizens for mutual benefit and wellbeing (Kawachi et al. 1999a, b). The concept and availability of social capital is considered essential for the development of healthy communities and places where people live. Taking account of the social situation described above, many people in New Zealand, now live in social environments where there exists minimal social bonds, which affects reciprocal relationships between individuals and impacts upon families and communities and their ability to care and look after each other. The outcome of these social environments is that these communities have minimal social capital and seen and described as being socially disorganised (Kawachi et al. 1999a, b).

To address the above patterns of behaviours described above, social and health interventions are often introduced into these communities focusing on resolving single issues, such as the low level of educational achievement of school leavers. There is often no real consideration of the relationships that exist between and across a whole range of issues and the general social trauma and chaos that many individuals, families and groups experience in these communities.

In sum, these communities often provide the opportunity for a wide range of health and social service organisations to be contracted and for workers to be employed in many different roles, often well paid, to provide assistance to those seen and defined by those in power as in "need."

Framing and Victimisation of Social Disorganised Communities

One of the outcomes of framing communities in need is that interventions are often "inadvertently designed," to support those living in socially disorganised communities to become more dependent, especially upon health and social welfare assistance and to be constantly victimised and seen as the "problem" or the "special at risk group." Due to this situation, many families and communities lose their social and cultural skills. They are no longer self or whanau reliant and are often in the spotlight, especially through the media, for negative events, which have occurred, such as child abuse and local violence.

A number of events as described above, have recently occurred in New Zealand and in particular in Manukau, a major growing urban city with the recent deaths of twins,[2] in which family members have closed ranks and refused to explain how these deaths may have occurred. As a result of this incidence along with other child abuse causes, many organisations and individuals are now asking themselves, how did this happen. This

[2] In June 2006, two babies who had been under the care of the Child, Youth and Family Service and were returned to the care of their parents and then were shortly admitted to Auckland Hospital and died with severe brain damage. Since the death of these twins, the family responsible for their care has been silent, under investigation by the Police, and have been scrutinised by other social agencies, for their social and economic circumstances and overall general lifestyle.

The death of these twins, including the public display of their photographs, at death, has been shown widely in the media. This case has generated considerable public debate as to the causes of death, what local services were available, who should be responsible for the situation that has occurred and what changes should occur in public policy to make these families accountable for their lifestyle (Cook 2006). Kahui kids return to family. New Zealand Herald. Auckland.

framing again, justifies the response that these communities are in need, they require more help, social servicing and funding.

The ability of these whanau and communities however to change their social environment in which they live in is minimal. They have little political power or influence to change their social or economic situation. Their human and democratic rights as citizens to have a say and control over their own lives and the authority to direct their own wellbeing is generally limited. The power and authority which shapes the nature of the communities lies elsewhere, such as in local authorities and government agencies. The power of these bodies over citizens is entrenched further in legislation, policies and the political processes of Government.

Communities' social capacity and the degree of social capital needed to change the nature of the communities and environments in which people live in are totally eroded. This makes them vulnerable and prey to social hazards such as gambling venues, the sale of liquor through cheap outlets, the consumption of tobacco, prostitution, loan sharks and poor quality of food which are all legalised, regulated, licensed and sanctioned in these communities (Dyall 2004).

Research in New Zealand has often focussed on these communities. It has often been found that ethnicity along with social deprivation, are key indicators to explain why certain communities and particular ethnic groups are at risk to specific health issues, such as problem gambling (National Health Committee 1998; Ministry of Health 2006e).

The proposition that the author would like to suggest, is instead of victimising Maori, Pacific and Asian populations for their risk and prevalence of problem gambling, their degree of expenditure on gambling and their underutilisation of problem gambling treatment services (Ministry of Health 2005; Ministry of Health 2006d, e), in New Zealand, that it is appropriate to take a new frame and ask as part of a public health approach to removing gambling related harm the following questions:

- *How well are communities organised and functioning to be able to protect and socialise their young people to adopt ethnic specific community values and norms as well as acceptable behaviours that do not label their young people as juvenile delinquents and therefore at risk of criminal offending and possibly imprisonment?*
- *What control and legislative authority do communities have in restricting, prohibiting or removing social hazards from being available in their local area such as liquor stores, gambling outlets, fast food outlets, pawn and loan brokers, prostitution venues?*
- *What financial and social assistance, including information for informed decision making, is provided to communities to help them to combat the placement of social hazards, such as gambling venues in their area?*
- *What financial and social assistance is available to communities to help them rebuild and reorganise to recover from the effects of social hazards in their area, such as gambling venues?*
- *What specific financial and social support is provided to Maori to support tangata whenua (people of the land) to be able to take a kaitiaki (guardianship) role and responsibility in supporting the development of their whanau, hapu, iwi and communities that they live in?*
- *What compensation is provided to communities for the harm that government agencies create through the development of interventions, policies and strategies that they implement with minimal involvement of whanau and ethnic communities defined as at risk?*

Demographic Profile of Maori and Gambling

From the 2006 Census, there were 565,329 people who identified themselves as Maori and now this population accounts for one in seven New Zealanders. The majority of Maori live in the North Island, the median age is almost 23 years of age, there has been a significant increase in the number of Maori in the workforce either on a part or full time basis (Statistics New Zealand 2007).

Using data from the 2001 census, it has been identified that two thirds of Maori live in areas defined as localities of high socio economic deprivation, deciles 8 to 10 (Ministry of Health 2006f). Despite this situation and an economy which has been growing over the past few years, many Maori household incomes have fallen or not increased significantly, while at the same time, the Government has reported a budget surplus (Ministry of Social Development 2006).

One in four Maori children now live in relative poverty and many are being discriminated against by the Government as their parent or parents do not meet the criteria for eligibility for financial assistance from the In Work Payment scheme, a policy which has been framed to provide income support to children in need (Wynd 2006). In contrast to children, elderly in New Zealand, predominately non Maori, receive financial assistance from the Government by way of income support, irrespective of their income or assets and as a result, less than one in ten over 65 years of age, live below the relative poverty line (Ministry of Social Development 2006).

Almost one in two Maori households are now headed by a sole parent, generally women, who are under considerable social, economic and cultural stress and due to their situation have limited options, to change their personal or social situation but are often victimised for their circumstances (Te Puni Kokiri and Ministry of Women's Affairs 1996).

The impact of problem gambling on the health and wellbeing of Maori tamariki and their whanau should be now a key focus in the Ministry of Health's proposed purchasing strategy taking account of the demographic profile of Maori.

Gambling for many Maori is now used to help cope with their daily life. It provide the means of hope for a better future and the possibility of wining extra money to cover household and children expenses, so that tamariki have similar opportunities as many non Maori kids who live in households with middle or upper incomes. Overall, gambling for Maori is not just a form a recreation. It is the means to escape from boredom, chaos and trauma from the daily realities of life (Dyall and Hand 2003).

This situation has been created as a result of past and current Government initiated policies which have often ignored recognition of New Zealand's founding constitutional document, Te Tiriti o Waitangi (Ministry of Health 2002). Lack of recognition of Te Tiriti o Waitangi has meant that Maori authority exercised through whanau, hapu and iwi has been eroded and this has led to the development of policies which have aimed to assimilate Maori rather than support and strengthen Maori values, beliefs and social structures, such as whanau, hapu, iwi and marae (Durie 2001). Although Maori have been identified clearly as population harmed by gambling, the Ministry of Health has little to offer to Maori in its purchasing strategy for preventing and minimising harm for 2007–2010 (Dyall 2006).

Current gambling intervention services are only reaching approximately 15% of the total population who are estimated to be harmed by gambling (Ministry of Health 2006e). This finding should encourage the Ministry of Health to reconsider its strategy and to engage with communities and populations harmed by gambling on an ongoing basis, so that appropriate solutions emerge (Ministry of Health 2006e).

In the new strategy for service provision for 2007 to 2010, the Ministry of Health proposes a continuation of its past strategy and especially so for Maori. This means the continuation at the same level of Maori gambling treatment services even though evidence emerging, suggests that overall gambling interventions services are not being utilised in relation to harm that has been created (Ministry of Health 2006d).

Gambling now impacts on Maori in many different ways. It erodes relationships and weakens the social bonds that exist within whanau and in communities. Borrowing or stealing money within whanau and criminal offending related to gambling is common in many Maori households. This often leads to other issues such as, sexual abuse and domestic violence. Escalation of gambling can also lead on to criminal offending and then community sentencing or imprisonment. One in three in prison, both males and females, have reported problems with gambling and this has affected their pattern of offending. At any time Maori make up 50% of the prison population in New Zealand (Abbott et al. 2005; Abbott and McKenna 2000).

Mental illness, especially depression, substance abuse suicide is now significantly prevalent in Maori communities, along with poor health, (Ministry of Health 2006a, b, c). This is a reflection again of the stress and general conditions that Maori experience as tangata whenua (people of the land) and gambling is increasingly associated with these issues.

A recent survey on the health of New Zealanders has identified that problem gamblers are likely to be heavy drinkers, smokers and rate their health poor in all areas of physical, mental, family and spiritual wellbeing. Further, that almost a third (28.5%) of problem gamblers are likely to be Maori (Ministry of Health 2006a, b, c). Problem gambling for Maori is a public health issue, it adds to existing health problems tangata whenua experiences and increases the social and health differential which exists between Maori and non Maori (Ministry of Health 2006f).

The profile of Maori that has been presented today is not new. It shows that the majority of Maori now live in communities which would be classified by Kawachi and Kennedy as being socially disorganised. The following question therefore can be proposed:

> *"Why has the Crown through different agencies allowed for the regulation and licensing of gambling venues in low income communities and especially where Maori live?*

There is now a real need for government agencies, such as the Ministry of Health, Department of Internal Affairs and Ministry of Social Development, to provide real support to assist Maori to rebuild their communities and to become socially organised. This role has been validated in the Gambling Act 2003, (section 102), in which local councils have a statutory role to consult and engage with Maori in the development of their gambling venue policy, defining where gambling venues should be sited, with the exception of Government supported Lotto outlets, which run bi-weekly lotteries and sell other gambling products (He Oranga Pounamu 2006).

Tangata whenua now have a statutory responsibility, consistent with obligations inherent in Te Tiriti o Waitangi, to act as "Kaitiaki," or guardians of their communities and to provide meaningful input into the development and or review of local government gambling venues policies. This cannot occur without community capacity and social capital.

Profile of Gambling and Concentration in Low Income Communities

Maori are now exposed to the normalisation of gambling in their communities. This is supported by marketing and advertising of gambling in many different community settings,

especially through the media, such as the regular advertisements for Lotto, Power ball, and Keno on national television and in major newspapers. The geography of gambling in New Zealand highlights that over five times as many non casino pokie machines are sited in the two most deprived deciles (8 to 10) instead of the two least deprived areas (1 to 2). A similar pattern exists for TAB outlets, where over half are sited in the three most deprived deciles (Ministry of Health 2006e).

The concentration of gambling venues and machines in low income communities has not changed since the introduction of the Gambling Act 2003, in New Zealand. The majority of pokie machines, TAB outlets and casinos cannot be removed unless the Gambling Act 2003, is amended to allow communities to remove machines licensed prior to 17 October 2001.

The concentration of machines in some communities is immense. Kaikoura, for example, which has a significant Maori and tourist populations, now has the highest concentration of pokie machines, 152.4 pokie machines per 10,000 people. This is followed by Thames-Coromandel (122.8 per 10,000), Mackenzie District (118 per 10,000) and then Kawerau District (110.3 per 10,000). Other areas such as Waitakere City (24.9 per 10,000, North Shore City (32.0 per 10,000) and Manukau City (32.7 per 10,000) have a lower concentration of machines but they are accessible to a wider population and are harmful. (Ministry of Health 2006e)

The deliberate placement and concentration of pokie machines in specific communities requires the following questions to be asked.

- *Why are these communities being targeted by the provision of gambling outlets?"*
- *What is the flow on effects of having such a high concentration of pokie machines in such small communities?*
- *How organised are these communities in being able to object to the placement of gambling venues, especially sites with pokie machines in their communities?*

To facilitate political change to reduce gambling harm, it is proposed that these communities should not to be victimised for the behaviour of some of their members. Instead these communities should receive resources, skills and information to assist them become socially and politically organised and engaged with different stakeholders to influence the removal of machines if they desire and to be actively engaged with their local council in shaping the environment they live in.

Impact of Gambling on Maori: Synopsis of Qualitative Interviews

In 2004, a series of qualitative interviews were undertaken with Maori both heavy and social gamblers, to identify their views on the social, economic and cultural impacts of gambling. This research was undertaken under the auspices of the "Centre for Social and Health Outcomes Research" at Massey University, Auckland, and was conducted as part of a project to develop a methodology and a research tool to measure gambling related harm in New Zealand. The findings of this project has not been published, but it has laid the foundation for further work in this area to be continued (Ministry of Health 2006d).

Maori interviewed as part of the study to assist in the development of a research tool to measure the impact of gambling, were very clear. From both Maori heavy and social gamblers, they considered that gambling created considerable harm for individuals, whanau and communities and generated wide social and economic costs to the country overall.

From their perspective, they saw clearly the effects on children. However, although children are significantly affected, interventions to reduce gambling related harm are generally focused on the problem gambler or those who are able to present for help and therefore generally, adults. At present, almost one in three identify as Maori when seeking help with gambling problems in New Zealand and the number who seek help under represent those Maori affected by problem gambling (Ministry of Health 2006a, b, c).

Taking account of the demographic profile of Maori, it is suggested that tangata whenua should be supported to become organised to protect their children and others from gambling related harm. Without considerable intervention in the development of Maori to engage in addressing gambling and problem gambling as a public health issues, it is predicted that many young Maori today, are likely in the near future, to become the next generation of problem gamblers. As discussed previously, gambling venues are sited predominately in low income communities and these are the locations where Maori predominately live.

Some of the effects of gambling on children were very clearly identified by Maori who were interviewed as to the effects of gambling and problem gambling. The effects on children were seen as follows:

" Neglect of kids," *"no money for food*," *"having to go home with no groceries or meat in the cupboard*,"*" placing children in Kohanga Reo so able to gamble*,"*" it takes time away from kids and partner*,"*" no clothes for the kids*," *"children being left at home by themselves or with one parent*,"*"getting angry at the kids for small things*," *"kids stressed when they worry what they're going to have lunch*," *"late in picking up the children*," *and "lying in the relationship to get out of the house and unable to do things*."

In addition, one participant, explained that as a result of his partner's gambling they

" *have had to move house four times in the last two years because the rent wasn't paid, the power has been cut a few times and we have argued to the point of nearly separating because of gambling and the kids had all seen this*."

and further he felt he could not work as he had to due to

" look after the baby while she's in there gambling and had to go where ever she goes."

This is just some of the effects that gambling has on many Maori children and those who are affected by problem gambling.

Conclusion

Gambling and problem gambling now has many effects on individuals, families and communities in New Zealand. Maori as tangata whenua, are now significantly affected by gambling related harm as gambling venues have been strategically licensed, placed and validated by Government, through the Gambling Act 2003, to be able to continue to operate in low income communities, irrespective of the harm that they create and irrespective whether communities, wish to have such venues in their locality.

The deliberate placement of gambling venues like other social hazards, such as cheap liquor outlets, bars, and local prostitution have all been approved by way of way of national and local regulation and licensing. The majority of gambling venues in New Zealand

cannot be significantly removed or changed without local government input and legislative change.

The deliberative placement of these venues in particular communities supports and adds to the disorganisation of these communities, it reduces their social capital and increases their social economic and cultural deprivation. To counteract this situation, new questions are proposed to support the development of disadvantaged communities and to support the creation of new public health interventions to reduce gambling related harm.

As part of a public health approach to address gambling related harm, it is proposed that considerable resources and support should now be given to low income and indigenous communities to help them become organised to be able to challenge and seek removal of social hazards, such as gambling venues from their locality, which have been deliberately placed to create harm. This new approach challenges those who hold power and who often victimise such communities and define what their needs are and what interventions are appropriate.

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