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Gambling help seeking and self-management in New Zealand and Australia: a cross-sectional survey with quota sampling of priority populations

Background: Efforts to address gambling harm often rely on narrow definitions of help seeking that focus on professional treatment. This approach overlooks the many other ways people seek support, use tools, or take action to reduce or control their gambling. This study aimed to examine the uptake of a broader range of help seeking and self-management approaches among people who gamble, across priority populations, including Māori, Pacific, Asian and Australian Aboriginal and Torres Strait Islander (ATSI), and among people experiencing different levels of gambling harm.

Methods: A 58-item checklist on help seeking options contained three domains: *People and Places* (n=33 items), *Tools and Resources* (n=12 items) and *Self-Help Strategies* (n=13 items). It was administered online to 514 adults in New Zealand and Australia, using quota sampling for ethnicity and gambling severity (75% past or current problems, 25% regular gamblers). Respondents indicated how often they had engaged in each help-seeking behaviour over the past 12 months.

Results: Overall, 97% of participants reported using at least one help-seeking option. *People and Places* were widely used (80.5%) with the most frequently endorsed items being partner, family member, or friend (62.3%), peers in social or cultural groups (44.9%), general practitioners (44.6%) and mental health counsellors (44.4%). *Tools and Resources* were used by 87.0% and included time-outs (64.8%), reading online information (63.0%), and spending limits (62.5%). *Self-Help Strategies* were used by 95.5% including lifestyle change (84.2%), setting time or money limits (83.3%), thinking differently about gambling (80.9%), and self-monitoring thoughts, feelings, or behaviours (77.0%). Priority populations had higher uptake of help-seeking options across each of the three domains than non-priority populations. Help seeking increased across levels of gambling severity. Eighty percent of people with no gambling problems reported using any option, compared with 97.9% at low risk and 100% among those with moderate risk or problem gambling.

Conclusions: Help seeking extended well beyond specialist gambling services and included family, community and general health settings. This suggests that responses to gambling harm already occur across a wide range of everyday settings and highlights the need to better understand and strengthen these community responses. Future research should examine how different options connect to form pathways of support and how effective these pathways are over time.

Key words: Help-seeking; gambling; self-help; treatment; measurement, prevalence; recovery; public health

BACKGROUND

The increased availability and normalisation of gambling over recent decades has been linked to rising rates of gambling expenditure and related harm, disproportionately affecting those already experiencing social inequities [1, 2]. Risk of gambling-related harms are particularly high among those who gamble on rapid-play games, such as gaming machines and internet gambling, those with co-occurring mental health or addiction issues [3-9] and indigenous and culturally diverse communities [10, 11]. Public health frameworks that address the commercial determinants of gambling harm emphasise the importance of early intervention and harm minimisation [12, 13]. This includes offering a broader range of services and supports that prioritise health and wellbeing over economic interests, such as expanding treatments to address the full spectrum of gambling-related harm and implementing early detection initiatives, including screening in allied health, mental health, and addiction services [14-19].

The expansion of treatment options is critical given that a recent systematic review and meta-analysis found that globally, only one in five people experiencing problem gambling seek professional help, informal help, or self-help, with help-seeking reducing to about one in 25 among those with low- or moderate-risk gambling [20]. Convenience samples with indigenous people in Australia suggest rates are even lower with one study reporting 5 in 100 indigenous people “had sought help for gambling related problems” [21]. Gambling help-seeking has traditionally been framed around professional in-person

treatment and mutual aid models such as Gamblers Anonymous [22, 23]. Similarly, in the mental health field, help-seeking is generally defined as obtaining external assistance [24-29]. Research over the past 20 years suggests, however, that people can recover from gambling problems without accessing professional or peer support [30, 31], with some evidence suggesting that over 90% of people who attempt to reduce their gambling do so without involving another person [32]. Research demonstrates that almost all gamblers use self-help strategies to reduce, limit, or manage their gambling [33], including limiting access to money, seeking support from family or friends, using digital self-help tools, and self-excluding from gambling venues and platforms [32, 34-38].

The World Health Organization [39] defines help seeking broadly as any action taken to improve or resolve emotional, psychological, or behavioural problems, including formal, informal, and self-help strategies. This framing suggests help seeking is an intentional process that often precedes professional treatment, which is particularly relevant in gambling, where pathways to support are diverse, nonlinear, and frequently informal. This is especially evident in Indigenous and collectivist cultures, where addiction is understood as a family concern and recovery is grounded in cultural knowledge and practices [10, 40, 41]. For example, in Aotearoa New Zealand, Māori communities, help seeking reflects embedded cultural strengths and protective factors such as strong family and community networks, culturally based practices, and collective healing processes [42, 43]. Recognising and resourcing these Indigenous systems is central to building a more inclusive help seeking ecosystem that honours Indigenous ways of knowing and being. In Australia, multiple studies examining service delivery and gambling harm prevention have similarly recommended culturally relevant approaches, including community control and engagement, holistic models of care, a culturally responsive workforce, and strengthened capacity to respond to gambling harm [10, 11, 40, 44, 45].

A comprehensive understanding of help seeking is important to inform stepped care models and low threshold interventions that reflect real world behaviours. It is also critical for guiding the design and resourcing of services across the spectrum of gambling harm.

Very little is known about help seeking by priority populations, defined as those who experience disproportionately higher gambling harms [2, 11, 21, 46]. Priority populations in New Zealand include Māori, Pacific, and Asian people, while priority populations in Australia include Aboriginal and Torres Strait Islander (ATSI) peoples. This exploratory quantitative study therefore aimed to examine the uptake of a broad range of help seeking and self-management approaches among people who gamble, including the priority populations of Māori, Pacific, Asian, and Indigenous peoples, and among people experiencing different levels of gambling harm.

METHODS

This study was preregistered on the Open Science Framework (https://osf.io/qt7ha). Ethical approval was granted by the Auckland University of Technology Ethics Committee on 23 June 2023 (AUTEC Reference number 23/148). Participants were informed at the beginning of the questionnaire that completion of the anonymous survey would indicate their consent to participate.

Recruitment and sampling

This study was conducted across New Zealand and Australia, which are jurisdictions that offer free community-based treatment for gambling harm. Interventions may include psychological and behavioural therapies, financial counselling, pharmacological approaches, and culturally or socially informed supports [47]. Service provision varies across jurisdictions. In Australia, some states and territories fund specialised multicultural and ATSI programs. In New Zealand, dedicated services are available for Māori, Pacific, and Asian communities. Additional support options may include multidisciplinary or intensive programs, residential treatment, peer-based services, legal assistance, and digital interventions.

To be eligible for the current study, participants were required to: (1) be aged 18 years or over, (2) reside in New Zealand or Australia, and (3) either have a current or previous issue with gambling or have engaged in gambling (excluding lotteries) within the past 12

months. Respondents were recruited between 11 November to 10 December 2024 via a Qualtrics-managed research panel. Panel members received standard compensation offered through the platform in exchange for completing the survey. Quota sampling was employed to ensure a diverse and representative sample based on geography, age, ethnicity, and gambling history. Country quotas ensured that 50% of the sample was drawn from New Zealand and 50% from Australia. Age quotas specified that at least 10% of respondents were aged 18–34 years and at least 10% were aged 65 years or older. Ethnicity quotas were applied to ensure that at least 10% of participants identified as Māori, 10% as Pacific, and 10% as Asian. As the study was funded by the New Zealand Government, there were no specific quotas for Aboriginal and Torres Strait Islander (ATSI) participants. Quotas required that 75% of respondents had a self-reported previous or current issue with gambling, while the remaining 25% self-reported they had gambled in the past 12 months but did not have a previous or current issue with their gambling. Participants completed the survey online at a single timepoint. No personal identifying information was collected. The target sample size was 500 participants.

Measures

Help seeking

A 58-item checklist was developed to capture the range of actions people may take to mitigate or resolve gambling problems. Items were informed by analysis of open text survey responses on what people considered help seeking and treatment, academic literature and cognitive interviews with people with lived experience of gambling harm and people working in treatment services (unpublished manuscript). The checklist was organised into three domains: *People and Places* (33 items), *Tools and Resources* (12 items), and *Self-Help Strategies* (13 items). *People and Places* included talking to others, including gambling services, family and peers, allied health or mental health services, and cultural supports such as an elder or peer group. *Tools and Resources* included those developed by professionals or operators including self-exclusion, limit setting and tracking

tools. *Self-Help Strategies* included gambling specific strategies such as setting a budget and managing urges, as well as broader wellbeing focused actions. Items were rated on a four-point scale, (0) never, (1) rarely, (2) sometimes and (3) often, and were collapsed into a binary variable for analysis (scores of 0 cf. 1-3). Total scores ranged from 0 to 58, with domain specific ranges of 0 to 33 (*People and Places*), 0 to 12 (*Tools and Resources*) and 0 to 13 (*Self-Help Strategies*).

Demographics and gambling behaviours

Demographic outcomes were collected to describe the sample and examine any differences between priority and non-priority groups. Respondents were asked whether they belonged to any of four priority ethnic groups (Māori, Pacific, Asian, ATSI), gender, age group, level of education, annual gross household income (in the past 12 months), and country of residence.

Gambling severity was assessed using the nine-item Problem Gambling Severity Index [48], which measures gambling behaviours and related consequences over the past 12 months. Scores range from 0 to 27 and are categorised into four levels: non-problem gambling (score of 0), low-risk gambling (scores of 1–2), moderate-risk gambling (scores of 3–7), and problem gambling (scores of 8+). Respondents were asked to separately report their online and land-based gambling behaviour over the past 30 days, including the number of days they had gambled (frequency) and the total amount of money spent (expenditure). Response options for the two frequency items (online and land-based) ranged from 0 to 30 days and were grouped into five categories for analysis (0, 1–2, 3–4, 5–8, 9+ days). Response options for the two expenditure items (online and land-based) used predefined brackets (e.g., none, $1–$50, $51–$100, $101-$200, $201-$501, $501-$1000 and $1001 or more).

Statistical data analysis

Descriptive statistics were conducted using STATA version 19.5 (StataCorp, College Station, TX). Demographic characteristics and gambling behaviours across populations

were summarized using numbers and percentages. The total number of help-seeking options endorsed was summarized using medians and interquartile range (IQR), overall and by domain. Use of help-seeking options was also reported by priority group and PGSI category. Differences were assessed using Pearson chi-square or Fisher's exact tests, as appropriate. When overall tests were statistically significant ($p < 0.05$), post hoc pairwise comparisons were conducted, using non-priority and problem gambling as the reference groups for priority populations and PGSI comparisons, respectively. The same approach was used to examine uptake of at least one help-seeking option within each domain.

RESULTS

Sample characteristics

Of the 650 respondents who began the survey, 522 completed all items and eight responses were removed by Qualtrics during data cleaning because they failed quality checks, including unusually fast completion times and straight lining, resulting in a final analytic sample of 514 respondents.

Table 1 presents the demographic characteristics and gambling behaviour of the sample. There were 249 males (48.4%), 262 females (51.0%) and three gender diverse respondents (0.6%). The largest age groups were 35 to 44 years (n = 146, 28.4%) and 25 to 34 years (n = 138, 26.8%), with 9.7% aged 18 to 24 years and 11.1% aged 65 years or over. In terms of education, 159 (30.9%) had up to high school qualifications, 149 (29.0%) held vocational qualifications and 206 (40.1%) held a university or postgraduate degree. The majority met criteria for problem gambling on the PGSI (n = 295, 57.4%), with 102 (19.8%) classified in the moderate-risk category, 47 (9.1%) in the low-risk category, and 70 (13.6%) in the non-problem gambling category. Overall, 411 respondents (79.9%) had gambled online in the past month and 347 (67.5%) had gambled on land-based activities at least once. Significant differences were observed between priority and non-priority groups across age, education, gambling severity, gambling frequency, and gambling expenditure

in both land-based and online formats, with rates of problem gambling approximately double in priority groups compared with the non-priority group.

INSERT TABLE 1 ABOUT HERE

Endorsement patterns across the three domains

Over the past 12 months, 97.1% of participants reported using at least one of the 58 help-seeking options (based on yes/no endorsement), with a median of 25.5 options endorsed (IQR = 34). Across the 33 help-seeking options related to *People and Places*, 80.5% of participants reported using at least one, with a median of 8 (IQR = 26). Across the 12 options for *Tools and Resources*, 87.0% reported using at least one, with a median 7 (IQR = 9). Across the 13 options for *Self-help Strategies*, 95.5% reported using at least one, with a median 11 (IQR = 5).

People and Places

As shown in Table 2, the most endorsed source of support was help from a partner, family member, or friend (n = 320, 62.3%). Specific cultural and community-based supports were also commonly endorsed, including peers in social or cultural groups (n = 231, 44.9%), religious leaders, advisors, or elders (n = 209, 40.7%), cultural advisors or elders (n = 200, 38.9%), holistic or cultural health providers (n = 199, 38.7%), and spiritual advisors or healers (n = 183, 35.6%). Health services were endorsed at similar levels, including general practitioners or medical doctors (n = 229, 44.6%), mental health counsellors (n = 228, 44.4%), psychiatrists (n = 172, 33.5%), and nurses (n = 171, 33.3%). Gambling specific supports were moderately endorsed, including online chat or email (n = 220, 42.8%), gambling counsellors (n = 209, 40.7%), and gambling helplines (n = 205, 39.9%). There was an overall difference in the use of all help-seeking options related to *People and Places* across priority groups (global $p < 0.001$), with proportions significantly higher in

each priority group compared with the non-priority group, indicating that priority groups accessed these help-seeking options at higher rates.

INSERT TABLE 2 ABOUT HERE

Tools and Resources

As shown in Table 3, the most endorsed tool or resource was the time out or break feature on an online gambling site or app (n = 333, 64.8%), followed by reading information or resources online (n = 324, 63.0%), setting a spending limit with a gambling company (n = 321, 62.5%), and self-exclusion or bans from an online gambling site or app (n = 302, 58.8%). Priority groups also differed in their use of help-seeking options related to *Tools and Resources* (global $p < 0.001$), with priority groups reporting significantly higher uptake of all *Tools and Resources* than the non-priority group.

INSERT TABLE 3 ABOUT HERE

Self-Help Strategies

Table 4 presents the uptake of *Self-Help Strategies* to reduce gambling among the total sample and across priority population groups. For most strategies, overall, more than 50% of participants reported using them. The highest uptake was for strategies focusing on personal well-being or lifestyle changes (n = 433, 84.2%), setting time or money limits (n = 428, 83.3%), and thinking differently about gambling and its impact on life (n = 416, 80.9%), followed by self-monitoring thoughts, feelings, or behaviours (n = 396, 77.0%). Comparisons across priority and non-priority groups were statistically significant for all strategies except set time or money limits (global p = .397). Overall, use was higher in priority groups, although not all strategies or comparisons showed evidence of significant differences.

INSERT TABLE 4 ABOUT HERE

Help seeking by PGSI category

Help-seeking was common across all PGSI categories. Endorsement of at least one help seeking option was reported by 80.0% (n = 56) of participants with no gambling problems, 97.9% (n = 46) with low-risk gambling, and 100% of participants with moderate-risk (n = 102) and problem gambling (n = 295). As indicated in Supplementary Tables 1–3, there were significant difference across almost every option in each of the three domains (global $p < 0.001$). Help-seeking options were more commonly used in the PG category compared to the other categories, although this was not statistically significant for all options or comparisons.

Overall engagement with *People and Places* was reported by 44.3% (n = 31) of participants with no gambling problems, 63.8% (n = 30) with low-risk gambling, 74.5% (n = 76) with moderate-risk gambling, and 93.9% (n = 277) with problem gambling (global $p < 0.001$). Speaking with a partner, family member, or friend was consistently the most widely used support, reported by 20.0% (n = 14) of those with no gambling problems, 27.7% (n = 13) with low-risk gambling, 54.9% (n = 56) with moderate-risk gambling, and 80.3% (n = 237) with problem gambling, indicating that close relational contact is common across all severity levels. Across severity levels, the uptake of gambling-specific supports, such as gambling counsellors or online chat services, increased with gambling risk, showing that people with higher severity sought more targeted help. Cultural and community-based supports were used at lower but meaningful levels in all categories, suggesting that engagement with cultural advisors, spiritual leaders, and peers in cultural or social groups contributes to help-seeking behaviours alongside relational and general health contacts.

Engagement with *Tools and Resources* occurred across all PGSI categories. Overall engagement was reported by 28.6% (n = 20) of participants with no gambling problems,

68.1% (n = 32) with low-risk gambling, 91.2% (n = 93) with moderate-risk gambling, and 97.6% (n = 288) with problem gambling (global $p < 0.001$). Use of time-out or break features was among the top used across all groups. For participants with no gambling problems, the highest was to set a spending limit with a gambling operator. For low risk, the highest was to source information and resources about gambling management. The largest difference between moderate risk and problem gambling was the use of self-assessment and self-directed courses.

Engagement with *Self-Help Strategies* varied across PGSI categories. Overall, 68.6% (n = 48) of participants with no gambling problems, 97.9% (n = 46) with low-risk gambling, 91.2% (n = 93) with moderate-risk gambling, and 97.6% (n = 288) with problem gambling reported using at least one self-directed strategy to manage gambling (global $p < 0.001$). The *Self-Help Strategies* most used by people with no problem or low risk were set time or money limits, set up a budget or track spending, and focus on personal well-being or lifestyle change. These approaches were also used by people with moderate risk and problem gambling, with higher endorsement of strategies about thinking differently about gambling and its impact on life and taking actions to manage urges.

DISCUSSION

This study aimed to examine the uptake of a broad range of help seeking and self-management approaches among people who gamble, including among priority populations (Māori, Pacific, Asian and ATSI peoples) and among people experiencing different levels of gambling harm. In the current sample, in which 75% of respondents self-identified concerns about gambling, nearly all respondents (97.1%) reported using at least one type of help-seeking behaviour over the past year, spanning not only interpersonal and professional supports but also tools, resources, and self-help strategies. Specifically, 80.5% reported using at least one interpersonal support, 87.0% used at least one tool or resource, and 95.5% engaged in at least one self-help strategy. These rates of help seeking suggest much higher rates than previous studies as detailed in a global systematic review and meta-analysis [20]. This was because the definitions were align with the broad WHO

definition of help-seeking [39] and thereby capture a much wider set of behaviours than those typically assessed in gambling research [20, 22, 23, 30, 31].

In this study, 80.5% of participants reported speaking to at least one person about their gambling, with a median of 8 people over the past 12 months. This highlights that interpersonal help-seeking is common across all levels of gambling risk, including among those with low- or moderate-risk gambling. People in the low-risk gambling category reported speaking with a partner and family, Citizens Advice Bureau and financial, budget or banking advisors. It is possible that help seeking for gambling at these levels were specific to harms rather than addressing psychological dependence on gambling. Similar to other studies [40, 49], participants also turned to non-gambling supports, such as general practitioners, relationship counsellors, financial advisors, and mental health professionals. This pattern reflects broader service system realities: people often turn to trusted or accessible providers rather than specialist gambling services. This was demonstrated even more strongly amongst priority populations who reported significantly higher rates of non-gambling pathways with a focus on relational and collective well-being. Yet in New Zealand and Australia, general practitioners, allied health professionals, mental health or addiction clinicians typically receive little or no formal training in how to identify gambling harm, conduct screening, or make effective referrals [14-19, 50]. This lack of system-wide support for gambling harm responsiveness disproportionately affects priority populations, which are more likely to access a broader range of services than other groups.

Tools and Resources reported in this study included online self-exclusion features, spending limits, information websites, and mobile apps. In this study, 87.0% of participants reported using at least one tool or resource, with a median of 7 per person over a 12-month period. These types of support are typically products or services provided by professionals or venues but used independently by the person experiencing harm [51, 52]. Usage was significantly higher among priority populations including using self-directed courses or mobile apps for gambling harm. Previous studies suggest these approaches are attractive to different cultures because of shame around gambling which prevents people from

talking to a professional and a preference for an approach that appears more confidential [53]. This highlights the importance of ensuring they are co-designed and available in different languages to meet the needs of diverse groups. For example, using a co-design approach grounded in Indigenous or cultural knowledge and frameworks can help ensure the tools are relevant, accessible, and appropriate [54].

Self-Help Strategies such as substitution, self-monitoring, and planning were the most used option in this study, with 95.5% of participants reporting the use of at least one strategy and a median of 11 strategies. These findings align with previous research showing that almost all people who attempt to reduce or manage their gambling use some form of self-help, often without involving professionals or peers [32, 34-38]. Studies suggest that over 90% of people making a change attempt to do so independently [30-32] although based on the current study it is likely these strategies are combined with other interpersonal support. Priority populations reported higher use of *Self-Help Strategies* compared to non-priority groups, which is consistent with other studies that suggest self-help and the use of *Tools and Resources* may be attractive to priority populations who are not comfortable with seeking psychological help [40]. This suggests a strong reliance on these approaches and highlights the need to better understand what supports or limits their success. Many self-help resources have received limited research attention, with almost no culturally specific examination, and often lack alignment with evidence-based behaviour change techniques such as structured goal setting or implementation planning. Strengthening these resources by integrating them within stepped-care models and supporting their use through appropriate referral and follow-up pathways, may enhance their effectiveness. This may be particularly important for individuals who prefer to manage behaviour change on their own.

Strengths and limitations

This study has several important strengths and limitations. The study used a large, diverse, and anonymous survey sample, which helped reduce any potential social desirability bias

when studying a sensitive behaviour like gambling. Recruitment quotas ensured representation of priority populations, including Māori, Pacific, and Asian people, resulting in findings that likely differ from many past studies that underrepresent these groups. This approach allowed the study to highlight culturally specific help-seeking patterns to support the design of more culturally responsive services. Although no quotas for ATSI, there was good representation that allowed for the examination of help-seeking in this important group. While this is the first study to comprehensively examine strategies to mitigate gambling harm, conflating four different cultural groups into the same analysis is limiting. Future research should examine these findings further with studies on specific cultural groups to understand how, when and why the range of options are used. We also did not look at other priority groups who also experienced elevated gambling harm. Future research could expand the focus or analysis to include other priority populations like young and older people, women and families on low incomes, people with disabilities and other culturally and linguistically diverse communities [40, 46].

Several methodological considerations also warrant attention. While quotas were used to promote diversity in the sample, this study did not employ a representative general population design and therefore cannot provide help-seeking estimates that are generalisable to all people who gamble. Because this was an exploratory study, no adjustments were made for multiple comparisons, increasing the risk of type I error.

Frequency is difficult to interpret across heterogeneous actions. Some strategies, such as seeking legal or financial advice, may be sufficient if undertaken once, whereas others, such as engaging in psychological treatment or ongoing self-monitoring, generally require repeated engagement. Reporting frequency across these qualitatively different actions risks obscuring meaningful differences in dose and purpose. For this reason, items were coded as binary indicators of whether a strategy had been used in the past 12 months. While this approach improves comparability across strategies, it does not capture duration, intensity, sequencing, or responsiveness to specific episodes of harm. We also did not report cumulative help seeking across domains. There is likely overlap between some

actions. For example, a person who sought assistance from a financial advisor may also have been given a budgeting tool and then established their own tracking system. Summing these actions could overestimate the breadth of engagement. Strategies were therefore examined individually rather than combined into a cumulative index. Other limitations include potential variability in participant understanding of terms and reliance on retrospective self-report. Because participants were asked to recall their help seeking behaviours over the past 12 months, there is a risk of memory bias or inaccurate recall. Prior research suggests that people do not always accurately remember or report the strategies they have used, particularly when behaviours are informal, episodic, or overlapping [33]. Future studies should consider real time monitoring approaches to better understand how and when people engage in help seeking and self-management in response to gambling related harm.

Conclusions

These findings indicate the need to rethink how the support system for gambling harm is structured. Help seeking extended well beyond specialist gambling services and was embedded within family, community and general health settings. Consistent with previous research, priority groups relied strongly on family members and trusted generalists, suggesting that support is often accessed through existing social and cultural networks [40]. This underscores the need to strengthen responses across the wider health and community sector, including improved screening in mental and allied health services, greater workforce capacity and professional development, and clearer cross sector referral pathways [15, 17, 55, 56]. Research based primarily on general population samples risks overlooking how priority populations engage with support and may contribute to ongoing service gaps. People reported taking independent action, yet little is known about the quality, cultural fit and practical utility of currently available tools and materials. Together, these patterns highlight the need to reconsider what constitutes valid help seeking and to ensure culturally led pathways are recognised, resourced and embedded within service

system design. Accurately capturing how people seek help, particularly within priority populations, is central to strengthening equity in service provision.

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Table 1. Participant demographic characteristics and gambling behaviours across priority versus non-priority groups (n, %)

	Non-priority group (n=232)	**Māori (n=91)**	**Pacific (n=60)**	**Asian (n=79)**	**ATSI (n=52)**	**χ^2(df)**	**p-value**
Gender						5.64 (4)*	0.227*
Male	107 (46.1%)	48 (52.7%)	36 (60.0%)	33 (41.8%)	25 (48.1%)		
Female	124 (53.4%)	42 (46.2%)	24 (40.0%)	45 (57.0%)	27 (51.9%)		
Diverse	1 (0.4%)	1 (1.1%)	0 (0.0%)	1 (1.3%)	0 (0.0%)		
Age (years)						142.34 (16)	<0.001
18-24	12 (5.2%)	15 (16.5%)	4 (6.7%)	17 (21.5%)	2 (3.8%)		
25-34	42 (18.1%)	39 (42.9%)	23 (38.3%)	25 (31.6%)	9 (17.3%)		
35-44	47 (20.3%)	21 (23.1%)	23 (38.3%)	23 (29.1%)	32 (61.5%)		
45-54	40 (17.2%)	5 (5.5%)	6 (10.0%)	10 (12.7%)	8 (15.4%)		
55+	91 (39.2%)	11 (12.1%)	4 (6.7%)	4 (5.1%)	1 (1.9%)		
Education						43.89 (8)	<0.001
Up to high school	84 (36.2%)	38 (41.8%)	13 (21.7%)	9 (11.4%)	15 (28.8%)		
Vocational	76 (32.8%)	27 (29.7%)	17 (28.3%)	18 (22.8%)	11 (21.2%)		
University	72 (31.0%)	26 (28.6%)	30 (50.0%)	52 (65.8%)	26 (50.0%)		
Gross annual household income						13.32 (12)	0.346
<$30,000	30 (12.9%)	12 (13.2%)	2 (3.3%)	6 (7.6%)	7 (13.5%)		
$30,001-$50,000	32 (13.8%)	10 (11.0%)	4 (6.7%)	8 (10.1%)	4 (7.7%)		
$50,001-$100,000	75 (32.3%)	26 (28.6%)	19 (31.7%)	28 (35.4%)	14 (26.9%)		
$100,001 +	95 (40.9%)	43 (47.3%)	35 (58.3%)	37 (46.8%)	27 (51.9%)		
PGSI gambling severity						76.82 (12)	<0.001
No problem	52 (22.4%)	8 (8.8%)	4 (6.7%)	5 (6.3%)	1 (1.9%)		
Low risk	33 (14.2%)	5 (5.5%)	4 (6.7%)	4 (5.1%)	1 (1.9%)		
Moderate risk	59 (25.4%)	15 (16.5%)	10 (16.7%)	14 (17.7%)	4 (7.7%)		
PG	88 (37.9%)	63 (69.2%)	42 (70.0%)	56 (70.9%)	46 (88.5%)		

Online gambling frequency						33.41 (16)	0.007
None	64 (27.6%)	17 (18.7%)	6 (10.0%)	12 (15.2%)	4 (7.7%)		
1-2 days	43 (18.5%)	14 (15.4%)	15 (25.0%)	15 (19.0%)	8 (15.4%)		
3-4 days	37 (15.9%)	10 (11.0%)	12 (20.0%)	19 (24.1%)	6 (11.5%)		
5-8 days	43 (18.5%)	25 (27.5%)	14 (23.3%)	19 (24.1%)	15 (28.8%)		
9 or more days	45 (19.4%)	25 (27.5%)	13 (21.7%)	14 (17.7%)	19 (36.5%)		
Online gambling expenditure						44.86 (24)	0.006
None	66 (28.4%)	17 (18.7%)	6 (10.0%)	13 (16.5%)	4 (7.7%)		
$1 to $50	42 (18.1%)	9 (9.9%)	12 (20.0%)	18 (22.8%)	8 (15.4%)		
$51 to $100	33 (14.2%)	9 (9.9%)	13 (21.7%)	13 (16.5%)	7 (13.5%)		
$101 to $200	28 (12.1%)	20 (22.0%)	10 (16.7%)	8 (10.1%)	15 (28.8%)		
$201 to $500	36 (15.5%)	16 (17.6%)	9 (15.0%)	11 (13.9%)	10 (19.2%)		
$501 to $1000	16 (6.9%)	13 (14.3%)	5 (8.3%)	11 (13.9%)	7 (13.5%)		
$1001 or more	11 (4.7%)	7 (7.7%)	5 (8.3%)	5 (6.3%)	1 (1.9%)		
In-person gambling frequency						64.93 (16)	<0.001
None	98 (42.2%)	33 (36.3%)	6 (10.0%)	21 (26.6%)	9 (17.3%)		
1-2 days	68 (29.3%)	17 (18.7%)	17 (28.3%)	19 (24.1%)	5 (9.6%)		
3-4 days	30 (12.9%)	14 (15.4%)	18 (30.0%)	16 (20.3%)	11 (21.2%)		
5-8 days	21 (9.1%)	13 (14.3%)	10 (16.7%)	14 (17.7%)	15 (28.8%)		
9 or more days	15 (6.5%)	14 (15.4%)	9 (15.0%)	9 (11.4%)	12 (23.1%)		
In-person gambling expenditure						56.4 (24)	<0.001
None	98 (42.2%)	33 (36.3%)	6 (10.0%)	21 (26.6%)	9 (17.3%)		
$1 to $50	43 (18.5%)	9 (9.9%)	11 (18.3%)	14 (17.7%)	7 (13.5%)		
$51 to $100	21 (9.1%)	9 (9.9%)	14 (23.3%)	13 (16.5%)	11 (21.2%)		
$101 to $200	28 (12.1%)	17 (18.7%)	13 (21.7%)	10 (12.7%)	10 (19.2%)		
$201 to $500	24 (10.3%)	10 (11.0%)	5 (8.3%)	9 (11.4%)	11 (21.2%)		
$501 to $1000	10 (4.3%)	8 (8.8%)	9 (15.0%)	8 (10.1%)	3 (5.8%)		
$1001 or more	8 (3.4%)	5 (5.5%)	2 (3.3%)	4 (5.1%)	1 (1.9%)		

ATSI=Aboriginal and Torres Strait Islander; * Chi-square test statistic excluded gender diverse (n=3)

Table 2. Uptake of People and Places by priority versus non-priority population groups (n, %)

	Non-priority group (n=232)	Māori (n=91)	Pacific (n=60)	Asian (n=79)	ATSI (n=52)	Total (n=514)
Partner, family member, or friend	103 (44.4%)	65 (71.4%)*	49 (81.7%)*	59 (74.7%)*	44 (84.6%)*	320 (62.3%)
Peer in social or cultural group	54 (23.3%)	49 (53.8%)*	38 (63.3%)*	48 (60.8%)*	42 (80.8%)*	231 (44.9%)
GP or medical doctor	55 (23.7%)	43 (47.3%)*	43 (71.7%)*	47 (59.5%)*	41 (78.8%)*	229 (44.6%)
Mental health counsellor	60 (25.9%)	47 (51.6%)*	38 (63.3%)*	42 (53.2%)*	41 (78.8%)*	228 (44.4%)
Wider community or social network	50 (21.6%)	49 (53.8%)*	36 (60.0%)*	44 (55.7%)*	44 (84.6%)*	223 (43.4%)
Financial, budget, or banking adviser	50 (21.6%)	43 (47.3%)*	39 (65.0%)*	48 (60.8%)*	41 (78.8%)*	221 (43.0%)
Gambling online chat or email	50 (21.6%)	44 (48.4%)*	40 (66.7%)*	44 (55.7%)*	42 (80.8%)*	220 (42.8%)
Relationship or family counsellor	52 (22.4%)	39 (42.9%)*	41 (68.3%)*	43 (54.4%)*	39 (75.0%)*	214 (41.6%)
Peer or community support worker	43 (18.5%)	41 (45.1%)*	39 (65.0%)*	44 (55.7%)*	43 (82.7%)*	210 (40.9%)
Religious leader, advisor, or elder	34 (14.7%)	40 (44.0%)*	41 (68.3%)*	53 (67.1%)*	41 (78.8%)*	209 (40.7%)
Gambling counsellor	40 (17.2%)	43 (47.3%)*	38 (63.3%)*	43 (54.4%)*	45 (86.5%)*	209 (40.7%)
Staff of online gambling site or app	42 (18.1%)	39 (42.9%)*	39 (65.0%)*	44 (55.7%)*	41 (78.8%)*	205 (39.9%)
Gambling helpline	47 (20.3%)	36 (39.6%)*	39 (65.0%)*	43 (54.4%)*	40 (76.9%)*	205 (39.9%)
Peer online social media or discussion group	38 (16.4%)	42 (46.2%)*	38 (63.3%)*	46 (58.2%)*	40 (76.9%)*	204 (39.7%)
Mental health helpline or crisis line	46 (19.8%)	41 (45.1%)*	40 (66.7%)*	36 (45.6%)*	41 (78.8%)*	204 (39.7%)
Cultural advisor or elder	32 (13.8%)	42 (46.2%)*	40 (66.7%)*	45 (57.0%)*	41 (78.8%)*	200 (38.9%)
Holistic or cultural health provider	37 (15.9%)	34 (37.4%)*	42 (70.0%)*	46 (58.2%)*	40 (76.9%)*	199 (38.7%)
Allied health practitioner (e.g., OT, PT)	44 (19.0%)	43 (47.3%)*	31 (51.7%)*	38 (48.1%)*	43 (82.7%)*	199 (38.7%)
Work-based support (e.g., EAP)	39 (16.8%)	39 (42.9%)*	40 (66.7%)*	43 (54.4%)*	36 (69.2%)*	197 (38.3%)
Case manager or social worker	44 (19.0%)	41 (45.1%)*	38 (63.3%)*	33 (41.8%)*	39 (75.0%)*	195 (37.9%)
Life or wellness coach	33 (14.2%)	37 (40.7%)*	37 (61.7%)*	46 (58.2%)*	41 (78.8%)*	194 (37.7%)
Alcohol or drug (AOD) worker	40 (17.2%)	40 (44.0%)*	37 (61.7%)*	36 (45.6%)*	40 (76.9%)*	193 (37.5%)

Peer in 12-step group (e.g., GA)	33 (14.2%)	39 (42.9%)*	36 (60.0%)*	42 (53.2%)*	40 (76.9%)*	190 (37.0%)
Teacher or student counselling	32 (13.8%)	41 (45.1%)*	36 (60.0%)*	43 (54.4%)*	38 (73.1%)*	190 (37.0%)
Staff at in-person gambling venue or casino	41 (17.7%)	31 (34.1%)*	37 (61.7%)*	40 (50.6%)*	39 (75.0%)*	188 (36.6%)
Spiritual advisor or healer	25 (10.8%)	41 (45.1%)*	32 (53.3%)*	46 (58.2%)*	39 (75.0%)*	183 (35.6%)
Peer in group therapy	30 (12.9%)	40 (44.0%)*	32 (53.3%)*	40 (50.6%)*	39 (75.0%)*	181 (35.2%)
Residential treatment program	30 (12.9%)	35 (38.5%)*	37 (61.7%)*	37 (46.8%)*	39 (75.0%)*	178 (34.6%)
Lawyer or legal advisor	29 (12.5%)	40 (44.0%)*	34 (56.7%)*	35 (44.3%)*	39 (75.0%)*	177 (34.4%)
Psychiatrist	33 (14.2%)	33 (36.3%)*	30 (50.0%)*	38 (48.1%)*	38 (73.1%)*	172 (33.5%)
Citizen's Advice Bureau	35 (15.1%)	35 (38.5%)*	31 (51.7%)*	35 (44.3%)*	36 (69.2%)*	172 (33.5%)
Nurse	29 (12.5%)	33 (36.3%)*	33 (55.0%)*	40 (50.6%)*	36 (69.2%)*	171 (33.3%)
Community respite staff	23 (9.9%)	30 (33.0%)*	33 (55.0%)*	39 (49.4%)*	39 (75.0%)*	164 (31.9%)
Any uptake of people and places	150 (64.7%)	84 (92.3%)*	54 (90.0%)*	74 (93.7%)*	52 (100%)*	414 (80.5%)

Comparisons were performed using Pearson χ^2 tests; global p-values represent overall differences across groups; * indicates $p < .05$ compared with the reference (non-priority) group; ATSI=Aboriginal and Torres Strait Islander.

Table 3 Uptake of Tools and Resources by priority versus non-priority groups (n, %)

	Non-priority group (n=232)	Māori (n=91)	Pacific (n=60)	Asian (n=79)	ATSI (n=52)	Total (n=514)
Time-out or break feature on an online gambling site or app	110 (47.4%)	67 (73.6%)*	48 (80.0%)*	63 (79.7%)*	45 (86.5%)*	333 (64.8%)
Online information or resources about gambling management	110 (47.4%)	67 (73.6%)*	49 (81.7%)*	56 (70.9%)*	42 (80.8%)*	324 (63.0%)
Spending limit set with a gambling company (online or at a venue)	114 (49.1%)	65 (71.4%)*	43 (71.7%)*	56 (70.9%)*	43 (82.7%)*	321 (62.5%)
Self-exclusion or ban from an online gambling site or app	94 (40.5%)	65 (71.4%)*	44 (73.3%)*	59 (74.7%)*	40 (76.9%)*	302 (58.8%)
Podcasts or videos about gambling management	71 (30.6%)	58 (63.7%)*	44 (73.3%)*	55 (69.6%)*	43 (82.7%)*	271 (52.7%)
Self-exclusion or ban from an in-person gambling venue or casino	77 (33.2%)	59 (64.8%)*	45 (75.0%)*	49 (62.0%)*	42 (80.8%)*	272 (52.9%)
Budgeting or money management tool from a financial institution	72 (31.0%)	55 (60.4%)*	42 (70.0%)*	56 (70.9%)*	37 (71.2%)*	262 (51.0%)
Mobile, computer, or website blocker for gambling sites or apps	70 (30.2%)	52 (57.1%)*	45 (75.0%)*	53 (67.1%)*	40 (76.9%)*	260 (50.6%)
Books or workbooks about gambling	59 (25.4%)	51 (56.0%)*	40 (66.7%)*	52 (65.8%)*	41 (78.8%)*	243 (47.3%)
Self-assessment tool or questionnaire	63 (27.2%)	48 (52.7%)*	37 (61.7%)*	49 (62.0%)*	38 (73.1%)*	235 (45.7%)
Mobile phone app for gambling management	57 (24.6%)	50 (54.9%)*	40 (66.7%)*	46 (58.2%)*	40 (76.9%)*	233 (45.3%)
Self-directed course or program for managing gambling	50 (21.6%)	49 (53.8%)*	40 (66.7%)*	51 (64.6%)*	35 (67.3%)*	225 (43.8%)
Any uptake of tools and resources	176 (75.9%)	89 (97.8%)*	58 (97.7%)*	74 (93.7%)*	50 (96.2%)*	447 (87.0%)

Comparisons were performed using Pearson χ^2 tests; global p-values represent overall differences across groups; * indicates $p < .05$ compared with the reference (non-priority) group; ATSI=Aboriginal and Torres Strait Islander.

Table 4: Uptake of Self-Help Strategies by priority versus non-priority groups (n, %)

	Non-priority group (n=232)	Māori (n=91)	Pacific (n=60)	Asian (n=79)	ATSI (n=52)	Total (n=514)
Focus on personal well-being or lifestyle changes	182 (78.4%)	84 (92.3%)*	52 (86.7%)	69 (87.3%)	46 (88.5%)	433 (84.2%)
Set time or money limits	186 (80.2%)	77 (84.6%)	54 (90.0%)	66 (83.5%)	45 (86.5%)	428 (83.3%)
Think differently about gambling and its impact on life	171 (73.7%)	85 (93.4%)*	50 (83.3%)	62 (78.5%)	48 (92.3%)*	416 (80.9%)
Self-monitor thoughts, feelings, or behaviours	161 (69.4%)	75 (82.4%)*	52 (86.7%)*	64 (81.0%)*	44 (84.6%)*	396 (77.0%)
Take actions to manage urges	147 (63.4%)	75 (82.4%)*	51 (85.0%)*	66 (83.5%)*	47 (90.4%)*	386 (75.1%)
Set up a budget or track spending	155 (66.8%)	73 (80.2%)*	52 (86.7%)*	58 (73.4%)	45 (86.5%)*	383 (74.5%)
Calculate money and time spent on gambling	152 (65.5%)	68 (74.7%)	45 (75.0%)	68 (86.1%)*	47 (90.4%)*	380 (73.9%)
Make a plan to limit gambling	149 (64.2%)	71 (78.0%)*	44 (73.3%)	67 (84.8%)*	48 (92.3%)*	379 (73.7%)
Substitute gambling with other activities	130 (56.0%)	77 (84.6%)*	51 (85.0%)*	64 (81.0%)*	47 (90.4%)*	369 (71.8%)
Avoid specific people, places, or venues	134 (57.8%)	74 (81.3%)*	49 (81.7%)*	61 (77.2%)*	43 (82.7%)*	361 (70.2%)
Limit or remove access to gambling funds	122 (52.6%)	77 (84.6%)*	47 (78.3%)*	64 (81.0%)*	45 (86.5%)*	355 (69.1%)
Practice meditation, mindfulness, or relaxation	110 (47.4%)	58 (63.7%)*	43 (71.7%)*	60 (75.9%)*	46 (88.5%)*	317 (61.7%)
Prevent or remove access to gambling apps or websites	105 (45.3%)	72 (79.1%)*	41 (68.3%)*	59 (74.7%)*	40 (76.9%)*	317 (61.7%)
Any uptake of self-help strategies	213 (91.8%)	90 (98.9%)*	59 (98.3%)	78 (98.7%)*	51 (98.1%)	491 (95.5%)

Comparisons were performed using Pearson χ^2 tests; global p-values represent overall differences across groups; * indicates $p < .05$ compared with the reference (non-priority) group; ATSI=Aboriginal and Torres Strait Islander.