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# Official Report of Debates (Hansard)

**Wednesday 24 March 2010**

# Journal des débats (Hansard)

**Mercredi 24 mars 2010**

## Select Committee on Mental Health and Addictions

## Comité spécial de la santé mentale et des dépendances

Mental Health
and Addictions Strategy

Stratégie sur la santé mentale et
les dépendances

Chair: Kevin Daniel Flynn
Clerk: Susan Sourial

Président : Kevin Daniel Flynn
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LEGISLATIVE ASSEMBLY OF ONTARIO

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

# SELECT COMMITTEE ON MENTAL HEALTH AND ADDICTIONS

# COMITÉ SPÉCIAL DE LA SANTÉ MENTALE ET DES DÉPENDANCES

Wednesday 24 March 2010

Mercredi 24 mars 2010

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*The committee met at 1631 in committee room 1, following a closed session.*

## MENTAL HEALTH AND ADDICTIONS STRATEGY

## ONTARIO PROBLEM GAMBLING RESEARCH CENTRE

**The Chair (Mr. Kevin Daniel Flynn):** If we can come to order, we've got the Ontario Problem Gambling Research Centre: Judith Glynn and colleague. If you would introduce yourselves for Hansard, that would be great, and then we've got you until about a quarter after five.

**Ms. Judith Glynn:** What I'll try to do is keep the presentation to about 20 to 25 minutes so you can ask questions at the end, but it may go a little longer.

Thank you very much, Ms. Sandals and committee, for inviting us here today. My name is Judith Glynn. I'm the director of operations with the Problem Gambling Research Centre. I'm here with the chair of our board of directors, Lynda Hessey. Just as a piece of information, Janine Robinson, who is here from the Centre for Addiction and Mental Health and will present after me, and I have tried to coordinate our content. Between the two of us, our plan is that we will give you a comprehensive initial understanding of problem gambling, and then of course we're available for any questions.

The other thing is that I did not print copies of the presentation, but I can make any of this information available to you afterward—any reduced version thereof—so just let me know.

I'm going to focus on what the research has told us, or what we know about problem gambling based on the research, and then Janine will speak more specifically about treatment and the treatment system here in Ontario. I'm hoping that's a good division of information and allows you to catch your breath a little bit.

Gambling means risking something of value. If you can imagine, I had a call from three reporters in the last week wanting me to comment on Roll up the Rim. I said it's just not gambling. I mean, you're getting your cup of coffee.

*Interjection.*

**Ms. Judith Glynn:** You won. The idea of gambling is that you're putting something of value to you at risk on a chance outcome and on the chance that you will get more than you put at risk. In terms of participation rates, we've seen them kind of stabilize in Ontario over the last few years. We had high rates when gambling was first expanded maybe 10 or 15 years ago, in the 1980s. We now have participation rates that have stabilized around 63% of the population. You can see that the predominant form of gambling is lottery tickets, but about 23% of the population regularly goes to casinos or plays slot machines. Those figures are probably quite stable.

Of course those rates are higher among young adults, as many of you might know from your own young adults, particularly the rate of online gambling. Very quickly, among young adults we're looking at a variety of vehicles for gambling, now including cell phones. The rates that you see rising from 2001 to 2005 have probably increased quite substantially since then; we just haven't assessed prevalence since 2005. But you can also see that the types of games they're playing are different and they're playing frequently.

In terms of problem gambling, there are many definitions out there, but basically we're looking at gambling where someone is excessively involved in the activity. They're spending more time and money than they can afford, and they're suffering negative consequences. It's usually a combination of those two things: The behaviour is out of control or in excess, and there are consequences. In terms of problem gambling, if we use the latest prevalent study, we're looking at about 3.8% of the population with a moderate to severe gambling problem. That's fairly stable across the country—some provincial variation, but that's not unusual. Again, you see that young adult population with the highest rate of problem gambling. Interestingly, one in 10 people report that they have personally been negatively affected by someone else's gambling.

In terms of those negative consequences, the most common one is clearly financial difficulty. Just by the nature of the activity they're engaging in, that shouldn't surprise any of us. Relationship conflict is, of course, equally understandable. The co-occuring mental health issues are quite startling if you've never seen them before: 20% of problem gamblers will attempt suicide, and 15% to 24% of them have a lifetime history of clinical depression. That is definitely a worry, and then there are impacts on work and school and, less commonly, resulting physical health impacts and criminal activity.

Just quickly, I wanted to give you a picture. If you don't know a lot about gambling in Ontario, this is the

complex map of the players. I have copies of this if anyone wants it afterwards. You can see that the blue column is the regulatory function. There's the operational function and harm minimization, and government oversight across the top. So you have a number of government ministries involved in the regulation, operation and minimization of harm related to gambling. "You are here" is the Ontario Problem Gambling Research Centre. We're fully funded by the Ministry of Health and Long-Term Care. You can see there are some private sector relationships in there, in terms of the delivery of gambling. So this gives you a good sense of who all the players are in this complex world of gambling in Ontario.

**1640**

The way I'm going to discuss what we know about the research is using a model that I suspect you've all seen, because you're dealing with mental health. This is sort of the dominant model for addiction, the bio-psycho-social model. It's sort of widely understood now that addiction is the result of a complex interaction of these factors. As you'll see as I go through some of the information, they're very much intertwined. Many of the psychological factors are genetically or biologically derived, and some of the social-environmental factors are hard to disentangle from genetic factors, like parental gambling. We'll just look into each of these areas, and what I'm going to give you is the research that is quite solid. This is information where we have research evidence to say, "This is the case." It doesn't mean there isn't more out there; we just don't have the research to confirm it. At the end, I'll talk about how we can address that.

If we start with our biology, because that's where it all begins, we look at what we know about the genetic predisposition for gambling. The genes they're looking at, not surprisingly, are the same alleles they look at for other addictions. They have found some commonalities; in particular, the genes that are associated with dopamine—dopamine receptors—and then those other elements of that transmitter reward system in our brains: serotonin and norepinephrine.

Basically, what's happening here is that these are the reward and inhibitory systems, and they don't work as well in problem gamblers as they do in the rest of us. So it's not surprising that these are the genes they are examining. It's a complex area of research, but as this research continues to grow, we will see that there are ways to at least account for some of the variance in gambling problems by looking at these genetic factors. Then we'll look at some of the neurobiological factors, which are very closely connected. So you have those genes that are responsible for the dopamine receptors and that kind of thing, and then you go into what's going on in terms of our neurocircuitry. It's not surprising that what we're looking at, again, are those reward systems and what's happening.

We have research showing that in a problem gambler, sometimes the pleasure centre in the brain is bigger and the inhibitory sensor is smaller. So not only are they getting more bang out of the activity, but they have less of a stop signal that is going on and telling them to slow down. Some studies have shown that activity related to dopamine is different in problem gamblers from the way it works in normal controls. The interesting thing—this is where it gets hard to disentangle—is that as any addiction progresses, there are changes in that neurocircuitry. So some of it may be accounted for by the genetic predisposition, but as a person becomes addicted, they actually change those neuroprocesses. That's why some addictions are so difficult to address.

Again, there is a variety of these neurotransmitters that have been associated with problem gambling. If we go into the psychological area—I think I'm going to do that one last—this is the group of psychological factors that is most strongly associated with problem gambling. You probably won't find this surprising: 75% of problem gamblers smoke—that's dramatically higher than the general population—25% with alcohol abuse and 20% with other drug abuse. But even those rarer addictions, like sex addictions, are disproportionately represented in problem gamblers. So we know there is increasing evidence, with the combination of genetic and neurobiological information, that there is some kind of tendency to addiction, and we're seeing that in problem gambling as well as in other addictions.

The other issue I'll talk about a bit later that is difficult to disentangle is the causal or temporal order of these things: Did those other addictions come first; did they cause the problem gambling, or are they all caused by those same genetic and biological factors? Some of that information we don't know yet.

What is particularly powerful with gambling as a form of addiction is—you've probably heard a little bit about operant and classical conditioning in your hearings; am I right or wrong? Classical conditioning, if I understand it correctly—it's Pavlov's dogs: If you hear the bell, you're going to get meat, right? So you start to salivate. Operant conditioning is where you hear the bell and you might get meat, so you salivate anyway and you keep trying and trying. This is the rats that got cocaine, and they kept pushing the lever and pushing the lever. In fact, when the frequency of reward was variable rather than predictable, the process of addiction was faster and harder to extinguish. The most potent form of addiction is when you have a variable and high frequency of reinforcement, and we definitely have that with many forms of gambling.

In terms of other mental health disorders, again, these figures are fairly surprising. Problem gambling is strongly correlated with just about any other mental health disorder you can come up with. The mood disorders particularly: This is probably the area where the most research has been done. There's a very strong correlation between depression, anxiety and problem gambling. But even in those impulse disorders—and problem gambling is often considered an impulse control disorder—you again see this correlation between obsessive compulsive disorder, bulimia and those characteristics that are related to impulse disorders, like just simple impulsivity, ADHD or a high need for sensation.

All of these things are strongly correlated with problem gambling.

Then you get into those personality disorders: borderline personality disorder, anti-social personality disorder. You do see a correlation, but not only that: As the problem gambling severity increases, the number of co-occurring personality disorders grows. So they're really in a mess. All these mental health disorders are probable risk factors for problem gambling.

Quickly, I'm going to look at another area of the psychological, which is the cognition. This is really related to how the human brain understands gambling. I don't know if any of you read Steven Pinker, but he basically says that if we were able to understand the repeat randomness that occurs in a slot machine, we would never have survived as a species, because as a species, we have learned that we must guard our actions based on the learning from past events. You have to throw that out completely when it comes to a slot machine. You can play for 10 hours straight, lose every penny you've got, and there is no greater likelihood that the next play is going to be the winning play. That's what's very difficult for any human brain to grasp and particularly intransigent for people with gambling problems.

We have strong evidence that this illusion of control is strongly correlated with problem gambling. They overestimate their chances of winning, they overestimate the element of skill involved and they overestimate their control over the outcome. We do have some evidence that those cognitive errors are then further reinforced by the characteristics of the machine. So if they see a lot of near misses, if they see a "stop" button, they think they can press it at just the right moment to get the win. These things can feed into the cognitive error that can lead to the gambling problem.

The other thing that reinforces our understanding of this is that when treatment addresses those cognitions, it tends to be more successful. So we do know that cognitive error is a big factor in the development of gambling problems.

Now we'll go over to the social-environmental area. In some ways, this might be more interesting, just from a policy perspective. Let's start small. From family, we'll move up to culture and then into the broader social environment.

Not surprisingly, there is increased risk of poor mental health in the children of problem gamblers. Children of problem gamblers have a higher risk of developing a gambling problem themselves. There is some research that disentangles the genetic predisposition from the modelling, and it appears that both are playing a role in the development of problem gambling in children. Then you have those indicators that are strong indicators, probably, for many mental health disorders that you've been looking at, and those are lower income, being a member of an at-risk socio-economic status group and having any kind of abuse and neglect in your upbringing. These all seem to be predisposing factors to lead children to develop gambling problems.

We'll look at the culture and peer group. There's a lot of information here. I've tried to condense it.

What we know is that in international prevalence studies—a number of studies in a number of jurisdictions in the world—ethnocultural minorities have higher rates of problem gambling. It doesn't matter what colour they are or what ethnocultural group they belong to: If they are a minority, their rate of problem gambling is higher. Then we know that in Ontario, these ethnocultural minority groups—at least the ones which have been studied—do show evidence of higher rates of gambling. Normally, higher rates of gambling mean higher rates of problem gambling. The challenge here is getting a large enough sample size, one that's been randomly selected and is representative of that subpopulation, to confirm it. So we do have a strong sense that problem gambling is existing at a higher rate within those ethnocultural populations.

**1650**

In certain populations which have been studied here in Ontario, you see that: aboriginal, Chinese, Italian and Russian. They all show higher rates of gambling. There are other populations where there probably is more research needed to understand whether or not, culturally, gambling is a big factor or simply if the factor of being a minority in the population is playing a role here.

If we just step outside of culture, the other piece of that is peer group involvement. When young adults or young people have peers who are modelling gambling behaviour, not surprisingly, they're far more likely to engage in it. So it is a significant risk factor for children and young adults.

Then we'll look at the broader environment. This is the kind of social context in which gambling takes place. I've broken it up into a number of things, starting here with what types of gambling we know are most strongly associated with problem gambling.

I'm sure you all heard, 15 years ago, the quote that was all over the Star and other media that VLTs are "the crack cocaine of gambling." The evidence on electronic gaming machines is really interesting. I talked to you a little earlier about that variable, high-frequency reinforcement schedule; you definitely have that in electronic gaming machines. Electronic gaming machines have been shown to be most strongly correlated with gambling problems in several countries: in North America and throughout Europe. Definitely, electronic gaming machines are the most strongly correlated, among all forms of gambling, with the development of gambling problems.

However, in some Asian countries where they didn't have slot machines for the last 100 years and where other forms of gambling are more culturally popular, the forms of gambling that offer that variable high frequency—and some casino table games, in fact a number of them, offer that kind of reinforcement schedule—are the most strongly correlated with problems. So what we know is that it's that high-frequency variable reinforcement schedule that seems to be the culprit. Regardless of

what's happening in the rest of the world, in North America it is EGMs that are the greatest source of problems.

You have a few specific pieces of information here related to things like the "stop" button: There is research that shows that if there is a "stop" button, people will play for longer. I don't know why they persist for longer, but they do. If they're shown more near misses than would happen by pure chance, again, they will play longer in the session.

I want to talk a little bit about the issue of access. There's lots of debate on whether increasing the availability of gambling—the number of venues, the number of opportunities—is correlated with gambling problems. To their credit, the research community has tried to disentangle this. It appears that it is not simply the quantity of gambling that's out there, it really seems to be proximity; so the more gambling venues you have and the more you disperse gambling throughout the community, the higher your rates of prevalence of problem gambling are going to be, because more people—people like to gamble close to home. Problem gamblers gamble close to home. The proximity of gambling opportunities is definitely strongly correlated with the development of gambling problems.

That Ladouceur study, by the way, in Quebec, did a repeat design: he conducted his study and then, after new venues were added, conducted the same study and found a 75% higher number of problem gamblers. So we do know that this issue of access and proximity has some strong research evidence.

Advertising, marketing and promotion: You probably hear a lot about whether or not this is a factor in the development of gambling problems. There is not really strong research evidence yet. In fact, the evidence to date seems to suggest that it's not a strong effect. It may be a weak effect, because if you look at jurisdictions with restrictions on advertising, they don't have different prevalence rates from jurisdictions which have fairly wide open advertising available.

There is some qualitative research that shows that advertising for gambling does serve as a particular cue or trigger to problem gamblers, so they seem to notice the ads more, they seem to be cued more to gamble, they express more often desire to gamble when they see ads related to gambling. While the level of advertising, marketing and promotion may not be affecting prevalence rates in a society, it may be serving as a stronger cue to problem gamblers.

The other idea that has been posited is that what the advertising, marketing and promotion of gambling does on the larger social level is just influence social norms, so you have an increased acceptance of gambling, maybe more provision of it, perhaps loosened regulation of it. So the influence of gambling is weak in terms of prevalence, probably occurring at a higher level, and then at that micro-level with the problem gambler as a cue.

Responsible gambling programs, on the other hand—there is some fairly strong evidence that when you introduce pretty strict limits on people's ability to gamble too much in one day, or gamble too frequently in one month, you do see reduced prevalence. So in these countries that I've indicated here—Norway, Germany, Netherlands—you see much lower prevalence rates of problem gambling—0.4%, 0.6% and 0.5%, versus 3.2% in Canada. That's a dramatic difference.

You can't strictly account for that by these responsible gambling programs. There are different cultures, different societies, there are a lot of factors that are probably at play, but they have very strict requirements on operators to detect the presence of a gambling problem and to exclude.

In Germany, for example, the operator is legally obligated to detect problem gamblers and to exclude them, so you have much more sophisticated player tracking systems. You have much more going on in terms of helping people not to develop gambling problems.

In, I believe, Norway, if you suddenly double your participation at the casino, then you're asked to sit down for a meeting. If your rate goes up more than, I think, four times a month, then you're asked to meet with someone. They have a number of things that they do that are designed to detect early, intervene and prevent further development of gambling problems. It does seem to be making a difference, and the big test of that is the fact that Holland did see a decrease in their prevalence rate once they introduced some stricter responsible gambling programs.

*Interjection.*

**Ms. Judith Glynn:** What was that?

**Ms. Sylvia Jones:** It's now 0.5%. What was it?

**Ms. Judith Glynn:** I can't remember. I'll have to get that for you.

That's kind of the spectrum of factors that are contributing to the development of gambling problems. I'm going to just quickly show you which risk factors have the strongest research evidence. This doesn't mean they're the strongest risk factors, but there is the most research to clearly demonstrate that these are risk factors.

You can see, some of these are things that can be modified and some of them can't. We can't change someone's gender, their age, their ethnocultural origin; we can't really even necessarily change parental gambling. When you look at these risk factors, I'm going to quickly talk about what we can and can't do with those that are modifiable and those that are non-modifiable, but basically, these are the ones where there is the strongest research evidence that they play a role in the development of gambling problems.

We have those demographic characteristics: the role of parental gambling, the proximity to gambling venues, those erroneous cognitions, the type of game, addictions—very strongly predictive of gambling problems—other mental health disorders, and delinquency and criminal history—very strongly predictive of gambling problems.

So what do we do? For those non-modifiable risk factors, we can't change the risk factor, but as a society

there are things we can do. We can have protection policies that are particularly aimed at at-risk populations; for example, our restrictions on underage gambling. That's an example of protection policies.

We can have education generally to the target population and the public about particular populations being able to identify themselves as being at-risk and what they should do about it. Then we can have detection and identification of those populations, we can increase early intervention, and finally—Janine will talk about this more—we can customize treatment to those particular populations, whether they're a demographic age group or an ethnocultural group.

**1700**

With the modifiable risk factors, the first thing you can think of is, should we just change the policy or the practice? Of course, that's ultimately where you want to get to, that question. But there are some things, from a research perspective, that I think you need to do first. In some cases, those factors—we need to confirm that risk factor and we need to confirm how strongly it's contributing to gambling problems, but, realistically, as policy-makers, you should also know what the impact of that risk factor is on game enjoyment, and then what the economic impact of modifying the risk factor is.

For example, I presented a framework a year ago that asked: So what do you do if you know that certain features of a machine are associated with harm? Well, you need to know how strongly it's associated with harm, you need to know how strongly it's contributing to enjoyment for the non-problem gamblers, and then you need to know the economic impact of removing the feature or changing it. Then you're in a position to make a policy decision. So, in terms of those modifiable risk factors, in some cases we have this information; in other cases we don't.

My final slide is just going to be where we might go from here in terms of the research to provide you with more information to answer those important policy questions.

One of the things that we don't really understand yet is, we have this configuration of risk factors. We know they interact. We don't know the relative contribution of each one. So if you asked me, "Which one should I focus the most resources and energy on?" it would be a debate. I might be able to pull on some research, someone else might draw on other research, but we really don't know the relative contribution of these different risk factors. Those findings, in many cases, were found in laboratory settings. We need them to be confirmed in a naturalistic or a real gambling setting, and we need those longitudinal perspective studies, because what those will do is help us to disentangle the relationships among these risk factors.

I kind of alluded earlier to the fact that in terms of many of those risk factors, like the addictions and the co-occurring mental health disorders, there are probably three different pathways or routes that are being taken. So in some cases that risk factor is indeed causing the gambling problem. In some cases, the depression, the criminality—whatever the co-occurring issue is—and the problem gambling have common roots. They're not causing each other; they are both caused by the same set of other factors. And then, finally, problem gambling can be causing things like depression, anxiety, some of those physical health issues. So what we need is the kind of research that will continue to help us disentangle those roots, and that will put us in a better position to understand exactly where we need to put resources and our emphasis.

That's my overview. If you have questions—

**The Chair (Mr. Kevin Daniel Flynn):** Do you want questions now or do want us to hear from the next speaker and then—

**Ms. Judith Glynn:** I was going to suggest that. I didn't know if that would be too bold. But if you're okay with two presentations in a row, and then Janine and I can just field the questions—that works?

**The Chair (Mr. Kevin Daniel Flynn):** Yes, that works.

## PROBLEM GAMBLING INSTITUTE OF ONTARIO, CENTRE FOR ADDICTION AND MENTAL HEALTH

**The Chair (Mr. Kevin Daniel Flynn):** We're a little bit ahead of schedule, so don't panic.

*Interjections.*

**The Chair (Mr. Kevin Daniel Flynn):** Go right ahead. We're all yours.

**Ms. Janine Robinson:** Can everyone hear me all right?

My name is Janine Robinson. I'm an addiction trainer and a therapist. I've been specializing in problem gambling for the last 11 years now, working with people across the province who provide counselling services to people affected by problem gambling and their family members, and also actually counselling people. I'm located here in Toronto, just down the street at the Centre for Addiction and Mental Health.

We've just rebranded ourselves and aligned our services and programs to be a little more streamlined in what we do. We're now calling ourselves the Problem Gambling Institute of Ontario at the Centre for Addiction and Mental Health.

In the time that I've been in the field—and one of the things that I want to encourage us to remember when we're talking about this whole gambling thing is how new the field is compared to substance abuse, compared to tobacco. It's still very young, so a lot of the research needs that my colleague pointed out are absolutely legitimate. At the same time, for such a young field, we know so much in this province compared to some other jurisdictions in the world. We're really well situated in this province to make some really informed decisions about where we go next with gambling in Ontario.

My areas of interest, since I started doing this work, have always been around cultural influences on people's

decisions, on their knowledge systems and how they decide to play which games, and how they interact with the actual gambling itself. I know a lot about culture and problem gambling, and it's something that has always been interesting to me.

I'm also interested in the games themselves. Right now, for example, I'm studying poker. Everyone here, I'm sure, knows that the craze of poker has just swept, and continues to sweep, North America; it just seems relentless. In our agency, where we see hundreds and hundreds of clients a year, poker clients are surfacing in very low numbers. I've been very interested in what it is about the way we offer help to people that maybe isn't suitable for poker players, isn't hitting them, isn't making sense for them—some of the dynamics or the culture of the game and the culture of the players and whatnot. That's one of the things I'm studying right now, for example.

I also have been involved in working with the OLG as a trainer and consultant around content for them to work with their staff in the gaming environment to get to patrons in the gaming venue while they are having problems. I've been doing that for quite some time now. It's very interesting work.

So I can speak to all those areas with some level of authority.

**1710**

I'm just going to acquaint you with the Problem Gambling Institute of Ontario. We have a provincial mandate. We are one of the four provincial partners that Judith Glynn showed in the far right column of her chart there. We provide treatment services, outpatient counselling, telecounselling. We're developing online materials to support people who have problems with gambling. We develop professional education and community resources. Everyone has a handbook in front of them, the orange one: The Issues, the Options. We've developed handbooks for allied professionals—bankruptcy trustees, people who are in seemingly unlikely positions to identify people with gambling problems, but if you think about gambling and money, the bankruptcy trustee connection has actually been a very useful alliance for us to get people support who are dealing with financial issues of bankruptcy.

We provide research. Some of that at least, if not much of it, is funded by the Ontario Problem Gambling Research Centre. We are also provincially responsible for communication and information dissemination. We're currently calling it knowledge exchange or knowledge transfer. Our role with the research centre, for example, would be to take current findings and help translate them into clinical practice. So if the current finding is that young Chinese men are experiencing higher levels of problem gambling than someone else, it's our role to take that information and do something with it that's helpful and gets to the actual client need.

Our funding for problem gambling treatment, I'm sure you know, has come from 2% of charity slot machine revenue. Does everyone know this? Yes? That's one of the positives, I think, of our field being so young. If we had a similar situation with substance—a penny off of every bottle of beer that was sold—the treatment system would be much better resourced than it is today. This has been a very strong and positive situation, having this funding, and it's ongoing, early implementation. It's vital to us being effective provincially.

Gambling is very big business in Canada. In 2008, over $13 billion was the net revenue from gambling. It's Canada's largest entertainment industry and it's approximately the same as television, recorded music and professional sports combined. That's just staggering to think of. That is big, big, big business. When we think about it—I'm seeing most of the people in the room are over 30—in our lifetimes, we've gone from having gambling be considered in this province as something really on the outskirts of our moral acceptance to grudgingly accepted—Las Vegas, the crooner era—to being promoted and linked to positive virtues.

When I was training to become a problem gambling counsellor I had in my mind that I was going to treat Frank Sinatra or Dean Martin. I did. I had this stereotype that this is the type of person I was going to be treating, and I've treated some people like that. But I didn't have in my mind that I was going to be treating grandmothers. It didn't really cross my mind that a large percentage of my caseload of people who were in distress were going to be in retirement years—grandparents. Our culture shift has changed so dramatically that now casinos are a nice place for grandma to go and have an outing. Just in my lifetime, the shift has been just astounding around how we've accepted and changed our views about gambling.

Promotion: over $2 billion every year in the nation; very large money.

In our province—Judith already touched on this—about 63% of Ontarians gamble. The electronic gaming machines—the slot machines—are the most problematic. The fact that Ontario has no video lottery terminals in corner pubs, in venues like that, is a real source of relief to us. It has been associated with some really high problem rates in other provinces, and clinicians I work with who are in the border cities like Ottawa, or who work on the border with the States—Sault Ste. Marie, for example. People who work in those regions tell me really in an unqualified manner to tell you that we're glad there are no VLTs in the province. I'm just passing that message along.

In the north, a lot of the games that will be played will be quite different than in some of the regions. In the north there's going to be a bigger emphasis on card games than there might be in some regions, and that's largely due to the lack of casinos in remote areas. There might be more women playing poker; there are, in fact, more women playing poker than there would be in the south. Bingo is big. Do people know what Nevada tickets are? Okay. Near large urban centres, we have casino-based gaming, so the large casinos in Niagara Falls, Windsor, Orillia, Rama—Mnjikaning First Nation—those areas. Then there are also the smaller slot venues

that you can see on the blue signs across the province. Next time you drive from Sarnia to wherever—London, Toronto, North Bay—count the signs as you go by. Look at it as if you're a tourist to the province and see how many charity casino signs you see on the way. It really is fascinating.

These are the games you can play if you live in a large urban centre, and if you live in a semi-rural place like just outside of Barrie, there's the racetrack. We're calling them "racinos." There are racetracks and they're attached to slot machine venues, so those two businesses have supported each other and, in fact, adding the slot machines to the racetracks really saved the industry. You can get those everywhere and anywhere.

If you have a BlackBerry or a cell phone or a computer, you can of course gamble online. There are all kinds of online gambling to do. I just named some of the more prevalent ones. In Ontario—oh gosh. I think I have it later—I can't remember the man's name now. Duncan—

**Ms. Judith Glynn:** Paul Godfrey.

**Ms. Janine Robinson:** Thank you. Paul Godfrey just recently expressed an interest in Ontario joining the online gaming business.

This is from this week. I was trying to find out for you how many people have called the Ontario Problem Gambling Helpline, now known as ConnexOntario, to discuss slot machine problems, because that is by far the number one.

That is a direct quote from that correspondence: "Out of the 1,567 people who called regarding their own concerns with problem gambling during fiscal year 2008-09, 1,144 reported problems with slots"—astronomical and not inconsistent with any other year, as far as I can see. It seems very consistent. You have a stats page, a little two-pager, there. That's the one. That quote and the contact person is there. There are also some other relevant statistics and if you want to follow up about any of these, you can find that there.

I just want for a second to ground people in what that actually means, because I'm sure you're hearing a lot about balancing public interest with revenue generation, and I just want to bring it down to the individual level of a player who's playing an EGM, playing a slot machine. Everyone has seen this type of slot machine. This was in my granddad's day. It operated on a mechanical system. It had a cog. If you watched that machine for thousands of plays, you could actually have a sense when this machine was due to pay out because it's set up on a mechanical system that's somewhat predictable and not as erratic as today's machines. My grandfather used to put a coin on a string and keep going until he won, which was illegal, but so was the slot machine. My grandfather is dead, so I feel okay about getting that on the record.

Today's EGMs are quite different. People have seen this one. This is one of the easiest ones to understand. It looks like this old one. It has three symbols. It has one pay line, the line in the middle. It costs 25 cents. This machine actually probably costs 50 cents or 75 cents, because you play two or three coins per spin. What you can't see about this machine is that this machine is computer-operated and there's this thing called a random number generator. It's a microchip that's inside the computer. If this were a slot machine, the slot machine is on right now. The whole time I'm talking, the slot machine is running. If I press the button now, I get a different outcome, because that number string changes thousands of combinations per minute—thousands—and it happens so fast that you could never, ever, ever predict when it's going to pay off. How many in the room knew that? Sort of?

**1720**

**The Chair (Mr. Kevin Daniel Flynn):** I thought the machine had to empty itself every so often.

**Ms. Janine Robinson:** Yes, that it gets to a certain level and then it's bound to pay out. We call that a pregnant machine; the machine is pregnant.

**Mr. Bas Balkissoon:** There's legislation for the payers.

**Mrs. Liz Sandals:** There are legislative laws.

**Ms. Janine Robinson:** There are. The machines do have to pay out a certain percentage of the money that's put in them, and it's highly regulated, that's true. But this machine—you could play this machine for a year and not hit a jackpot or you could play it for five minutes and get two jackpots. That's how random it is. So when you were hearing earlier about conditioning, it's very potent.

Players who play this game today, a lot of them, especially when you think of older adults—those grandmothers I was telling you about—they're thinking that is happening, but it's not; this is happening. In fact, most of the machines are even more complex—and this is still a very simple one. I had to find one that was simple enough for me to explain. This one has 20 lines and it's a one-cent machine. If I were going to tell my teenaged daughter who's 19, and she's going to the casino for the first time, "Play safe. Don't go crazy tonight," and she said to me, "But there's a one-cent machine there," what would I think? One cent, one cent, one cent. This one-cent machine has 20 lines and it might take as many as 20 credits per line. That's 20 times 20 now on a one-cent machine, and similar. I'm going to tell you in a second about a slot machine experience.

If you go online, you can join something called Slot Machines Forum. It's an online friendship group. This is moderated by The Shamus. I'm just going to read this for you. It's called, "Fun Day at the Casino."

"Yesterday, I decided to take the day off work, and make a visit to my local racetrack slots place"—because who doesn't go to the raceway when they take a day off work?—"Mohawk Casino.

"Overall a great day. I convinced my mother to go 50-50 on all of the machines we played"—so he took his mother when he was skipping out on work—"whatever we won or lost, we would split the win (or the loss). It was a good arrangement."

Here come the highlights: "On the 'Panda' game ... we scored 25,000 credits on a two-cent denomination

machine ... for a total of $500—playing 100 lines"—100 lines at Mohawk.

"On a 'Quick Hit' nickel machine ... we scored over 6,000 credits, when we got eight 'Quick Hit' symbols ... I don't even want to think of the jackpot we would have won with a maximum bet.... From a $10 bill, we got $342 in ... two minutes.

"On 'Palace of Riches 2'"—and I'm just going to cut to the chase for you: They won $182. On other machines, they won at least $100 with only $20 on everything they played.

"Overall, we split the proceeds of over $1,100 after all of our 'seed money' is factored out. So ... we both took home $550, primarily on two-cent slots. For us, it was a profitable four hours of fun!"

Anybody can read that. You can google that. And then everyone else writes the stories: "Congratulations. I had the same thing." It's amazing how nobody ever loses. I mean, really, if I could skip off work with my mother, go to the raceway and make $1,100—that's more than I'm making in a day, I'll tell you—that sounds okay. Our culture has really embraced a lot of the myths about the easy win and the gambling. We've really glamorized it, and the perspective is getting a little out of touch with the reality of it. This is only one example.

I'm going to get into some of the treatment issues now and some of the things we're seeing. Some of the emerging issues in the previous discussion about the research covered a lot of this, so I'm not going to belabour it, but Internet gambling and the problem of regulations I think are really something that we're going to have to consider as a province, and it's coming at us very quickly. The normalization of gambling—what I just talked about—and the poker on TV, issues with youth—how do I teach my youth to gamble safely if she says, "It's just a penny machine," and I don't know what that means? How do I do that? There are issues with seniors, people who were never exposed to slot machine gambling growing up and don't know how the machines work. There are issues with aboriginal people and trauma—I'm going to touch on that in a bit—as well as gambling employees. We know that in most sectors, the people who work in the gaming environment are overexposed to winners all day, and they think, "I know something about this." They will be overrepresented—I didn't finish that sentence. You know what I mean, though, right? They have a disproportionately high representation of people with gambling problems.

Co-occurring disorders: So the last three research questions that Judith Glynn was teasing out. Something I'm especially concerned with is the mental health and addiction connection when it comes to gambling; the acute need for coordinated services is very real and really pressing. People with gambling problems are surfacing in other systems, for other reasons, or their symptoms are going completely unrecognized. We've had clients who have gone to psychiatrists—again, I'm going to use an elderly client as an example—who have said, "Oh, dear, you're slot machine gambling. It's a good way for you to spend a day." This woman ended up having quite a serious gambling problem. Because she had other depression, or whatever else she was getting treated for, this went completely unnoticed by her primary care provider.

Aboriginal gambling: I was just in Thunder Bay two weeks ago; I do a lot of work in the north with people working with aboriginal clients. Since the residential schools settlement has started to take place, one of the things happening for some people—in fact, quite a few people, and this is anecdotal information that I'm sharing with you—is this. Say I live in a community where there's a high incidence of problem gambling, I'm struggling with addiction problems myself, my whole community has collective trauma and the residential school settlement hearings are being made—and the worse my trauma, the more money I'm going to get paid; the worse the story of what happened to me is, the higher my cash payout is going to be. People who have very serious histories of trauma are sharing their stories, going public with it and saying it out loud, without any psychological support to do that. What is happening is that it's retraumatizing them. If you don't have support and you have a very serious issue like that in your past, if you just put it out there and get no support whatsoever, it could be very retraumatizing. This is happening to people, some of whom have gambling or other addiction problems, and now they have $15,000. So if I have a gambling problem, you give me $15,000 and I feel really, really terrible because I have just ripped off the scab that has been protecting me by discussing this trauma in a public setting with you, it seems quite likely that that's going to end up being possibly problematic for me to handle.

So people have been struggling with some of the settlement money. They've been gambling it, they've been losing it, and then there have been other consequences in their families based on what just happened with that money. This is a really pressing issue in the north. It's very serious. I don't have any great solutions on it, but I just wanted to bring it up, because it's quite a serious problem.

Treatment options in Ontario: Have you already been briefed on what kind of treatment there is here, outpatient and whatnot?

*Interjection.*

**Ms. Janine Robinson:** Okay. The people who get counselling treatment—this is what I'm calling treatment—usually fall into the moderate sphere: they're the 3.2% of people whom the previous speaker mentioned. Those are the people who come for some sort of formalized treatment. Those people have access to outpatient counselling services: you come to see a counsellor, once a week or whatever. There are residential treatment programs in four locations, and there has been a pretty good response to that. You can get counselling from A to Z in the province—except actually, only to W: From Atikokan to Windsor, there are 50 treatment agencies, and gambling treatment has been rolled into the existing

addiction services that are there. One of my jobs has been to help people with addiction counselling skills get the gambling counselling skills, to be helpful in that area too; so two birds with one stone.

Online self-help and telecounselling: I'm just going to talk for a minute about online gambling and treatment, because this is—oh, there it is. Paul Godfrey, chair of the OLG board, recently stated that online gambling is "something I would explore." If that is something to explore, we need to look at how to minimize the harm associated with such an exploration and how to make sure that there's online access to help and resources that are actually effective.

**1730**

This is the current continuum of services that exist online in the province. The technology is coming. We have a few obstacles around the freedom-of-information and privacy laws that we're sort of grappling with around how to provide secure treatment online.

There are self-help tools that are anonymous, all the way up to the possibility to do video conferencing with a counsellor. We don't do that yet, but we could do that. We could also be doing email counselling, we could be doing online counselling, and we could be doing group counselling. So far in the province, we're not doing that, but it's something that could be explored.

When we're looking to the future, there's clearly no single solution to the thing that is problem gambling in the province of Ontario. We know that, while it's definitely important to look at using best practices and also acknowledge that the field is quite young, we have a great body of practice—counselling, awareness, different systems—which knows a great deal that hasn't yet been empirically validated about some of the needs in treatment. Rely on evidence-informed practices, yes, but also rely a little bit on practice-informed evidence.

The need for online treatment: It seems that it is abundantly clear, and we have the capacity at the Problem Gambling Institute to do that. It would be particularly effective for populations who aren't emerging for counselling, like poker and sports bettors. It's low-cost, and it's high-impact.

Here's just a snapshot of our website. I gave you a pamphlet about that.

The other issue is other behaviours that are associated with problem gambling, which were also mentioned. We see a lot of clients who have online shopping addiction, online gaming addiction, online pornography addiction, sex addiction etc. There's nobody who is funded, as far as I know, to treat these people. There are all these people who have these problems that are causing a lot of relationship problems, family problems, work problems and so on, and there's nobody who's designated to treat them.

In the problem gambling stream, the counsellors who are already seeing clients with these co-occurring disorders, as Judith Glynn mentioned, would be ideally situated to have their mandate expanded and get some supplemental skill sets to treat people with Internet addiction.

I'll move on from that. Concurrent disorders: I think that has already been spoken to.

I think the direst need is in the north. Whenever I'm working in the north, the counsellor always says to me, "Yes, but I'm it. I'm the one. That's me. I'm the person." They're not necessarily people who are fully qualified to work with issues of trauma and concurrent disorders. But it does seem to me that bundling those services—if the research is still teasing out which caused which, we can still be treating them simultaneously.

Another successful model that has been happening is the use of webinars. Do you know this expression? It's web-based training, Internet-based training. You sit at your computer and listen to me on the phone, and I blather away like I am now and show a PowerPoint presentation or do something online. We've done this with bankruptcy trustees at our institute. We've done it with family doctors, and we have the capacity to do that on a widespread basis. We know most people who have gambling problems go to their family doctor, and it's missed, right? The gambling piece is missed. We could help develop that skill set. We also train gambling counsellors online.

I don't want to suggest that online is ever going to replace face-to-face training for counsellors, just to put that out there. It is a human service; we do need that human element in it when we're working.

Another really successful model is the multilingual program gambling service. You have the brochure about that; it's the multicoloured striped one. This has allowed us, in the province, to offer gambling counselling in 17 languages for less than $70,000 a year. What we do is we have trained people who are working at family counselling in the Spanish language to provide treatment for problem gambling, and then we pay them on a fee-for-service. They see a client—we pay them $66 for the hour to see the client; we pay them to do that—and they treat the client in their language.

We have reached so many people this way. It's cost-effective and it's got reciprocal benefit—the clients benefit, the non-mainstream agencies benefit and the mainstream agencies benefit because we're reaching those people who we weren't reaching before and we're also building our cultural capacity at our agencies. It's been a very, very successful model. I think it could be expanded to other regions.

I'm going to end here in a second, but I just wanted to mention working where the people with gambling problems are. The work that we've been doing with Ontario Lottery and Gaming to help them identify and respond to problem gambling red flags in the casinos has been a very good way to do early prevention with players, but also to do later stage referrals for people who already have gambling problems. They can get the brochure to come and call us.

That's it for me. I would be very happy to have any follow-up discussions with you and I'm more than happy to take any questions.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you very much. We asked you to come because, obviously, we didn't hear a lot about it during the proceedings. I guess we anticipated that we would and we didn't, and through Ms. Sandals, we were able to arrange this visit today.

Just to start the discussion off, is there a reason we didn't hear from you or from somebody else talking about the same subject? We just didn't hear all that much about it.

**Ms. Judith Glynn:** I'm surprised that you didn't. I wonder if there was a lack of awareness, but we do know, for example, that problem gamblers don't show up for treatment. The percentage of people who have a moderate to severe problem who actually present for treatment is extremely low. Now, I know it's low for many mental health disorders, but I think for problem gambling, it's perhaps on the extreme end of that.

What we think is going on there is that some of the same barriers to treatment are probably the same barriers to even acknowledging that it's an issue. That might account for the fact that you didn't hear personal testimony from problem gamblers.

The fact that you didn't hear from service providers surprises me, and I wonder if it's whether—because the problem gambling service providers are fairly well-funded, and that system is fairly stable, then—I mean, there are needs there, there are areas into which they can expand, but if you had a treatment centre that was providing service for all forms of addiction, they may have emphasized the other forms of addiction because that's where the funding pressures existed.

I wonder, do you think that problem's somewhat true?

**Ms. Janine Robinson:** It doesn't resonate falsely, but I'm a little baffled, especially that online gambling hasn't been a strong feature for people. Yes, I'm surprised. People just get mired in what they've been working in for years and years, and some of the newer issues they haven't really fully contemplated. I don't know; I can't quite understand it.

**The Chair (Mr. Kevin Daniel Flynn):** I mean, I've had friends who claim they always win when they go to the casino. I know that's obviously not true. There's a stigma attached to it. Obviously, when you do talk about it, you don't talk about the $5,000 you lost last night; you talk about the $20 you won. Does it always just come crashing down at the end with "The house is lost," or do people sort of realize at some point along the way that "I'm on the road to that"?

**Ms. Janine Robinson:** Most people alter their problematic behaviours on their own right now, largely due to financial pressures. When they come to counselling, unfortunately, they're at the very end stage of problems, and overwhelmingly they're divorced or bankrupt. So the people who do end up coming to our services across the province have very severe consequences. The ones who are less severe, or even who are bankrupt, might just resolve the gambling in another way.

**1740**

**Ms. Judith Glynn:** Just to add to that, there is a very high rate of self-recovery and it will reflect in year-over-year assessments of the prevalence of problem gambling. What the emerging results from a study that has been following 4,000 people in the Belleville area will show is that there is a fairly high percentage of people who move in and out of problem gambling status. Approximately 50% of the annual turnover is people re-entering problem gambling status, who seemed to self-recover, and did for a period of time, probably because of those financial pressures. But then the problems re-emerge within, I think, a two-year cycle.

**The Chair (Mr. Kevin Daniel Flynn):** Let's hear from Jeff and then Liz.

**Mr. Jeff Leal:** It was interesting—you talked about how Norway has a fairly sophisticated tracking system for people who are problem gamblers. We often hear, through the various media outlets here in Ontario, about the Ontario lottery corporation talking about responsible gaming, and the proceeds from gaming in Ontario—a certain amount—are put back into programs.

What is preventing us—or should we be looking at the Norway example that you provided? I don't know how much training is given to people. In my riding of Peterborough we have Kawartha Downs, which is a harness race operation, plus a slot operation. How much training—or should we provide additional training for those individuals to be on the lookout to better identify people who are potential problem gamers?

**Ms. Judith Glynn:** I think one of the major obstacles is that in all of those jurisdictions you must present ID when you go into the facility, so they know who you are. That's not the case in Ontario. There has been a lot of resistance to that. I'm not entirely sure where the resistance comes from because the attraction of remaining anonymous might only exist for people you might not want in the facilities anyway. I think what you have are cultures in those countries where the requirement to present ID is not thought of as a strange request. I think that's probably the very first barrier.

The other thing that they do in those countries is that in some cases they don't allow people who are full-time students, in school, or recipients of social welfare to gamble. They're simply not permitted to enter gambling facilities. I think what you'd find is that some of those measures would be considered intrusive in our culture. But the presentation of ID is really the foundation to being able to do all of this tracking and detection. I think you've got resistance at that front end for the presentation of ID. If a person inserts their player card, then the operator will know who they are while they're in there gambling.

But I think the other place where you're going to get resistance is in that requirement. Whose job is it to first detect and identify the possibility of problems, and then to intervene? I think what you'll get is a lot of nervousness around assuming that responsibility here in Ontario. If we were going to move in that direction, there

would have to be really strong legal analysis and provisions. You'd need some technology to support the identification of people coming in and you'd need the technology to do the tracking, and then you would need—I think the staff could easily be trained to intervene. That would be something that Janine could speak to. But the resistance is going to be in identifying people as they come to the venues, and then once you have signs, based on their play behaviour, that they probably have a gambling problem—there is quite a bit of research to tell you what those signs are—you have to have an environment where the operator is responsible legally for detecting and intervening, and we do not have that in Ontario.

**Mr. Jeff Leal:** Thank you.

**The Chair (Mr. Kevin Daniel Flynn):** Liz?

**Mrs. Liz Sandals:** A couple of questions. I found the research that you had around bio-psychosocial factors and how gambling addiction is interrelated to other addictions and to mental health issues really fascinating.

Do we have any information about, if you treat problem gambling, what happens to all those other concurrent disorders or, conversely, if you treat the other concurrent disorders, what happens to the problem gambling? Do we have any information on how treatment one way affects the other concurrent disorders?

**Ms. Janine Robinson:** Can I speak to the clinical experience first, and then you can speak to the stats about it.

Clinically we know—let's take depression, for example. We will assume a client who comes in our door for gambling counselling is experiencing depression. In 80% of the people who are experiencing depression, the depression will clear up when we control their gambling. The other 20% won't. So then we know the depression was either—

**Mrs. Liz Sandals:** The depression is the primary—

**Ms. Janine Robinson:** It pre-existed, right, or it's endogenous depression and needs to be treated additionally. We also know treating people with certain antidepressants has a spin-off effect. There are certain drugs that will regulate the impulse systems that are effective. So we know some of that.

Most of our counselling services in the province don't prescribe medication. Most of our counselling services are talk services. One of the needs that we have there is really to have more consultation services with psychiatrists because we do need to be able to figure that out for clients. If they present for gambling and they need to be treated for terrible debilitating anxiety, we can do that, and we should be able to do that in the same place.

**Ms. Judith Glynn:** In terms of the research, there is some research that looks at how you treat those multiple co-morbid disorders, but it's minimal. Definitely, if I was talking to the research field and telling them a place where they perhaps have failed to provide the information that policy-makers and health system designers need, it is that health systems piece. So which disorder do you emphasize in terms of treatment? How do you integrate the treatment? Is there a certain order that should take place? In that case, Janine's point about evidence-based practice, if there's evidence that's there, the research really doesn't exist, so we might have to come at it in the other direction.

The other thing that I think Janine will confirm is that when you look at the different pathways to problem gambling that have been modelled, there is some sense that of those who do present for treatment, a large percentage are the ones with the most complex set of co-occurring challenges. So there is some need to address that in the treatment system, and Janine referred to that. There is some need for the treatment system to have the capacity for coordination and perhaps working with researchers and seeing what works best in terms of integrating the treatment of multiple presenting conditions.

**Mrs. Liz Sandals:** So you've got some capacity to switch back and forth between the medical and the counselling?

**Ms. Judith Glynn:** Yes.

**Ms. Janine Robinson:** They complement each other.

**Ms. Judith Glynn:** Yes. I think they need to complement each other, and counsellors need to have access to MDs and psychiatrists in a case consultation sort of approach.

**Mrs. Liz Sandals:** Okay. Then, the other thing that I found interesting was that—well, all sorts of things were interesting, but what twigged my curiosity was a lack of understanding about how an electronic gaming machine really works, i.e., it's a random number generator and the odds are set, and the fact that you've gone for hours and didn't win doesn't mean you're going to win next. Is that something that's a prevention opportunity and have we looked at ways of educating more people so that they actually understand probability?

**Ms. Janine Robinson:** That has been happening. The Responsible Gambling Council in the province is responsible for that type of messaging. They've certainly been doing some work.

In the casino training that we're developing, that we've been doing, the number one role of staff is to help create an informed customer, to help players understand how the games truly work and what the true odds of winning a certain game are. The drawback of that is it doesn't happen automatically. It only happens if the player is complaining or demonstrating some sort of problematic behaviour. So if somebody's just quietly playing for four hours, they'll never get that information, but if they say to the person, "Jeez, I just spent $400 and I haven't won anything," then we're training them to say, well, this is how the machines work and how to convey that information pretty clearly. There's no way people get that information until they're demonstrating a problem—

**Mrs. Liz Sandals:** But you're finding that people who are addicted to slots genuinely don't understand how slots work?

**1750**

**Ms. Janine Robinson:** Absolutely. They don't. They'll tell us—when I'm working with them in a

session they'll tell me there's a random number generator. Yet still, when they go to the bathroom at the casino, they'll put their chair up on the thing so no one can steal their jackpot, which demonstrates they really don't believe—

**Mrs. Liz Sandals:** They don't understand.

**Ms. Janine Robinson:** It hasn't gone in, because I can go like this and press the button, or I can scratch my nose and press the button—I'm going to have a completely different outcome. So people really, truly don't know how the games work.

There's a lot of public messaging that could be done about the game itself. These games have no brakes. They have a gas pedal without a brake.

**Mrs. Liz Sandals:** Thank you.

**Ms. Judith Glynn:** Sorry, I was going to just add to that. In terms of research about the success of education around how gambling works, it's mixed. There was a large study in Alberta where they educated university students about randomness, and they did a really—it was a strong research design. Over a period of time, they showed a dramatic increase in the understanding of how randomness worked in different forms of gambling, and yet, it had a very minor impact on gambling behaviour.

Then there was some research by Ladouceur in Quebec which showed that you could correct the cognition. People would report an improved understanding of gambling, but once they got into the venue something sort of took hold, and I think Janine will have heard this as well.

But that doesn't mean that we shouldn't make those attempts to educate. The research evidence is mixed, but you do have to ask yourself, as responsible providers of gambling—and we know that this is a difficult concept for all of us to understand; there is still a compelling case for doing the education you're talking about, for doing a really good job of trying to dispel those myths.

OLG has had some campaigns in the last couple of years that have tackled some of those myths. I think there is a very compelling case for trying to correct those errors, but in terms of treating problem gamblers, there is resistance and those are difficult cognitions to correct.

**Mrs. Liz Sandals:** Yes. What's really interesting is the study with the university students who, presumably, were a range of people who reflected the general population, and it didn't change their gambling behaviour.

**Ms. Judith Glynn:** They were quite surprised by the result.

**Mrs. Liz Sandals:** Okay.

**The Chair (Mr. Kevin Daniel Flynn):** Any other questions? Thank you very much for coming. I remember a line from a movie that said people weren't addicted to winning, they were addicted to losing. Is there any truth to that, or is that just Hollywood?

**Ms. Janine Robinson:** I've heard that line too. That's one of the first sort of psychological understandings about it. People with gambling problems had a failure—do you know what it's called? The drive to punish yourself; they had that. It hasn't been scientifically supported.

**Ms. Judith Glynn:** Except to some extent, I think what they might be talking about—that's the Matthew McConaughey-Al Pacino movie, the name of which I've forgotten, a great gambling movie about sports betting.

**The Chair (Mr. Kevin Daniel Flynn):** That's right, yes.

**Ms. Judith Glynn:** I do think that if you look at that whole idea of the reward schedule—the high-frequency, variable reward—gamblers do report that the activity of gambling, the excitement in those moments before they know the outcome, is part of the reward. So winning is not the only reward; that's not the only thing that's going on.

In that sense, whether there's that intransigent group that really does want to lose, or whether just gambling, generally—certain forms of it—offers that thrill all the time, and then the chance that there will be the bigger thrill of a win; but the chance outcome itself seems to provide them with something that they want.

**Ms. Janine Robinson:** Absolutely.

**The Chair (Mr. Kevin Daniel Flynn):** Jeff?

**Mr. Jeff Leal:** Just an anecdotal story. You talk about new Canadians—Chinese—I always remember when I was in residence in university, on Sunday night, Chinese students would get together for a game called mah-jong, which, as I understood it—and they were right next door to my room in the residence—was a game like dominos of some description. But big money was exchanged during the game of mah-jong. It was always very fascinating to me to watch them. They were very intense as they were playing—

**Ms. Janine Robison:** It's a very important cultural game, mah-jong.

**Mr. Jeff Leal:** It is, yes; I've heard.

**Ms. Janine Robison:** Yes: it's weddings and all kinds of very important times. It's very lively. People will say, "I was at my grandma's knee—that's when I learned it."

**Mr. Jeff Leal:** Certainly, it was interesting to watch, but the dollar value that was on the table in playing this game—I mean, for students, you know, you're living on Kraft dinner and a lot other things. It was fascinating.

**Ms. Judith Glynn:** It must have been strange to watch that kind of money disappear. I was going to say, related to that, in North American countries and much of Europe, lower socio-economic status is strongly correlated to problem gambling status. In some Asian countries, the reverse is true because it is a status—

**Mr. Jeff Leal:** Upper income—

**Ms. Judith Glynn:** Yes. You have higher rates of problem gambling in—

**Mr. Jeff Leal:** Very much so.

**Ms. Judith Glynn:** Yes, and that's why, and you've—

**Mr. Jeff Leal:** Hong Kong is a classic example of upper income—

**Ms. Judith Glynn:** Yes, because it's status to gamble, and to gamble large amounts.

**The Chair (Mr. Kevin Daniel Flynn):** Thank you very much for coming today.

**Ms. Judith Glynn:** Thank you. Thanks, everyone.

**The Chair (Mr. Kevin Daniel Flynn):** We really appreciate it. That was a great presentation. Thank you.

**Ms. Judith Glynn:** If there is any material you would like forwarded or condensed or anything, let us know.

**The Chair (Mr. Kevin Daniel Flynn):** Perfect. Thank you.

For the members of the committee, you've been given three reports today, I think, or three pieces of information from the Legislative Assembly. One is the final report deliberations and the recommendations from the interim report. If we could bring them to the next meeting—I know we've been swamped with paper, but this is one we need to have at the next meeting.

*Interjections.*

**The Chair (Mr. Kevin Daniel Flynn):** We're just having a discussion about all the summaries we've received to date, and now we're starting to get into the final report and saying whether it's reasonable to expect the members would still have the summaries that were provided by staff. I know, if we kept all the paper each had, we'd fill this room. Do you have copies of the summaries? You do?

*Interjections.*

**The Chair (Mr. Kevin Daniel Flynn):** Because if we don't, we may as well admit it, and ask you to bring them.

**Mrs. Liz Sandals:** I have a binder with some summaries—but I wouldn't guarantee they're all there, and the other thing is, it's getting quite weighty to carry around—

**The Chair (Mr. Kevin Daniel Flynn):** Yes. Well that's just it.

**Ms. Carrie Hull:** What about if we have binders that we keep here—

*Interjections.*

**The Chair (Mr. Kevin Daniel Flynn):** That's a good idea.

*Interjections.*

**The Chair (Mr. Kevin Daniel Flynn):** Bring what you have.

Is that it?

*Interjection.*

**The Chair (Mr. Kevin Daniel Flynn):** Oh, right. The interim report will be ready Monday, and the intent is to table it before our meeting on Wednesday. Just so we know everything went smoothly with the printing and the translation.

Thank you very much. We're adjourned.

*The committee adjourned at 1756.*

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