MASSACHUSETTS GAMING COMMISSION

FORUM ON PROBLEM GAMBLING

JUNE 25, 2012

COMMISSIONERS:

Stephen Crosby, Chair
Gayle Cameron
Enrique Zuniga
James F. McHugh
Bruce Stebbins

PANELISTS:

Kathleen Scanlan, Moderator
Marlene Warner
Rachel Volberg
Debi LaPlante, Ph.D.
Kevin Mullally
Mark Vander Linden
Christine Reilly
Sarah Nelson

(Commenced at 1:10 p.m.)

CATHERINE ANDERSON: Good afternoon. On behalf of President Wayne Burton at North Shore Community College, I welcome you to our Lynn campus. We are situated here in our MBTA building which houses some classrooms, and the main campus building is across the street, the Thomas Magee building. We also have two other campus facilities, one is in Beverly at the Common Center where we house our Institute for Corporate Training and Technology, and in Danvers where we have our three facilities, our three buildings. Our newest building is actually a zero net energy projected building, actually the first in the Commonwealth and the second in the nation.

On top of that we service 16,000 students per year in both credit and noncredit programs, and we are here at the ready to help any workforce industry needs, and as the gaming industry moves forward, we hope that you look to us to help you. Have a good day. Commissioner Zuniga.

COMMISSIONER ZUNIGA: Thank you, Ms. Anderson. My name is Enrique Zuniga. I am one of

the commissioners of the Massachusetts Gaming Commission. I want to welcome to our fourth educational forum. The topic of today is compulsive gambling. So on behalf of my fellow commissioners all sitting here at the front with me, we would like to welcome you here today.

We are streaming live on our website so we also welcome those watching at home or at their offices. For the record in our website mass.dot/gaming, all of the minutes and videos of our previous meetings and also our previous educational forums.

So let me mention a couple points about problem gambling or compulsive gambling. There seems to be some debate in the medical community as to whether compulsive gambling constitutes an addiction or a behavior problem, and many would agree however that regardless of that, the tools to address it are very similar and are known. It really comes down to identifying, preventing and treating people with that problem. Of course, we will hear about some of that today with the distinguished panel that we have.

This issue is a little bit personal to me

because I grew up with my mom and my dad both being psychiatrists and psychoanalysts, so from a very early age I came to just appreciate the relevance and importance of human behavior, studying and addressing issues around human behavior. So even though my father has spent a lifetime treating people like most in the medical community, to recognize and say and advocate a lot for the issue of prevention and to address prevention, we really need to think about education and information which brings us to today. We will be hearing a lot about that today as I suspect, but we also are thinking about that as an ongoing issue that we will be addressing and thinking about as we move forward.

So the Gaming Commission has a lot to do in many many aspects in the expanded gaming law, but addressing the potentially negative effects of the expanded gaming law is really at the top of its priorities, and one very important effect in that regard is the issue of problem gaming.

So with that, I would like to turn it over to Kathy Scanlan who is going to introduce our panel. Let me mention one more thing. Because this issue is such a priority to this Commission,

forming partnerships with the Mass. Compulsive Gambling Council and others in the health and public health community are also a top priority for the Gaming Commission. So with that, thank you very much.

KATHLEEN SCANLAN: Good afternoon everyone and welcome. Thank you again to the North Shore Community College for hosting us today, and especially to Cathy Anderson for all her help for setting up all the many details that went into this, and thank you also to the Mass. Gaming Commission and welcome to the Commissioners.

It's been a long time since Massachusetts has started -- since Massachusetts starting discussing expanded gambling. My memory is 1995, and as a way of background into introducing the panelists that we have today and the program for today, I wanted to mention a couple of things.

First of all, the Mass. Gaming Commission, we are extremely grateful to the Mass. Gaming Commission for the, first of all for holding this forum as well as for the process that you're using in looking at the expanded gambling

legislation. There are so many ways that could have been done, but to choose one where there is a thoughtful process of building information on the issues that you need to implement is extremely encouraging to us, and so we are really grateful for that process that you're selecting.

When we looked at the legislation that the Governor and the legislature produced and signed last November, we were extremely pleased to see that there was not only an emphasis on maximizing benefits for the Commonwealth of expanded gambling, but also as much of an effort put into minimizing the harms, and we saw the legislation taking problem gambling extremely seriously when they looked at their provisions, and that they seek to reduce the harms by including several provisions that would address prevention, intervention and treatment of gambling problems as well as research into the issue as well as responsible gambling policies and practices that would be required of the potential casinos.

These measures that were required, and I'm going to mention a couple of them so you understand where we are heading today with this

forum. Some of the provisions in the legislation that are related to gambling problems are prohibiting under age gambling and under age refers to 21. Prevention strategies would be required for vulnerable populations. Limits on credit and check use. Limits on marketing where it's requested by patrons. Training of gaming industry employees. Identifying patrons with problems and intervening. Posting signage of help line, and in as many languages as that would be deemed necessary. Self exclusion programs where a person could say they don't want to be admitted into the casinos. On site counseling available all the hours that the casino is open. Research that studies problem gambling as well as what are some effective interventions in reducing harms. Public health trust fund established for programs that address gambling-related problems, as well as other public health strategies being required, and a gaming policy advisory committee with a sub committee on addiction services. So looking at those provisions brings us to today's forum and why we are here today.

Our aim in putting this forum together

is to hope that it will be of help to the Commission in beginning to implement the provisions that relate to problem gambling. So today's forum we intend as pretty much an overview, and as Commissioner Zuniga said, this is probably the start of the conversation rather than the final word. It was challenging to find what we were going to do in this time period and what we were going to leave out. There is more to be said than is being covered today.

So in presenting that overview, we intend to do two different sessions. One is on understanding the issue of problem gambling and that's what our first session will cover, and then the second panel will talk more about identifying some of the challenges as well as some appropriate solutions that have worked for other folks.

So we are going to begin our panel unless there is anything anybody needs to add or ask. We are going to start our panel by introducing our panelists, and we have with us today Marlene Warner who is Executive Director on Massachusetts Council on Compulsive Gambling. Besides her presentation, I want to thank her also

for her work in setting this up today, as well as the work of Amanda Hogenberg from the offices here. They did a lot of background work in making this happen.

We also have speakers in recovery, Jodie Nealley and Scott Seely are going to speak with us. Also Rachel Volberg and Debi LaPlante who have been pushed over to the side for a few minutes, but not really. They will also come up when there is a little bit more room at the table, and will talk from their perspectives.

So our first session is going to really talk about what is it and who is impacted, and we are coming from several different perspectives, many perspectives. Academic perspectives, service delivery perspectives as well as personal life perspective on understanding what this issue is and maybe some ways to respond to it later, so are you set Marlene?

MARLENE D. WARNER: Again, thank you very much Kathy. What Kathy failed to say was that she was the executive director of the Mass Council and program director and then executive director for 24 years, and has recently retired, but still

serving the Council as a special advisor for the Council, so I thank her for setting all of this up and still be willing to talk about this and have energy for this topic because it is an important one.

Thank you to the Commission. I got a chance to meet each and every one of you through various events, and I can't stress enough again the Commission is very much dedicated to this issue, has been showing up at our -- we had a western Mass symposium on June 1st and two of the Commissioners were there. We had a meeting last Tuesday with industry members and one of the Commissioners was there, so there is definitely an ongoing interest since day one since we first met with Chairman Crosby, so thank you very much for having us.

My role is to kind of give you an overview and tell you a little bit about this topic, give you the right language, and set all of these folks up to give you more details about this.

So first let me just introduce the Mass. Council. The Mass. Council on Compulsive Gambling's mission is to provide leadership and reducing the social, financial and emotional costs

of problem gambling and to promote a continuum of prevention and intervention strategies including information and education, capacity building, advocacy and referral services for problem gamblers, their families and the greater community.

I would be remiss if I did not talk about the founder of the Council. It was founded in 1983 by Tom Cummings who experienced problem gambling in his own lifetime. He secured funding in 1987 for problem gambling services statewide, and then set us up in the office today we are actually still currently in at 190 High Street and really advocated for treatment system in 1998.

Again, another important piece and one thing that a lot of people ask us about, we are neutral on the issue of legalized gambling, neither for or against which is why we are here to talk about the issue of compulsive gambling. We provide services and advocate for those who might develop a gambling problem, and we advocate for responsible gambling related to public policy in the Commonwealth.

Some Council programs I mentioned some of these and I am happy to give some more details.

We are certainly out doing a lot of trainings, putting things out on the web, and doing a lot of media campaigns. Certainly working with individuals and working with larger entities such as schools, correctional facilities, things like that to give them more capacity around this topic. We run a 24-hour help line and do a lot of assistance via other telephone numbers for other languages, and certainly a wide array of prevention recovery services, and advocate and this is really a piece of the advocacy making sure the voices of folks with gambling problems and their family members are heard.

Here are our help lines and a little bit about how we connect people to some of our resources. You will hear actually probably a little bit about the first step of change later through the NCRG and the DOA. 12 step help meetings, self help meetings like Gamblers Anonymous, and there are 13 treatment centers across the state with clinicians and then there is also private practice clinicians in Massachusetts. There is our address and phone number.

So what is problem gambling? This is

something that a lot of people ask us. There is even just confusion about the title, problem gambling or the name problem gambling. You will hear it referred to in a number of ways. Pathological gambling which is really the diagnostic, the DSM-IV, and I will talk about that in a minute, but the Diagnostic and Statistical Manual on Mental Health Disorders. Title for it pathological gambling. Compulsive gambling which is a bit more antiquated, but something that also talked about the severity, and certainly in 1983 was a popular title. Any Council's being born now are not being called Council on Compulsive Gambler. They are called problem gamblers.

Gambling disorders which really represents a wide array of problems and also gambling addiction. Again, you will hear future speakers today talk about the wide array of symptoms within addiction. The definition that we think is really helpful and useful and something that came out of David Corn and Howard Shaffer's studies was risking something of value and the outcome of event when the probability of winning is less than certain. It really clarifies for folks

how this is different from other ways you might be spending money or time, and it's specific -- I like this one specifically because the something of value. It's important to be aware, especially in illegal gambling, that a lot of kids especially will be gambling with things other than money. That they'll be using like sneakers or electronics or other things, and it's not just kids but certainly that's where we hear mostly about it. And in the event the problem of winning is less than certain, that's another key piece. I often explain to anyone who has heard me train, I talk about the difference between shopping and gambling, and that you're certain when you hand the money over, you should be certain you get what you paid for, and that's not the case with gambling. And so having people really think about that, people will say all the time I don't gamble. I just scratch a ticket every once in a while or I just enter a raffle, but thinking about what that actually means, how they are spending their money for something of value.

Problem gambling, this is a very wide definition but one that I think serves us well is

the term used to cover the entire range of harmful gambling involvement, that is gambling that results in some kind of negative impact on the person's life or the lives of the person's family, friends and/or coworkers. It can be an occasional impact or an ongoing and serious situation. When you hear a little bit more about this today, this will make a little more sense because it can show up and develop in all different ways for different people and it's really depending on that individual, and that's something that's really key for us to remember when we are talking to people on our help line that this can manifest itself in very different ways.

The DSM-IV definition of pathological gambling is persistent and recurrent maladaptive gambling behavior that disrupts personal, family or vocational pursuits. A similar definition but not as wide, so again we talked about it in a very general way.

This is a chart that we developed from the Corn and Shaffer article and is something that we find very helpful to explain a number of things. I should have brought a pointer. The level of zero

is no gambling, but we know the vast majority of people in Massachusetts and certainly in the United States will gamble at some point in their lifetime, and that can be all forms of gambling, so that's why that is really small and what they consider level zero.

Level one is the vast majority of people in the United States which is gambling with no adverse consequences. They gamble at some point in their life, but they are not having any problems.

Level two is gambling with some adverse consequences. So this is, I will tell you what those ten diagnostic criteria are, but this is four or less, so sub clinical gambling would also be considered, some people call that problem gambling. Some people use problem gambling that describes the whole spectrum, and some people talk about problem gambling as four or less, but that's that level two. So this is similar to someone who says they are having some trouble drinking, but may not be a full blown, you know, having a full blown addiction with their alcohol so this is similar there.

Level three, and you can see the level two is larger than level three. Level three is

much much smaller. That's people who are experiencing a problem with gambling and are having severe consequences. They are having five or more of those diagnostic criteria. Again, much smaller but you can see level two and level three are still smaller than level one. Most people are experiencing a problem with level one.

And level four, someone may talk about this today, but level four is the amount of people who actually entered into treatment. One of the hardest things about this addiction and you'll hear called the invisible addiction, the hidden addiction. It's very difficult to diagnose, and even when it's diagnosed, sometimes people still don't want to have the proper intervention. They may not be ready yet. They may not be interested. They may have another thought. Level four are people who are in treatment.

We stress to the people who are clinicians or training to be clinicians that they have a really special task because of so few people who enter into treatment, the folks who get into treatment and hopefully stay in treatment are typically the ones that are having the hardest time

figuring out how to solve this problem that they are experiencing. What do they do with themselves. Level four is just that. This gives you a better sense of how this all works out.

The other thing that I really like about this is that you can get -- you certainly can get worse, but you certainly can also get better, and you will also hear a little bit about that today.

Just some high risk categories that I think it's important for folks to think about, and there's certainly a lot more we can say about these categories, but high risk categories, child of a compulsive gambler or child of a person with another addiction. The fact that you have seen that, been around that certainly is a genetic component and others will talk about that today. Belief that a skill is involved and that's certainly another piece that you will hear over and over of whether it's a game of chance or a skill and whether it impacts somebody's ability to play it.

An early big win. For my nearly 11 years at the Council, I would say that's the number one thing I hear on the help line is that an

early big win is a huge factor for folks. It didn't take much time, effort or money for me to win. I think I can do it again. I think I have that special touch. Something is special about what I'm holding. Something that's special about what I'm doing. Something that's special about what I know. That early big win is really kind of infectious for that person.

Feeling that one must chase gambling loss with more gambling. Chasing is really a huge piece of this addiction, and I'll talk more about that in a moment. Early age of onset. 8.5 years for pathological gamblers and 11.5 years for non pathological gamblers. It's a little surprising --

CHAIRMAN CROSBY: 8.5 years old?

MS. WARNER: Old, yeah. So folks who are now going to end up with gambling disorders start gambling around 11 and about 8 or 9 for pathological gamblers, and typically similar to other addictions, that's typically gambling with a family member.

A large first bet and otherwise addicted or with a mental health disorder is definitely a huge risk factor for folks. Characteristics of low

risk gambling. For fun or recreation never for financial gain. Knowledge that over time nearly everyone loses. Socially with family and friends and not alone. A limited time and frequency, limited time, frequency and duration with predetermined limits for loss, and acknowledging that knowing a lot does not make you a better gambler.

These are the DSM-IV criteria. I will tell you the DSM-V has been scheduled to come out for a very long time. When it's going to come out, I know one of these ladies may be able to give you a better sense than I. If they know that, they are great. It's a million dollar question. 2013, is that what you said Rachel?

RACHEL VOLBERG: That's what I heard.

MARLENE WARNER: That's the latest, 2013. It's been years in the making so. Some of these will be debated in that, but they are pretty good and pretty indicative again being a non clinician talking with folks on the help line and the work that I do, I can tell you that they are pretty indicative of folks with gambling problems.

Preoccupation with gambling. A lot of

these are similar to drugs and alcohol. Preoccupied with gambling. Needs to gamble with increasing amounts of money to achieve desired excitement. This is tolerance. It used to take $50 for the game to be exciting and now it took $500. Repeated unsuccessful efforts to control gambling. It's very difficult to stop. You have done everything in your power. You've asked people around you to help you to stop and you just can't stop. Restless or irritable when you're trying cut down or stop. Again, we'll hear more about this today, but this is something that is often surprising for folks given this is a behavioral addiction. Looking at the physiological responses that folks have when they are trying to cut down.

After losing often returns another today to get even. This is the chasing. Again, I thought that today would be the last day that I gambled and then I have to go back because I just know that I'm hot or I'm due or whatever the thinking is that I need to go back and get that money back because I'm ready.

Lying to conceal extensive involvement with gambling. I tell you most people who call us

that their spouses think it's an affair that's happening. They can't account for the money or they can't account for the time and they just assume there's another person in their spouse's life, but indeed it's a lot of lying related to the gambling.

Has committed illegal acts to finance gambling. Again, surprising, I often say I never thought I would know so many disbarred lawyers but I've met a lot of them at least on the help line.

Has jeopardized or lost significant relationship, job, education or career opportunity due to gambling. I hear this all the time. The last person in the world who trusted that person, gave him a home, gave him the clothes on their back, gave them some pocket change and they still jeopardized that relationship because of the overwhelming power gambling had over them.

Relies on others to provide money to relieve a desperate financial situation caused by gambling. The chasing of this bail out which is really what you would call that is pretty unique to gambling as opposed to other addictions, and that is it for me. So I am now going to turn it over to

Scott who's going to talk to you a little bit about his own experience.

SCOTT SEELY: Good afternoon everybody. My name is Scott Seely and I am a compulsive gambler. I live out in Western Massachusetts and I have been away from a bet now for about 50 months, just over four years. I'm very fortunate. I also am an alcoholic and in recovery just about 30 years, so I'm familiar with addiction. When it was mentioned whether this is a behavioral -- I am nervous, excuse me -- or, you know, an addiction, I can tell you one thing. I dabbled in some drugs when I was young and experienced cocaine addiction for perhaps six months which probably helped me get into recovery for my alcohol problem, and when I hit a slot machine for $4,500, it was very similar, you know the rush.

Anyways I, you know, like I said, I entered recovery for alcohol and drugs when I was 23 years old, and probably two years into that I went down to Atlantic City. It had just opened probably four years before that. Maybe it was open for a little longer than that, but I had been there previous to that while I was still in my active

addiction. But when I got clean and sober I went down and spent, you know, a day and a night and left the next day and realized I had a problem with gambling and I didn't belong in casinos. I chased it all night long, and I felt bad about it and I realized I should stay away from it. That's as far as I addressed it, and years later I had a problem with scratch tickets. I was probably kind of 15 years clean and, you know, got into a period of, you know, planning my trip downtown which store I was going to stop in, you know, I was going to hit a big one and came out of it and said, you know, I can't do this so I just stopped scratching tickets.

And then the casinos south of us opened 15 years ago, and I occasionally make the trip down there and play some Black Jack and usually lose and stay until I lost whatever I brought with me, probably two or $300. So at that point problem gambling, compulsive gambler, I knew enough not to dip into the credit cards and I still was skirting the edge of my addiction.

But in 2005 or actually in '99 I was diagnosed with a medical condition and I went through a period of, you know, acceptance in

dealing with it, and then in 2004, I had some other issues going on and I wasn't really taking care of myself like I should be. I was busy with life. I wasn't attending many recovery meetings, you know. I became depressed and I was still once in a while down at the casino and never liked to play the slot machines because it wasn't much excitement.

But one particular day I was playing the machine and I hit it for $4,500. That started a year of just like a compulsive downfall, was just self destructive behavior, whatever you want to call it, but it was a ride that I hope and pray I never have to take again.

Over the years of being at the casino, some nights I would be there late, try to get a room and couldn't get a room. I tell you after I hit that slot machine for $4,500 I had whatever room I wanted. I was a high roller, and I continued to play the high limit slots. You know, I had a casino host approach me in the middle of the night. I was playing a high limit slot machine and offered me a room, and you know, any concert tickets just to make me comfortable. You know, within a month's time I hit probably ten machines

for a total of perhaps $50,000.

So I also have another business. I am in construction in Western Mass. I'm a concrete contractor, and you know, in 2007 it was my best year in business and I ended up just losing it all in a year's time.

Just recently I found out what my total handle was from, you know, right around March of 2006 to April or May of 2007 when I bottomed out, you know. I got a daily play list from this casino what I put in, what I won, what I gave back was a million and a half dollars, and my income level at that time was probably 35 to $36,000. So the casino knew that I was way in over my head and nobody ever intervened. Nobody approached me. Nobody said why don't you cool it Scott. All I had to do is pick up the phone and talk to my host and, you know, wallah and I had a suite. I had whatever.

They continued to, you know, make me comfortable and I just named it up. Going down that road where enough wasn't enough, I'd go down on a Thursday night, stay until Monday or Tuesday, lose. I had a line of credit. I would drain that.

I'd use that to the extent and then the wheels would start, you know, on the way back home what am I going to sell. How can I get the money to pay my line of credit so I can start it all over again. It's a vicious cycle.

I couldn't see it. As mentioned I was very secretive. I wasn't drunk falling down the street. I wasn't driving erratically. Any time I talked to anybody about my gambling it was well, I just won $9,000 and I was, you know, ecstatic, and they didn't see the other side of it when I was in depression and, you know, trying to figure out where my next bet was going to come from. It was just, you know, a quick slide to the bottom. You know, I was incapable of addressing it at the time.

I was seeing a psychiatrist at UMass Medical Center for my medical condition. I was on antidepressants, and it just didn't matter. I just couldn't wait and I would be sitting and sharing with a psychiatrist and looking out the window so I could jump on 395 and head south. It was just all consuming.

My business started to fall apart, and then the economy fell apart. You know, I went

through, you know, my life savings, my retirement and cashed it in. I ended up with a second mortgage for $100,000. I ended up selling an antique car, motorcycle, camper, anything in possession, and my next step was to commit an illegal act and that's perhaps where I bottomed out. It was just uncontrollable. I had no power over it and I just couldn't be honest. I couldn't face the fact that I was in an addiction again. It was like that gorilla was back on my back.

I would go to the casino credit and the last weekend I was there I had a line of credit of $3,000 that they let me draw it out to $4,500, and I was just, you know, a con. I was a liar, cheat and thief all over again. Like I said, I had experienced recovery in another addiction but I couldn't see it for myself 'til I hopefully reached that bottom and was able to reach out and say help.

When it all came tumbling down, I ended up really depressed and reaching out for help. Four and a half years ago or four years ago I live in Western Mass. and I needed a counselor. I needed 911 right away because I ended up in my back yard with a pistol to my head, and the only reason

I didn't blow my brains out was cause I have two dogs. I live alone. They saved my life. I reached that despair, but there wasn't anybody available close by. The closest trained counselor at the time was in Amherst and he was six weeks out for an appointment, and I needed the emergency room.

Hopefully, you know, you people have a large job in front of you and hopefully you can work with the Mass. Council and provide, you know, intervention, you know, prevention, intervention and treatment, you know, because it's definitely needed.

You know, I am a miracle to be standing here today because I was this close, you know, and finally I attended some Gambler's Anonymous meetings and through that I was introduced to the Mass. Council, and I reached out there and got connected with a counselor finally and developed a relationship with these people, with the Mass. Council and they have been fantastic, just a really great group of people that are full of knowledge and compassion and just really on board to help in any way they can.

So when I was asked to come here today, I was honored to come and hopefully put across to you folks, you know, there is a definite need for, you know, some real serious help on this issue and, you know, I just really want to thank you for letting me share with you today and you know, I think that's enough out of me and I will let Jodie share next, so thank you for listening.

JODIE NEALLEY: Hi. I'm going to sit if that's okay. Can you all hear me? All right. Seven years ago I had it all. Turning 50, big party at a rented house on an island in the Thousand Islands, friends and family. I had what I used to call the big three. I loved what I did. I had the best job in the world. I loved where I lived, an affluent suburb outside of Boston, and I had a family who I loved and who loved me. Four years later I was in prison, sentenced to two years on three counts of larceny. So you wonder what happened.

I spent 30 years getting to that point seven years ago building the life, loving family, finding the perfect job, and in four years I tore it down. Seven years ago I was in 13 years of

recovery from alcoholism. Cool, you know. I quit. My father before me had quit. I was doing the right thing. I wasn't going to meetings but I didn't drink. I didn't know, like I know now, that what do they say? Your addiction will be in the parking lot doing push ups just waiting for you to walk out so it can clobber you. Something about turning 50, call it mid-life crisis. Call it whatever. Call it fate. When I walked out in that parking lot, that addiction took hold of me and throttled me.

I went to a conference in '05 and it was a conference at a hotel in Reno. There was a casino in there. I was so excited. I was wow, a casino. I had gambled here and there, nothing more nothing compulsive. Now I'm like the poster child for the DSM criteria, every single one of them. But in 2005 I had only gambled a handful of times, and I can't believe Scott said this amount, but I walked away from that conference with $4,500. Maybe it's the tipping point, I don't know, but that's very strange. And I thought wow, you know, and I had meetings to go to so I didn't gamble all the time. I would gamble and I would leave for a

meeting and that's the only reason I walked out with any money in my pocket.

And then I turned 50 and then something happened. Just something happened. I started gambling, I would say compulsively in 2006 and in twelve months I had lost almost $500,000. I had gone through everything, you know. There could be 20 of us and you will hear many similarities. All my savings, maxed out every credit card, taken every bit of money I could from my partner, home equity line, everything, but I had the desperation that addicts get. Irrational, insane, crazy, absolutely crazy desire to win back all I had lost. I had lost over a half a million dollars. Really, how was I going to win that back when the largest prize on the slot machine I was playing was $100,000. Anyway, remember, that rational thinking has nothing to do with an addiction, compulsive gambling especially.

So I began to steal from my employer, me. Nice girl in the suburbs, affluent suburbs in New Jersey who had a great job, who had everything like I said and I began to steal, and I gambled and I gambled for just really about a year and a half,

and in 2007 I was caught. I was fired and that was the end of my 30-year career.

By now I have lost, well let me put it this way. I like this metaphor, and those who were at Amherst forgive me for repeating myself. There is a movie Up in the Air with George Clooney, and he is at this motivational speaking thing and he's talks about his backpack and what we put in our backpack. Before I started gambling I had all the things I thought I wanted, a career, a loving family, things, things, things, a good car. I always wanted more, more, more is better. Putting all this stuff in the backpack. The backpack was really heavy. So I think it just had to come off, and when I was fired, it came off and I had to deal with this incredible threat of incarceration, and after waiting for nine months which was just interminable because the justice system takes a long time to make up their mind, I went to jail. And again I was a 53-year old sleeping on a top bunk, and it was just like amazing, how did I get there? Well slot machines, that was my thing. Slot machines was my thing. I don't know why. I don't know what it was, and I would sit in front of

that slot machine like a robot not eating, not drinking, not caring, throwing away everything I had in my life to feed in $100 bills. I started at five, twenty five cents, a dollar. It wasn't enough. It was more, more, rush, rush, rush. $100 bills was as high as I could go so that's where I was, and I would feed in these $100 bills like they were pennies. $200 pull. $200 pull. $200 pull. I lost $60,000 in a weekend and that was a good weekend.

My mom once said when this all came out, how could you do that. I said mom it has nothing to do with money. Think of them as pennies. Think of the hundred dollar bills as pennies. It has nothing to do with money. It's the thrill. It's the rush. You know, money was -- gambling was how I got high and money was the drug. Think of that. Money is what you're putting into your system and the high is what you get for me for pulling that slot machine.

No one tried to stop me. God forbid they should. I didn't talk to anybody. I didn't do anything. I did this all in isolation. I wasn't like everybody else. I just wanted to do my

thing. Sometimes I won. Sometimes I lost. Mostly I lost, and I would get credit lines, suites, you know. They treat you like you're a big shot, and one of the symptoms when we go to a 12-step meeting is that compulsive gamblers especially, we like to be treated like a big shot. We sort of think we are. Our ego is in control at that point big time. How else can you explain this irrational behavior.

So they come up to you and they bring me to a room and oh my God, I never would have stayed in a suite like that in my life. They bring you anything you want feeding that ego. As long as you keep feeding the dollar bills, and in my case the $100 bills into the slot machines, they are going to feed your ego and that worked well for me until it came crashing down. And I waited -- I just didn't understand. I didn't understand. I remember once talking to my host and she knew. She knew I was a compulsive gambler. We were talking about it and I said, well maybe next weekend I'll come back with some more money. She said, honey, there is not enough money in the world. She didn't say for me but what she was saying for a compulsive gambler, there is not enough money in the world to

satisfy the craving and you can't do it. It's bottomless. You will keep going. You will keep going until something stops you.

You know, there will be people who are more academic than me talk about addiction here, but addiction is a fatal illness. It will kill you in one way or another whether it be drugs, alcohol or gambling. In gambling I could have a heart attack from the stress. Of the 20 questions they ask you in GA, I answered 19 out of 20. The only thing I didn't answer was did you ever think of committing suicide because I'm an optimist. I always think something's going to get better. That's why I was such a good gambler. Sure, it's going to be the next spin. I'm going to win my money back on the next spin. Sure, it's going to be great.

That was the only time in my life my optimism failed me, but I paid my, you know, I realized that I was really sick and that obviously quitting drinking was not enough. So I went into recovery in 2008 also when Scott did. Very weird we both just recently celebrated our four-year anniversaries for that, and I found the room full

of losers who were really winners. These were other people that lied, stolen, cheated, betrayed everybody they love, every employer by stealing or being caught, betraying everybody they loved to scratch tickets or play poker or pull a slot machine, and these were my kind of people, you know. I said wow, they get me in a way that no one else who has not experienced this addiction could ever get me. You can't experience it. No one can understand it again because it's irrational.

So I was lucky enough to find the GA and since then I worked on it and I was in recovery for a year and then I was sent to prison in '09, and I spent almost two years there, a little over a year and a half, 20 months. 602 days but I wasn't counting, and I was very lucky I think because I came in with recovery. I came in with a good attitude. I may be doing time but I'm not going to waste time. I read Gulliver's Travels for God's sakes, really, and I went to every class I could and every spiritual class, every educational class. I learned a lot about people. I learned mostly a lot about myself, and I came out pretty much -- I came out a much healthier person.

So in that backpack I have now, it's not stuffed and it's not secrets and it's not stealing or lying. In that backpack now is mental health, a desire to be as honest as I can each day of my life, a passion for going into this field. I'm just about to complete my last class and get my certificate in substance abuse counseling at UMass Boston. I would like to get into the treatment of compulsive gamblers. There is not much out there right now, and I'm pretty old to be starting a new career but I'm optimistic so I shall go forward. I am healthier and happier with nothing. I lost my house and lost my marriage. I lost my career. I lost my freedom. All that for nothing, for nothing, for some comped suites, for a few TVs or whatever you can get from points from the casinos.

You know, the gambling, the casinos spin a dream, and compulsive gamblers are the first ones to believe in that dream because we live in this dream world. How else again can you explain it that we do what we do. We're in touch with reality. We are not.

So I found the Mass. Council. I have been out only about 15 months working very hard to

get my life back together. It's not easy. I am still on probation, but each day one day at a time I face what I have to do today. I have a child whom I love more than anything. I practice honesty. I work hard. I've never worked hard in my life, never, and these are the things that have been laid before me. This is the path I travel, and if I can pass on what I have learned to others in any form, whether they be compulsive gamblers or folks like you, then I will do that at the drop of a hat, and when Kathy and Marlene asked me to speak here, oh yeah. I will do that. I will tell my story, and they say that your altitude is determined by your attitude. I love that expression. And in the old days, I guess I had a pretty bad attitude because my altitude was crash and burn, whatever, and now, you know, I'm on the upward of life and I have a good attitude for the future. I am very blessed despite the burdens that I still carry, despite having to struggle with this addiction and other addictions every day because I am still moving forward, and that's the best I can do. Thank you for listening.

KATHLEEN SCANLAN: Thank you so much

Scott and Jodie. We can read a lot about this issue, but it's not the same as hearing people talk about what's happened in their life, and I am really grateful for them for doing that. Thank you.

CHAIRMAN CROSBY: Could I ask a question?

KATHLEEN SCANLAN: Sure. We were going to do questions, we had planned to do questions at the end of when Rachel and Debi also have spoken.

CHAIRMAN CROSBY: Scott and Jodie will still be here?

KATHLEEN SCANLAN: They will still be here at that point.

CHAIRMAN CROSBY: All right, I will wait.

KATHLEEN SCANLAN: If you prefer to do it now. Do you want to do it now?

CHAIRMAN CROSBY: Fine. First of all, thank you. That's obviously incredibly powerful and just a part of an important process for us to learn about how to do this job. But one of the things that's implicit in the stories that you tell is the complicity of the casino operators in

manipulating your disease, and I wonder. It sounds pretty clear that you believe that you were identified as a compulsive gambler and manipulated to maximize the amount of money that came from you. A, am I reading that right? And B, have you been involved in and others can talk to this about this as well but this is just personally about you. You would have a better way of helping people like us, regulators, figure out, you know, how you regulate because you know all the games, you know all the tricks. You have been there done that. I just wonder whether you have been involved in that process of helping people like us figure out how you manage that first problem, if I understood that first problem correctly.

SCOTT SEELY: I would like to address that. I had a situation with cashing checks, you know. I was trying to keep the game going and a few times I wrote checks and I figured I can get back home and deposit money in the account and the check would beat me so I bounced I think two or three checks down in Connecticut. And within a week or so they would allow me to cash another check. Towards the end of my gambling, I was out

in New York State at the casino that's on the thruway and I went to cash a check for $600 or something, and the casino cage said no, you can't and I said why? Well you need to go over, I believe it was the Gaming Commission in New York State. The Gaming Commission has an office right there, and they brought up, you bounced a check in the casino. You're never allowed to cash a check in this casino again, whether that's New York State law or that casino's policy, but it's a very good policy. It put the brakes right on it. I was slapped in the face. It just stopped my addiction right in its tracks and I left. You know, it was the end of the end. It was starting the beginning of the end for me. But there needs to be safeguards in place whether it's credit card use. I ended up with over, I think it was $58,000 in credit card debt, probably a lot more because I paid it off, and then ran it back up again, but it was a thousand dollars. You know, I'd go back to the cage and it was another thousand dollars, you know. In a 24 hour period I think I was allowed to run up with my line of credit $2,000 in credit card debt but, you know, there needs to be safeguards in

place through the whole, whether it's checks or credit cards because, you know, it's just out of control and nobody ever said, you know, until I went to New York and it was a very good safeguard.

On top of that with the line of credit that I had at the casino, as I mentioned I think that year my income level was around 30, 35,000 and they extended me a line of credit and they knew what my play was because I used a player's card. I had a host come up to me that first introduced himself to me. He was in charge of implementing the software that tracked every player. He was on top of it. He was a nice guy, very friendly. But he knew where I was at all times. He knew my level of play and he knew my income level. I was way above, you know, what I should have been playing. A million and a half dollars in a year, that's not what I lost. I probably lost three to $400,000. I'm not sure. I never sat down to add it up, but my total play from -- one experience I won $11,000 at the Black Jack table and I walked into the high limit slots and within an hour it was gone. There was no what are you doing Scott. There was no safeguards, but there needs to be safeguards in

place.

JODIE NEALLEY: I have never -- no one ever tried to stop me. In fact, like I said, I think I was playing some machine and this woman walked up and introduced herself as an employee. She was the host, and asked if I wanted to spend the night and gave me this incredible room, and that's really all I needed. It's what you said. They manipulate. It's a strong word, but I think probably it fits. There is no clocks in the casino. Someone told me, I don't know if it's a myth, they pump in oxygen so you stay awake. I never fell asleep in front of a slot machine. I didn't eat. I didn't drink. I wasn't drinking anyway but I didn't take advantage of all these things you can get for free when you're such a high roller. I just wanted to sit in front of that machine. I would stay awake all night, and when the machine broke, I would wait two hours for the guy to come in and fix it because I wasn't leaving that machine. All my money was in that machine. I knew the next spin I was going to get my money back, you know.

I did once go to a conference when I was

in the thick of this and I was in Kansas City, Missouri and man, was I mad. Talk about safeguards. If you lose $500 in two hours you can't play. I lost $500 in like 20 minutes. I was like really? Really? I went to another casino, signed up for that one, played. I went to four or five of them. I was just going, well this is just not working. So I chose something healthier to do, but I thought that was crazy, but most people -- I will generalize here -- don't lose $500 in two hours and then feel gipped that they can't lose more. So that's the only experience I had with control, but it certainly would have helped me because I'm a very -- I sort of -- I respect authority kind of person, sort of follow the rules except when I didn't, and if someone had said no, you had your limit, you really should go home, I would have been like okay. I'm a good girl, and off I would have went, so if that answers your question.

CHAIRMAN CROSBY: Thank you very much.

KATHLEEN SCANLAN: Any other Commissioners have a question at this point or do you want to hold them for later? How about if --

originally we were going to have some movement happen here, but I don't think it needs to because we had one presenter that didn't show up. Marlene has a son with a broken foot, so she has got issues she has to deal with so if you two folks can move over and Deb and Rachel can come up.

I forgot to introduce Rachel and Deb before. Let me do that right now. Rachel is President of Gemini Research, a research organization that has done much work through the years on problem gambling. And Debi LaPlante is the Director of Research and Academic Affairs at the Division of Addiction, and an Assistant Professor in psychiatry at Harvard Medical School, and so who would like to go first? Rachel, you're going to start I think and then Debi.

RACHEL A. VOLBERG: So the reason for my little outfit here is that my daughter left this morning or we thought she was going to leave this morning for China, but she texted me and she is still at the Hartford airport waiting for the flight out. But I forced her to listen to this talk several times because I wanted to get my timings right, so she knows exactly what I'm going

to say, and I hope that you all find it as informative as she did not.

Good afternoon, Chairman Crosby and all of the Commissioners and thank you for asking me to speak this afternoon. I want to focus on three areas in my remarks, and I should preface this by saying you are now moving into the academic section of the program. The personal stories are very very important though, and maybe if you can sort of keep those in mind to balance the more dry academic stuff that I am going to be presenting. So I wanted to just provide some definitions for some terms that are commonly used by epidemiologists.

I want to present some results from a recent study that Rob Williams and I completed on problem gambling prevalent studies, and then I actually wanted to present some new information that has just come out of the two international studies that I am involved with.

So first some definitions. Epidemiology is the study of distribution and determinants of health and illness in populations. It's the cornerstone method of public health research and practice and helps inform policy decisions by

identifying risk factors for disease and targets for prevention. The two most important concepts in epidemiology are prevalence which refers to the number of people in a population with a disorder at one point in time, and incidence which refers to the number of people who develop a problem over a given period of time.

Problem gambling prevalence in the general population is generally estimated between one and five percent of the adult population in jurisdictions with mature gambling markets. However, prevalence rates among adults who gamble and even more amongst adults who gamble regularly are far higher. In fact, problem gambling prevalence rates as high as 25 percent that is one out of four players who are regular heavy gamblers on a particular activity have been identified among slot machine players and race track bettors.

Early population surveys have identified or did identify a number of characteristics that were consistently correlated with problem gambling. I am just going to go through the mostly sociological ones, male gender, age under 30, low income, single marital status, low occupational

status and less formal education and also non Caucasian ethnicity were additional factors in a number of studies as was residents in large cities.

More recently in jurisdictions where electronic gaming machines also sometimes known as slot machines and a lot of other terminology, in jurisdictions where they have become wide spread, problem gamblers are just as likely to be female as male. A phenomenon that the Australian Productivity Commission referred to as the feminization of problem gambling.

There are also some groups in the population with interesting bimodal gambling patterns. In comparison to other groups, they contain large numbers of people who gamble very little, but a proportion who gamble heavily and experience gambling-related problems at much higher rates. These groups appear to be sectors of the population in the early stages of introduction to high risk forms of gambling.

For many years it was widely assumed that as gambling opportunities increased, there would be corresponding increases in the prevalence of problem gambling. The idea of a close link

between the availability of gambling and the prevalence of problem gambling is an example of what's known as the total consumption model, that has been found to apply in several areas of public health including alcohol and tobacco consumption, obesity, high blood pressure, low birth weight. The basic assertions of this theory are there is a close connection between average consumption of a product and the prevalence of excessive users, that consumption is distributed in the population in a bell curve basically characterized primarily by moderate consumption but with a minority of excessive behavior in the far tail, and that the curve actually responds as a single entity to changes in overall distribution.

So with alcohol for example, if you can reduce the population consumption of alcohol, you actually are able to reduce the prevalence of alcohol misuse, abuse and dependence.

The nature of the link between gambling availability and problem gambling prevalence has been challenged in recent years, although investigation of this relationship has been hampered by some variability in the aspects of

exposure that are selected for investigation, and also by difficulties in measuring the parameters of that exposure. Nevertheless, as you will be hearing from Debi since she is one of the authors cited here, researchers have proposed a modified formulation that includes both exposure and adaptation. With the impacts of exposure confined to the early stages of the introduction of new gambling forms while adaptation occurs subsequently at individual, community and population levels.

Along with Rob Williams, and Rhys Stevens, I recently completed an analysis of adult problem gambling prevalence rates to determine whether there was evidence that prevalence rates declined as populations adapt to gambling. To answer this question, we had to find ways to control for the many methodological differences among problem gambling prevalence surveys that have been carried out in different jurisdictions and in different times. We developed a number of weights, the application of which was intended to reduce the noise around the obtained prevalence rates and allow us to compare apples with apples between jurisdictions and over time within jurisdictions.

So this is just some information on the study, typical of Rob we found everything and reviewed it. So we identified and collected a total of 202 surveys conducted internationally between 1975 and 2012, and extracted pertinent information from the study. We then examined the impact of the main methodological elements that influenced the problem gambling prevalence rates obtained in these studies. This included the assessment instrument used and there are a variety of different assessment instruments that were used. Whether problem gambling was assessed as a lifetime or a past year disorder. Whether the survey was described as a gambling survey or something else to protect its participants. Whether the survey was administered face to face or in some other way. Whether the problem gambling questions were asked of everybody who had gambled, those who gambled in the past year or some other threshold. We also created ways for differences in telephone response rates which had declined rapidly in recent years.

Within each of these elements we have identified the methodological approach that produced a most valid prevalence rate and developed

weights that could be applied that would have been obtained if the valid approach had been used.

And finally, we applied these weights to create standardized problem gambling prevalence rates for all of the studies and here is the results of our work.

The results of this exercise suggests strongly that problem gambling prevalence rates started rising in North America, that's the red and the blue lines, and Australia the green line, beginning in the late 1980's to the early 1990's and achieved a peak ten years later in the late 1990's to early 2000. This time interval is roughly coincident with the most rapid introduction and expansion of electronic gaming machines and casinos in these countries, the greatest increase in per capita gambling expenditures and a significant increase in overall gambling participation.

However, there has been a worldwide downward trend in both gambling and problem gambling rates in late 1990's in America and early 2000's in Australia and other nations, and as you can see current rates are now very similar and in some cases below what they were in the late 1980's,

prior to or more often shortly after the start of gambling expansion.

Considering that gambling availability has increased steadily in most of these jurisdictions over the last 30 years, these results provide support both to the contention that increased gambling availability is related to increase problem gambling and the contention that populations tend to adapt over time. While problem gambling prevalence generally increases in the wake of the introduction of new gambling forms, decreases in prevalence can occur for several reasons, and a variety of factors are likely to lead to a decrease in problem gambling prevalence, including recovery and professional interventions at the individual level. Adjustment to the novelty of the gambling opportunities or increasing awareness of potential harms at the community level, and finally, natural selection at the population level. Which means that individuals are removed from the problem gambling pool due to severe personal or financial crises, criminal charges arising from their behavior or in extreme cases, suicide.

These different aspects of adaptation suggest quite different policy approaches, with prevention and early intervention, more likely to be beneficial where adaptation is taking place at the individual and community levels, but stronger measures relating to limiting or reducing gambling density and concentration more likely to be helpful in cases of population adaptation is occurring.

Until quite recently, the vast majority of research on problem gambling was based on cross sectional studies and like snapshots, these studies yielded information on correlations, statistical relationships between problem gambling status, demographics, gambling participation, other physical and mental disorders at a single point in time. If repeated, these studies also yielded information on whether problem gambling prevalence had gone up or down over a given period of time.

In contrast, longitudinal studies are more like movies where the same individuals are followed and reassessed at regular intervals over extended periods of time. They allow us to examine the characteristics of people who are contributing to increases or decreases in problem gambling

prevalence, and to identify factors that predict the development of gambling problems as well as successful recovery.

Longitudinal studies are particularly important in helping us identify risk and protective factors associated with changes in problem gambling status so that we can develop more effective interventions and more effective policies.

So this is all by way of studying the fact that I'm involved in a number of longitudinal studies that are currently being conducted internationally, and all of these studies started with very large samples of randomly-selected participants between 6,000 and 15,000 individuals at baseline, and we are looking both at individual and group projectory into and out of gambling. And fortunately for me, there is substantial overlap in the content of the questionnaires in the studies that I'm involved with which actually is going to let us make some cross cultural comparisons in the future

But in the current context, I would like to focus on the fact that these studies were

designed to allow us for the first time to measure incidence which if you remember at the beginning of my talk is the number of new cases that arise over a given period of time, and it's something that hasn't been looked at before in the problem gambling research field.

It's possible to do this because in each of these studies, nearly all of the participants in the baseline survey who agreed to be recontacted were followed up one year later. So think about 15,000 people and 10,000 of them said okay, you can come back to me in a year, and we went and found about 9,000 of them for the Swedish study.

In Sweden the prevalence rate of problem gambling was unchanged between wave one in 2008 and wave two in 2009. However, 75 percent of the problem gamblers in wave one were replaced with new problem gamblers in wave two, and of those new problem gamblers, 20 percent of them, one in five, were considered relapsing because they had a previous history of problem gambling, a lifetime history, whereas 80 percent were new cases with no previous history of problem gambling.

In contrast in Victoria, Australia, two

thirds of the new problem gamblers in that study were considered relapsing while one third were new cases with no previous history of problem gambling.

This next slide, and I sort of had a little fun with this slide, I realized I might be getting kind of boring by now. This next slide is from the Victoria wave two report and shows shifts in gambling and problem gambling status between wave one, which is on the right hand side and wave two which is the status at the top. This table shows that just under six percent of the wave two participants increased their risk status in the 12 months between the two surveys. At the same time, a little over four percent of the wave two participants decreased their gambling status or their risk status, excuse me.

The problem gambling group and the non problem gambling groups were the most stable groups, but there was a lot of movement in the non gambling group for example, and in the two low risk and moderate risk groups. The considerable churn identified in both of these studies, both the Swedish and the Victoria studies suggest that a far larger percentage of the adult population actually

experiences gambling-related problems than the small proportion that score as problem or pathological gamblers at a single point in time. The consequences of these gambling-related problems including financial difficulties and family relationships, school and work issues, can reverberate as you've heard long after the acute problem phase is resolved.

So now for some sort of final stuff. Across the Swedish and Victoria studies, a number of risk factors assessed at wave one, so at time one were associated with the development or recurrence of gambling problems at wave two. The strongest of these were gambling in the past year on electronic gaming machines and casino table games, as well as on the Internet or gambling weekly on course or dog races.

Other risk factors associated with the development of gambling problems at wave two in both studies included poor physical or mental health, use of tobacco and risky drinking habits at wave one. And finally we identified a number of additional risk factors for the development or recurrence of gambling problems across the two

studies including difficulties at work, changes in work conditions, the loss of a close relative, and changes both good and bad in personal and household finances, and I think that's it. That's it.

I hope my presentation has helped you kind of understand some of the complexities of what actually is contained in that one number called the prevalence rate and, you know, I look forward to answering your questions. Thank you.

DEBI LAPLANTE: So Chair Crosby and members of the Commission, thank you for the invitation to be here today to examine this very important and complex matter. I'm going to organize my time today to answer two primary questions. The first question is how can gambling become an addiction. The second is what is the public health impact of expanded gambling. To answer the first question, how can gambling become an addiction requires an understanding of the nature of addiction.

Historically, people have argued that things like alcohol and drugs cause addiction and that people consequently suffer from specific yet different types of addiction. Alcohol addiction

being distinct and different from tobacco addiction or gambling addiction, for example. Today researchers and treatment providers mostly hold a different perspective. Rather than many different types of addiction, experts suggest that addiction is a singular process that can be expressed in many different ways. Consistent with this understanding, the American Psychiatric Association is considering a major revision of its Diagnostic and Statistical Manual of Mental Disorders that will provide a universal addiction-related diagnostic process rather than separate object-specific diagnostic processes as is the current procedure.

This means that gambling-related disorders would be grouped with other expressions of addiction within a newly created categorization called addiction and related disorders. The addiction syndrome model that my colleagues and I from the Harvard Medical School developed is the most contemporary model of addiction that is consistent with this idea. The addiction syndrome model suggests that people express their addiction disorder depending on people's risks, exposures and

experiences. But what is the evidence that addiction is a singular disorder? What prompted this rethinking of addiction?

Evidence from a variety of scientific disciplines supports the notion that expressions of addiction have more in common with each other than previously thought. The commonalities across expressions of addiction outweigh the differences and suggest the existence of a syndrome which is in brief is a collection of signs and symptoms that reflect an underlying disorder.

From neurobiology we know that people have an area of the brain that's involved in processing information related to reward. Scientists have referred to this area as the reward center. Functional magnetic resonance imaging studies show that anticipation of things like drugs can activate our reward center, and interestingly, non drug experiences can also activate our reward center.

One study by researchers from Mass. General for example, found that beauty and money can also activate the reward center. Other evidence in support of the idea that addiction is a

syndrome includes patterns of comorbidity with other mental health problems and with other expressions of addiction. People with one expression of addiction are more likely than others to also deal with other expressions of addiction, and with other mental health problems.

There are also many observations of treatment nonspecificity, that is evidence of a single treatment successfully addressing many different expressions of addiction. For example, Topiramate for both alcohol and gambling or cognitive behavioral therapy for basically all expressions of addiction.

And finally, addiction hopping or addiction substitution. When people stop engaging in one type of addictive behavior, there are increased risks for adopting new and different expression of addiction. Think of overeating as a replacement for stopping smoking or increasing smoking after quitting alcohol. Taken together these instances of shared phenomena as well as others I haven't mention suggest that our early understanding of addiction needed a revision. The objects to which an individual became addicted are

part of the picture but the development and experience of addiction is much more than those objects.

In this series of slides you will see an illustration of the addiction syndrome model. Different individuals face the world with different sets of vulnerabilities and resiliencies, and in their life individuals also are exposed to different potential objects of addiction. Individuals who have little vulnerability like the person on the right there, are unlikely to develop an addiction, as are people who have no exposure. However, individuals who have much vulnerability are at risk for developing addictive behavior. The type of behavior depends on what people are exposed to.

For example, alcohol or gambling, and the response that they have to it. If the object generates a desirable subjective shift in experience, a high, it's a candidate for addiction. Ultimately when addiction develops, people develop a number of shared experiences like tolerance and withdrawal as well as object-specific experiences like bankruptcies or lung cancers depending on

whether one gambles or smokes.

So any object to which an individual is exposed and with which they interact holds the potential of becoming an object of addiction, if the person has sufficient risk and the object provides a reliable desirable subjective shift in experience.

This leads to the second question that I would like to discuss today. If exposure is a key component to the development of addiction, then what is the public health impact of expanded gambling? Many studies have suggested a relationship between increases in gambling opportunities and increases in gambling and gambling-related problems.

For instance the National Gambling Impact Study Commission reported early on that having a casino within 50 miles of one's home elevates that person's risk for developing a gambling-related problem. Similarly, our work at the Division on addiction illustrates the association between the presence of gambling opportunities and self exclusion rates in Missouri. You can see the small dots are the areas where

there are gambling opportunities. More intense red color indicates more use of the self exclusion program. The same thing here you see in Iowa. Again, you can see the areas of intense health seeking through the help line calls as well as the locations of the various gambling opportunities.

However, more recent research, some of which Rachel shared, reveals that these and similar studies only tell part of the story. In fact exposure effects like these vary on a number of different things. So exposure effects depend on location. Adding a casino in Las Vagus is going to impact a community differently than adding a casino where gambling opportunities are limited.

Exposure effects depend on populations. Some communities are more vulnerable than others and therefore the presence of a casino is likely to affect those communities differently than more resilient communities. Exposure effects depend on timing, and during the rest of my time today I'm going to discuss how the short term effects of the presence of gambling opportunities are different from the long term effects. So what you see on this slide is the prototypical exposure and

adaptation curve drawn from public health. Typically it's used to illustrate population level effects of biological and environmental toxins like viruses or lead paint. The Division has found that curve can also be applied to potential social toxins like gambling. Increase this curve suggests that the immediate consequences of new exposures results in increases in problems like disease. However, in most cases that initial increase reaches a peak indicating that most of the vulnerable already have succumbed and the rest of the population is more resilient. After this peak, people and society adapt and the original problem tends to return to earlier levels.

Although most studies concerning gambling exposure are not longitudinal, some are forthcoming. A few studies can provide insight into how exposure impacts populations over time. For instance, an examination of the self exclusion rates in Missouri over time indicates that those rates have changed from the early period of the program until the later in a way that's consistent with public health exposure and adaptation modelling.

And similarly, one longitudinal study conducted in Canada showed that gambling-related problems did not escalate linearly following addition of a new casino in the region. Rather rates of problems increased in the short term but they returned to previous levels.

And finally, as some of our own work at the Division involving Internet gambling, we have observed among more than 40,000 people that new subscribers to an Internet gambling service also followed a similar pattern. Initial increases in activity following new exposure and later evidences of adaptation. Taken together, these findings and others that I have not had time to mention suggest that exposure effects are not as straight forward as many people assume. Instead exposure effects vary depending on many different characteristics. Most specifically exposure seems to be of limited duration. This pattern suggests that different processes will be needed to deal with gambling-related problems over time. For example, it might be that in the short term more widespread intense intervention and prevention is necessary, but in the longer term people with those problems

might be more difficult to locate and their problems might be more entrenched. So intervention and prevention efforts might need to be more targeted and precise.

The exact approach that Massachusetts will need to take is not yet clear and effective contemporary research methods that allow for ongoing and efficient monitoring of gambling and gambling-related problems should guide the process.

Later today my colleague, Dr. Sarah Nelson is going to talk about the importance of empirical evaluation and evidence-based intervention. For now I would like to thank you again for your time and the opportunity to speak today. I'm happy to answer any questions at the end as I'm sure the other panelists, and for those who won't have the opportunity to ask questions, this final slide lists a number of Division on Addiction resources related to addictions. Thank you.

KATHLEEN SCANLAN: Thank you Rachel and Debi for that. We do have some time for questions if the Commissioners would like to ask some questions at this point.

CHAIRMAN CROSBY: Thank you. Thank you both for that interesting stuff. Like Jodie, I'm an optimist so I grabbed onto that chart that both of you described where clearly the introduction of casino gambling by all the evidence is going to have a substantial increase. Because of the increased exposure, there's going to be a substantial increase in prevalence, but there seems to be that standard decline that you showed for many kinds of public health problems, and that you showed. Do we know pretty well how to maximize the decline in that curve or is it just a matter of doing it or do we not really yet know how what the variables are that cause that decline?

RACHEL A. VOLBERG: I'm not sure -- can you hear me? Okay, we don't know very much about what specifically causes, you know, adaptation and decline, although it's very encouraging to see that it is there. It would be nice to be able to minimize the increase that you see at the beginning from the very beginning, and I've speculated with colleagues that if you had prevention and particularly primary prevention, public education and sort of media campaigns and social marketing is

what they call it, at least in New Zealand where they are engaged in a major social marketing campaign, the idea is that you inoculate people ahead of the availability of the new form of gambling. And so the idea there is that essentially you start your prevention program before the casinos become operational so then people are at least to some extent inoculated and informed what might be risky behaviors going into the casino and hopefully that will be a way to minimize the harms.

DEBI LAPLANTE: I would just build on that, I guess, by saying that one of the primary reasons that we don't know a whole lot about the adaptation process is that this work is so very new, and the amount of longitudinal studies that's available in the field is extremely limited in part because they are so financially prohibitive. I think that this, you know, might provide an overly optimistic perspective, and I would just be cautious, you know. Some people might think that interpret this both of our presentations to say well all you have to do is just wait and things will be fine. They will go back the way they were,

but I think that, you know, like Rachel said that it's important to address kind of the beginning end of that process and to push that along. Unfortunately, we don't know how long that process is going to be.

The Internet gambling slide that I showed, you know, suggested that that adaptation process started, you know, after seven days. The Missouri slide that I showed was over years. So it might be that, you know, we need to do a little bit more leg work here in Massachusetts to figure out exactly what's going to be happening over time. Every market is different.

RACHEL A. VOLBERG: I would just add to that that in addition to every market being different, many of the activities are quite different and appeal to different groups in the population. So for example, the feminization of problem gambling that I referred to early on in my remarks of the Australian Productivity Commission was so concerned about, that actually arose because the electronic gaming machines or these very sophisticated slot machines were legalized in a number of jurisdiction states in Australia and they

were legalized in a very sort of open door way so that essentially people who were going to social clubs, social clubs and sports clubs were allowed to have as many slot machines as they wanted in their venues. And what happened was social clubs in Australia are places where families go and people go to socialize, and suddenly there were all these very sophisticated slot machines, and they saw some very significant impacts, particularly in terms of women feeling comfortable in those venues and then starting to gamble on machines and then get in trouble with them.

CHAIRMAN CROSBY: A related question. From the anecdotal stories that Jodie and Scott told, it sounds like the degree of commitment of the casino operators to try to identify compulsive gamblers and control them vary tremendously. In some cases it sounds like they were targeting you and encouraging you. And in other places you went, Kansas and New York, it sounded like they were really committed to try to identify people and help you manage it.

I'm asking all of you, is that well known? Do we know pretty well what the tactics are

that the casinos can operate to minimize the abuse of gambling and the incidence of problem gambling or is that not known either? Are we missing the will or are we missing the knowledge to manage at the site?

RACHEL A. VOLBERG: I think that there is -- there is a small amount that's known, but there is far more that tends to sort of be, oh, well that's something that they did in, you know, in Missouri so or they did it in Iowa so we are going to do it in Missouri, and very similar to sort of how legalization happens. You know, one jurisdiction and then the neighboring jurisdiction, and then the neighboring jurisdiction, you know, feels that they need to introduce that form of gambling.

Policies like self exclusion programs really have taken on a life of their own in spite of the fact that there have only been 15 academic studies that have been done of the effectiveness of self exclusion. So there is all these jurisdictions now that have self exclusion policies but there is -- compared to the number of jurisdictions that have adopted it, the number of

jurisdictions that have evaluated it is tiny.

DEBI LAPLANTE: I would just add to that that one of the issues that we're facing as far as identifying people who have problems actually on the casino floor is that we have a hard time doing that even as researchers and as treatment providers. There are hundreds of different screens, you know, for pathological and problem gambling. The DSM itself has held one standard and now it's changing its standard. It's moving it from impulse control disorders over to addiction and related disorders.

So, if you're asking people, you know, who do this kind of full-time, you know as researchers, epidemiologists, treatment providers to do it, even they might not agree. So when you're asking someone who is on the casino floor and they are servicing slot machines or they are providing cocktails to be able to do the job of those professionals when the professionals can't even agree, I think it's a very difficult task.

CHAIRMAN CROSBY: Scott.

SCOTT SEELY: I would like to raise a point on the other end. When I got out of the

casino scene and got into recovery, one of the problems that arose was a tax issue with the Department of Revenue. I owed almost $20,000 in income tax because out of state they wouldn't take the Massachusetts tax, and whenever I hit a slot machine for $1,200 or more I got a W-2, you know. Well, yeah, I'll pay it off and when I bottomed out, that was faced to me. So I was making payments 400 and 500 a month, and I had a particular collector that was just ruthless. He wanted me to sign an agreement for a thousand dollars a month. I was in bankruptcy. My business was caput. I was struggling to pay my mortgage and he was just relentless. So I would go into the Pittsfield office to make a payment so I wouldn't miss the date. If I thought if I put it in the mail and it was late, he was going to take my driver's license and blah blah blah. So I got talking to a collector at the Pittsfield Department of Revenue office which you can probably get a lot of information from, and they said 40 to 45 percent of our cases are problem gamblers that we are trying to collect money from. That's huge. You know, that's huge. I don't know how accurate it

was but that's what I was told. So go to the Department of Revenue and ask them. I have since cleared that up though.

JODIE NEALLEY: I haven't. That's one of the many monkeys on my back. You said is there will or knowledge? I'm not an academic. I'd say it's a lack of will. There is knowledge out there. It may not be as much officially which is what I know most people have to respect, but I was an easy spot. You know, I was just easy. You just don't do what I did, and you just don't have a person show up out of the blue and say hey, would you like to spend the night and here's this beautiful suite. It's will. They want you there. They want to feed my ego. They want to feed our egos. They want money. It's a profit business and it costs one to five percent, I think that's what you said, one to five percent, lucky us. Feed an awful lot of that money into the casinos. So unscientifically speaking, I would say it's will.

COMMISSIONER MCHUGH: I want to follow-up on this discussion a little bit by asking really on what Jodie just said. What is the problem that we are trying to deal with? Are we

trying to deal with the identification or the correlation between gambling and addictive behavior or the way addictive behavior manifests itself, or if we have a singularity of addictive behaviors as was suggested in perhaps the forthcoming DSM, are we really looking for ways to check addictive behavior in different environments, the most effective way to check addictive behavior in different environments. It seems to me depending on how to identify the problem, the strategies for combatting it may be slightly different. They may be dramatically different. So I wonder what the essence of the issue is, particularly for regulators. For academics and for those who are trying to treat people, there may be a whole variety of different things, but for regulators what is the main problem or the issue we are looking at or the main issue?

DEBI LAPLANTE: I guess I would say that you can't ignore either. I think that you have to be looking for cues related to addiction and cues that are specific to gambling. The way that we understand addiction is that there are processes that are similar across a variety of different

expressions of addiction, and there are going to be markers that are going to be associated with those processes. But there are also going to be markers that are going to be more specific to gambling and gambling behavior.

I think that ignoring either side of that equation is going to, you know, pull the potential of misidentifying people in both directions, either as being having problems, you know, when a problem doesn't exist or not having a problem when one actually exists.

RACHEL A. VOLBERG: And I guess I would say from the point of view of the regulators, you know, there is a variety of tools that are available to you, you know, more probably than I realize because I'm not a regulator. I think the challenge that we face in terms of problem gambling is that we have had relatively little research done or, you know, investigation of what works in different environments.

You know, it's sort of conventional wisdom. It's widely accepted that Internet gambling is not only more pervasive than many other forms of gambling, but it also has the possibility

for being able to be more efficiently regulated in terms of, you know, if you're monitoring everybody's behavior at every single step of the way, your opportunities to intervene are that much greater. Whereas, if you're sort of looking at casino operators who are just dealing with massive numbers of people coming and going. Maybe they have got most of them on a loyalty program. There is a potential here in Massachusetts to be able to monitor the customer tracking data to see if there are measures that could be put in place. You know, as simple as sort of, you know, Jodie gets sent an e-mail or even a letter saying, you know, we noticed that you've been at the casino X number of times in the last three months and, you know, here's a coupon to go shopping instead of coming to the casino, or to do something that you enjoy because you signed up for the loyalty program and they know some of your preferences.

In the Netherlands, the casinos are all owned and operated by the Dutch government, but they have a very interesting program in place where because people have to show their identity card when they come in and it scans, so the Dutch

government, if you're a Dutch citizen, it knows exactly how many times you've visited any of the eight casinos that it operates, and if you visit a casino more than eight times, I think it's like a three-month period or whatever they've set, they actually have a program in place where someone will approach you when you sign in and say come have a cup of coffee. We'd like to talk to you about the fact that you have been to the casino too many times in this period of time. We would like you to cool off.

DEBI LAPLANTE: I think at the same time this afternoon you'll hear a little bit more about the need for kind of evidence-based regulation and policy making and you know, I think that people are, you know, have the best intentions and everyone is trying to kind of minimize the harmful impacts of gambling but, you know, some of the things that people come up with do need to be evaluated.

There is a potential for unintended consequences. For example, if you say that there is a certain amount that people are allowed to spend within a specific time or if they are allowed

to visit a certain number of times, people might think that that's a safe amount, and maybe they would only decide normally on their own to come once a month. But they say well, I can go up to eight times, and then maybe I will go eight times instead. I know if I go eight I'll be fine. If I go nine I'll be in trouble. So I think there needs to be some evaluation following some of these kind of well-intention proposals as well just to make sure that we're not incidentally provoking behaviors that we're trying to prevent.

RACHEL A. VOLBERG: I would absolutely endorse that, that you need evidence of what's working as well as evidence of what's not working in order to make decisions about what's good policy. So to the effect or to the extent that, you know, as policies are or as regulations are considered, you know, is there evidence base for that regulation or for that requirement on the licensing. I think it would be valuable to sort of look at the evidence base that exists for a given policy before you sort of, you know, oh they did it in Missouri and they did it in Iowa, and they did it in Indiana and they're doing it all over the

world. Therefore it must work. I wouldn't make that assumption.

KATHLEEN SCANLAN: May I ask a quick question about timing. We are into our break time a little bit. Do you want to keep asking questions and extend a little bit later in the day or shorten the break time or both?

CHAIRMAN CROSBY: We have been pretty flexible on the schedule since it's our TV show and it's our conference, I think the Commissioners think it's important enough we'll run over if we need to.

COMMISSIONER ZUNIGA: I had a question relative to something you mentioned, Rachel, which is this notion of inoculation. It's almost like a vaccine I guess prior to a casino becoming operational. Could you talk a little bit more about that, and I invite the panel of course. Also in the context of substitution that you've also talked about at other times, substituting perhaps an addiction on alcohol or let's say scratch tickets now with casinos going in. Anything you want to mention relative to what tools or processes or procedures maybe you've seen elsewhere relative

to this moment that we are in right now which is just about the proceedings.

RACHEL A. VOLBERG: I guess in terms of the inoculation issue, it seems like a sensible idea and I certainly agree that the idea that you sort of, you know, vaccinate people ahead of time. I mean we gave my daughter a typhoid vaccine before she went off to China, not because we thought she might need it but because the tropical medicine guy said well, she is in China so she has to have typhoid, okay. So it may not be that she ever is exposed to typhoid, but at least now we know she is protected.

I was sort of more thinking about an approach that's been taken in New Zealand where back in the early 1990's they had a very high rates of problem gambling, and they now have some of the lowest rates of problem gambling in the world. But part of that has been driven by an enormous amount of community engagement by a very significant investment in a public health approach to minimizing harm, and from a regulatory perspective they actually have implemented what's called a sinking lid approach where they passed a new law in

New Zealand in 2005, I believe, that mandated a huge number of measures by these social clubs because they also have them in New Zealand in terms of, you know, they had to have food and beverage and it couldn't just be like a little microwave and a coffee machine next to the five slot machines. They were trying to basically drive all of the marginal operators out of the market, and the data suggests quite clearly that is, in fact, what they did.

They also however, put an enormous investment into conducting this social marketing campaign which was basically about, you know, New Zealander's gamble in a healthy way, and it was directed at different communities in New Zealand. New Zealand is a very diverse country. They have an indigenous population. They have about 20 percent of their population is mainland Chinese who come over to learn English, but they have this sort of very comprehensive plan and they have -- they publish a strategic plan every three years for what they are going to do for prevention, for treatment and for research on the issue of problem gambling. So I think to the extent that we can

sort of think about this sort of as a planning process going forward, and learning from what's been done, that would be all to the good.

I'm not quite as confident about the question you asked about the substitution of addictions. I should think that some other people at the table might be better able to answer that. All of my work has been in gambling, and I have certainly seen, you know, people who switch from, you know, sports betting to betting on poker, when it becomes, you know, a faddish thing to do or when they think they have skills that they can transfer, but I wasn't quite sure if that's what you were asking about.

DEBI LAPLANTE: Can you repeat that part of the question again?

COMMISSIONER ZUNIGA: Well, I was more trying to find in the context of maybe there is a high risk population out there because we already know that they are addicted or they have been addicted to, you know, any number of things, that could be targeted for this notion of inoculation. I guess I was thinking rather than, you know, the public -- maybe approach is the wrong word --

targeting is what I'm kind of --

DEBI LAPLANTE: I think that that makes a lot of sense that there are different populations, different communities that are going to have more risk factors, more vulnerabilities, and it might make sense to kind of have a different or specialized approach in those communities. Now to my knowledge I don't know that anyone has ever evaluated anything like that prior to, you know the opening of new gaming opportunities. So whether speaking from a scientific perspective, I couldn't say whether or not that would be beneficial or not, but I think that it certainly makes sense.

You know, the addiction is kind of a recursive kind of problem. Each additional symptom that you gain, you know, with your primary addiction sets you up for additional risks for developing new problems, new mental health problems or new other expressions of addiction. So it's kind of this vicious circle and you know, historically people have really focused on the symptoms rather than treating the problem as a whole, and I think that, you know, anyone who has experienced a cold kind of can understand why that

couldn't work. You take some cough medicine and it might suppress your cough for a while but that doesn't mean that you're healed or that you're recovered. Your immune system is still battling and you're still at risk for developing other new infections. It's a similar kind of process here but at a social level.

COMMISSIONER CAMERON: I had a comment about this. Actually, interesting and not surprising I guess to hear about, you know, what we all just asked about which was the one addiction having maybe an addictive personality, you know, you're more at risk for this addiction.

I had an issue in New Jersey with some oversight from an enforcement standpoint. At one point we had over 200 troopers enforcing and regulating in the casinos in Atlantic City, and one of the things that I noticed was a higher level of risky behavior with those individuals. I mean I was on the phone with EAP lots of times moving troopers out of Atlantic City because of alcohol, prostitution, kind of getting involved with living the life. They worked in that environment every day. So I really saw it from that standpoint being

careful, protecting people, getting them the help that they needed, and that was just being around the -- they weren't allowed to gamble by the way. They were banned but the other behaviors seemed to be more prevalent.

DEBI LAPLANTE: That reminds me of some work we have done with casino employees, and we have actually found the casino employees themselves are at risk for a lot of those similar risk behaviors, alcohol, drug use, smoking and even gambling-related problems. That's definitely another population that is in need of some careful attention.

SCOTT SEELY: Are you familiar with slot machines on U.S. bases in other countries? The Council did a forum at a veteran center, and that was brought up and they provide, you know, because high risk, the high intensity of solders, it's a way to release, you know. Very susceptible.

RACHEL A. VOLBERG: Not many people know that the Department of Defense operates a network of 19,000 slot machines located in overseas bases.

COMMISSIONER CAMERON: Interesting.

RACHEL A. VOLBERG: That's a big

operation.

KATHLEEN SCANLAN: Anyone else on the Commission? Yes, I think Commissioner Stebbins?

COMMISSIONER STEBBINS: I want to go back and quickly address the inoculation piece which kind of came up at the end, and we talked about this situation more when counsel we had out in Western Massachusetts in terms of building capacity among the providers of treatment services. Is there, you know, as case workers and social workers, that whole professional level dealing with people with addictive personalities on other addictions. Is there a way to interject this kind of diagnosis or begin to assess somebody's ability to kind of fall into a gambling addiction before a casino opens, and then I have a follow up question.

KATHLEEN SCANLAN: I have some comments. The way that the Massachusetts Council has worked in trying to do that is we work through the Department of Public Health through the Bureau of Substance Abuse Services, and supposedly all of the substance abuse agencies have been trained or have had the opportunity for training to be able to identify and to recognize problem gamblers in their

case load, and then to be able to refer to the few gambling treatment programs if they are not feeling qualified to treat themselves.

One of the things that would have been a simple intervention that we hadn't been able to get through up to this point, and I'm an optimist too and I think it's going to happen some day and maybe the Commission will have some influence on this, but simply there would be screening in all the substance abuse agencies. It's such a simple, basic step and it hasn't materialized yet.

The other piece that we've looked at is we have worked with the substance abuse agencies for the Department of Public Health. There is a number of different state agencies. There is Department of Social Services. There is the Department of Transitional Assistance. There is the Department of Social Services where these issues all intersect, and again, we've talked with the Executive Office of Health and Human Services a number of times integrating those services into all of those agencies where they see people in vulnerable populations. I think those are all basic first steps that haven't really happened yet.

RACHEL A. VOLBERG: I think the only thing I would add to that is that they called the problem gambling a hidden addiction for a reason, it's hidden, and people don't like to talk about it. It really is very difficult to even get professionals who are trained sometimes to ask, you know, someone who is presenting for an alcohol problem, do you think you might have a problem with your gambling as well, but that is what's needed because, you know, only about three percent of people in the general population who have a serious gambling problem, I mean a diagnosable disorder, only about three percent of them ever actually access specialized services. So you've got 97 percent of them who are accessing health care providers for other reasons, but who are not being asked a question and may not want to answer the question that, you know, is some part of this problem related to your gambling. And if you can do that, at a minimum that builds that into the health care system in Massachusetts, I think it would be a game changer.

SCOTT SEELY: I brought that point up to my physician and he said there is, especially in

the elderly population, there is a big need for, you know, some attention. He sees it, but does it get addressed? No, but there is great opportunity to, you know, to present that, you know, integrate it.

KATHLEEN SCANLAN: And that it hasn't happened I think is not because there is any ill will any place. I mean I think people realize this, that whole system people talk about all the time with everybody is in their own silos. Funding goes to certain silos. It's just -- structurally it's a monster. It's hard to get to work together.

JODIE NEALLEY: I just want to say that I think and again, I am not an academic. I don't know the statistics. I am sort of living this disease versus studying it. I think compulsive gambling is where alcohol was 30 or 40 years ago. My dad when he didn't drink, he quit drinking in the sixties, and he was a banker. He went to all the parties, you know, like mad men. They had all those parties where everybody drank. He told me later he would just say, you know, you want a drink, no. Why not? It doesn't agree with me. He could never talk about it. Nowadays people could

say I don't drink. Either you don't want to or they assume you're a recovering alcoholic and good for you sometimes will come out. This is at that stage now, you know. People, generalizing, don't realize it's a problem, and you know, sure, you give scratch tickets in your kid's stocking. You give scratch tickets out at parties, you know. Oh, who's going to win. It's innocuous in the small term, but it's a part of the public awareness and you know, I think personally what needs to happen is a public awareness campaign that this is not a joke. That gambling is not a joke. It's a choice. We're not going to try to take it away from you guys, but isn't it all about balance?

You know, one of the things in my backpack is balance, and it's pretty nice when I can have it. It's a balance, and you guys, poor guys are, you know, given the task of trying to achieve that balance between public awareness which is going to take a lot of time. Look how long it took for people to put on their seatbelts. Years that campaign has gone on, so again it's probably a mixture of a lot of that.

KATHLEEN SCANLAN: Thanks to everyone

and should we take a break on that note and come back maybe how about 25 after three? Does that work?

(A break was taken at 3:14 p.m.)

KATHLEEN SCANLAN: Shall we gather again and get started. So without much more hesitation, let's begin our second session. Hopefully what we are going to be doing in this session is answering a lot of things that the Commission was asking about in the questions and period before. I am going to say again though, one of our feelings when we put this together was we are just going to be able to scratch the surface today, and I think you're seeing that we're really not able to answer everything or cover everything.

I had asked the panelists if they would try to think of what they weren't able to cover that they really wanted to cover when I told them they had ten to fifteen minutes. So if we have time at the end, I will ask people to tell us that as well, and maybe see some of the other places we need to go.

So we are very fortunate to have this afternoon Kevin Mullally, General Counsel and

Director of Government Affairs of Gaming Laboratories International. He's former Executive Director of the Missouri Gaming Commission. We have heard about Missouri a few times today so Kevin should be able to answer anything about those programs.

We also have Mark Vander Linden who is Executive Officer of the Office of Problem Gambling Treatment and Prevention in the Iowa Department of Public Health, and next to him is Christine Reilly, Senior Research Director at the National Center for Responsible Gaming, and Sarah Nelson, Assistant Director of Research at the Division on Addiction and Assistant Professor of Psychiatry at Harvard Medical School. Thanks to everybody for coming, and thanks especially for the folks who flew in and out for this project.

I want to say that Mark needs to leave by 4:25, so after he does his presentation, if you have questions of Mark, I will give you a chance to ask them at that point and let him respond so we don't lose his input to questions. So again Kevin you can start off.

KEVIN P. MULLALLY: Thank you. Good

afternoon Commissioners. I would be remiss if I didn't mention how fortunate you are to have Kathy and the rest of the Massachusetts Council staff. It is one of the most highly regarded councils in the country. I have dealt with them for close to -- I hate to say it but close to two decades now. So you are in very very capable hands as tested by the quality of the panelists that she has put together here today.

You have my bio. I won't go into any detail there. The only thing that I will mention is prior to my tenure at the Gaming Commission, I was Chief of Staff to the state senate majority leader. My career is deeply rooted in public policy. I started working for him when I was 18. I became Chief of Staff when I was 22 back when young people weren't really allowed that much in politics. So a lot of my presentation is going to be public policy based as opposed to the research based things that you have heard, but I am going to reference a lot of research because I do agree I'm a massive proponent of having research-based policy to the extent that that's possible.

I think there are times -- Howard

Shaffer and I always have this kind of back and forth argument. He said it's going to take ten years to study it. I said well, I can do a lot of stuff in ten years and help a lot of people. So sometimes you have to take some risks, but I think they should be informed risks, and hopefully that will come out in my presentation.

I am going to cover about six subjects. I'm going to try to be efficient. I'm going to go over the history of self exclusion. I'll give you my philosophy of what public policy objectives should be in just general regulatory decision making. I am kind of a public policy dork. I mean for entertainment I sit around and read public health care policy books. So you will see that my presentation will bleed over into a lot of just general regulatory topics or general regulatory philosophy in how you go about decision making. I'm talking about how sometimes these visions, these policy visions get morphed into other things that are less than what they are intended and how that can create implementation problems. And I'll talk a little bit about the research findings as they relate to self exclusion.

As was noted earlier, there have been some self exclusion studies done, not near enough, which I also sit on the board for the National Center for Responsible Gaming which is based here in Massachusetts, based here in Boston actually, and raises money for responsible gaming research. In fact, raises the vast majority of money for problem gambling research in this country.

And then I'm going to describe some key policy components based on those research findings that I believe should go into self exclusion programs, and then finally I'm going to wrap it up with some administrative considerations that I think often get lost in a lot of these programs. I think that sometimes, and I think Rachel referenced this as well, you know, I think sometimes regulators get caught up in what I call the grocery shopping list methodology for developing programatic elements. So they look around to see what other states do and they say we need a hot line, check. We need to train our counselors, check. We need a self exclusion program, check. And they pay less attention to not only administrative protocols, policies and procedures

and control mechanisms, you know. We put so much emphasis on the operators to follow their own internal controls that sometimes as regulators we don't do a very good job of that ourselves, and a big missing component in a lot of areas is follow-up. Having appropriate data collection mechanisms and performance measurement mechanisms so that you can actually see whether your regulatory policies are having the intended impact.

And so one of the things that I also wanted to congratulate you on is the fact that you're doing this ahead of time. It wasn't long ago that regulators felt like responsible gaming policy and responsible gaming issues in general were not a gaming regulatory topic. They felt like that should be punted to the mental health professionals. We are a regulatory law enforcement agency. We're not social workers, and frankly, when I got involved in this in the mid-nineties, very very few gaming commissions were involved in responsible gaming issues.

When I drafted the first self exclusion program in the United States, it was very controversial because they felt like we were

treading on water that was outside of our traditional mission. They felt like you should be paying attention to licensing factors. You should be paying attention to making sure that the casinos are operating within the parameters of the law. You should not be drifting into social issues here.

So I didn't really want to come to Boston without talking about baseball. I was told that if you wanted to ingratiate yourself to people in Massachusetts, you should satirize somebody from New York. So I relate this practice of regulators to what I call the Zek Bonura rule. If you're not familiar with Zek Bonura, he was a first baseman in 1930's of tremendous immobility, and yet he led the American League two times in fielding percentage because he understood the first rule of baseball that you cannot be charged with an error if you do not touch the ball, which is really how I saw regulators were looking at this subject. They felt like, okay, we are not going to get into involved in this controversial area. We are not going to get blamed for mistakes in this controversial area if we don't get involved in it at all. So I want to congratulate you for that and really some

tremendous opportunity here.

One of the things I didn't know and you ask questions of us. I didn't get a chance. It occurred to me during the question and answers, is there going to be responsible gaming money available before the casinos open? Okay, so you are going to have a funding mechanisms. So I will incorporate some things that you maybe can do with that money before the casinos open as part of this.

Self exclusion programs are really deeply rooted in very early U.S. casino lore. They actually existed in Las Vegas when it was totally unregulated in the Bugsy Siegel days. It was really when somebody was really having a problem. Well, the early self exclusion programs were kind of if you didn't pay your gambling debt, you got the hell beat out of you and run out of town. That wasn't really self exclusion but it was exclusion. But as casinos developed, there was this informal practice of people coming up and saying, you know, I really would prefer that you not serve me any more and casinos would honor that. There weren't any rules. They informed the security or whatever this guy shows up, escort him out, but it was

really the casinos themselves that started these programs.

It formerly emerged in Canada. I didn't really know this because I went around for about five years saying I came up with the idea and later learned about the Canadians that beat us to it. So I since had to correct that, so if you ever read a newspaper article that said I was the founder of self exclusion, you know it was before I knew the Canadians had done it.

We developed the first one in Missouri in mid 1990's, about 1995. It was really without the benefit of research, and we really came up with a bad idea at first, and then with the help of -- I think Kathy was involved in that and a number of clinicians and treatment people helped us refine it. It was really an extension. The original concept was an extension of our exclusion program. Almost every state -- I don't know if it's in your law or not, but most states have what they call an exclusion list or a black list. It's mainly for organized crime figures, gambling chiefs and things like that. People that the commission itself for law enforcement purposes will put on a list of

people that are not allowed in the casino. They do the whole post office, very unflattering picture thing and it's a publically available list.

We had a gambler who actually wrote us a letter and said -- and he was doctor. He said I've actually lost $100,000 in the last six months. I have tried to quit. I have been to GA. I've been to counseling and nothing seems to work. I have read about him. We put an organized crime figure on the banned list and he read about it in the newspaper. He said can you just put me on that list? And so I was the first lawyer for the Commission. The Executive Director came to me and said you're the policy guy. I want you to create a program and let's create a process for these people to go on a list. That's what we did. We are going to put him on the same list as everybody else. And there was like a very unexpected outpouring from the treatment and counseling community saying wait a minute. We know you're trying to do something good here, but by saying that I'm from the government. I'm here to help you, you're actually going to do more harm than good because rather than having the person admit that they have a problem

and accept personal responsibility for it and let's treat the underlying illness, you're really allowing them to push the responsibility for the problem off onto the government. They go and sign up on this list like getting a divorce. I'm no longer a problem gambler, the government is going to take care of it because they're going to stop.

They said one, you're not going to be able to do it and two, you're not treating the mental illness and I had decided they were right. So we revised the rules of the program and said, okay, let's do this. Let's create a program where it becomes a platform for the gambler to step forward, admit that I have a problem, agree to take personal responsibility for it, and have them accept the responsibility for staying out of the casino, and then we will provide them with tools to help them do that. We will stop the, you know, the invitations from the casino on your birthday and your anniversary or Christmas Eve to a free night. Sending you say hey, it's your birthday, come down. We will give you the presidential suite at the casino, or all the other triggers. We're going to stop the direct personalized marketing to them.

We're going to not allow you to cash checks in a casino any more, and we are not going to allow you in the player's club. So all the incentive-based things that the casino does, we can cut that off.

We are also going to provide some consequences to you in that we will not allow you, essentially you become an illegal gambler. You become like an underaged person. So, if you do happen to win a jackpot and we do happen to ID you, you're prohibited from collecting the winnings. So you can win small amounts when you're gambling anonymously, but if you do happen to be identified, anything over $1,200 you're not going to be able to win.

So it really goes to what is my philosophy of understanding public policy objectives. One of the things that I always used to do with my staff when they would come to me with this, you know, once you get staffed, the nice thing that you're going to have is about every other day some staff person is going to come running into your office and say, I've a great idea for a rule. And my first question was always what is your public policy objective? What risk are we

trying to mitigate or what public good are we trying to advance, and unless you can clearly and concisely answer those questions, it's probably a private business decision that should be left to the marketplace.

So really we wanted to clarify the objective of self exclusion, and the question that arises is, with self exclusion are we trying to use external factors to control the amount of gambling that individuals that sign up on this list? Are we trying to use an enforcement model and now that you're self excluded we are going to help to control your gambling, and with the goal of permanent abstinence so very, you know, enforcement-centered philosophy or is the objective good mental health. Are we going to try to treat the whole person and are we going to look at ways of not only abstinence which obviously is a goal for many people and is the right goal for many people, but with some it's harm reduction. It's trying to manage this thing, this problem that we are having, and all of that relates to the severity, the variations in severity that you have heard from all the speakers before.

So one of the things that happens with regulatory enforcement agency is it's so easy to turn to the enforcement tool. Commissioner, you may have seen this quote before. I'm sure you have heard of Mr. Maslow. There is a tendency for enforcement, regulatory enforcement. My dad was in law enforcement. He would tell me this. There is a tendency for regulatory enforcement agencies to quickly go to the enforcement tool because it's the easiest one to understand. We have rules. We should enforce them and arrest people.

This problem, I think, requires a broader -- I'm not saying we don't use enforcement because I think it's a critical component of self exclusion. There needs to be consequences, but it's not the only solution and it's not the only tool in our arsenal and I don't think we should use it as that. Rather than, you know, skew towards an enforcement model or embrace the real, the human desire to do something about a problem, I've got to do something. These people are suffering and the casinos may or may not be taking advantage of them but we need to do something about it. We need to have consequences that are meaningful, consequences

that are helpful, but we also need to be able to understand that we need to be able to treat the mental health condition, and that often recovery comes from within.

So in that essence, when we the government assumes the responsibility for the problem, we have not only created an impediment in my opinion to recovery, but it creates -- you're really setting yourself up for failure.

Trying to externally micro manage behavior has been shown time and time again in studies to fail. So one of the problems with micro management is people don't like it. It bothers them, and there is -- you're really -- in almost all cases you cast a broader net than you intended, so you end up micro managing people you didn't intend to micro manage.

A perfect example of this is the $500 loss limit. In Missouri for many, many years we had a $500 loss limit. The way this was really enforced was as a buying limit. So in order to gamble in Missouri you had to initially show your ID. You had to get a player's card. You had to be enrolled in the player's card, and whenever you

entered the casino, that player's card was swiped to activate it that you were on the casino floor. Whenever you went to buy in, for instance in a slot machine, you had to insert your player's card in order to insert currency. It would not accept currency without your player's card. Then it would keep track of how much you had bought in during that two-hour window. It was $500 every two hours really, and so if you went to a table game, you would hand your card to the dealer. They would swipe it and they would punch in your buy-in amount. Once you hit $500, you couldn't buy in any more.

Well, there's two factors. One, as you'll see in the studies 50 percent of the self excluded gamblers that attempted to access Missouri casinos were successful. So even with all those controls in place and even with, you know, Missouri is well known as one of the strictest, most well staffed enforcement states. We have an excellent state police in Missouri. They are highly trained in casino regulatory functions. There are officers on every casino floor at all times when gaming is being conducted, so even with that presence in

addition to the own casino security, 50 percent of the self excluded gamblers that wanted to gamble did.

Second of all, it was a rule that almost no one tried to violate. I asked the casino one time when it was being debated whether the $500 loss limit was a good thing or not to run a report for me that showed how many gamblers bought in for the full $500 in any given session. It came back, if my memory serves me correctly at three percent. So we spent massive amounts of money and human capital and enforcement policy that almost no one was even attempting to violate.

So the other problem that you assume is that when you do start to micro manage people, you assume responsibility for control. So when Brad makes a mistake in this cartoon, who do you think he is going to blame? Not himself, but the person who's micro managing the behavior, and that's what tends to happen when we don't set as our goal good mental health, and instead we try to micro manage. And so in this -- I love cartoons because it allows everybody's imagination to run with their own little ideas with the confines I have given you.

But in this picture, this person clearly still has an anger management problem. We just put a little glass bubble. So we have done nothing to treat the mental illness and that's the problem that haunts a lot of these control programs.

In Australia when they tried to put time limits on machines, what they found particularly with problem gamblers, so they would put like a two hour time limit and they would count it down. They would say okay, you only have five more minutes to gamble. What they found is with problem gamblers, as the time shortened and the bets increased, the acceleration, the frequency of the gambling accelerated. So they played faster for more money.

So if I'm down a thousand dollars and I only have five minutes, what am I going to do? Double the bet and play faster because I know I'm going to hit the big one. So when we try to manage behavior and we don't treat the underlying mental health issue, sometimes we make the problem worse.

So what I'm emphasizing is policies that strive towards treating the whole person and skewing towards good mental health. I am going to fly through these research findings because I know

I'm running short on time. I want to let Mark have his presentation and get to his plane.

I will have a handout that summarizes all these research findings. It's from the NCRG. That whole thing in on self exclusion, but it talks about the motivating factors for change. What motivates people to get into self exclusion and into treatment, and the demographics which I think you've already seen. We didn't benefit from seeing everybody's presentation so some of this is redundant any way. It emphasizes a public health model. It also shows the ineffectiveness of command and control strategies, and that there's actually more satisfaction with self exclusion than many forms of therapy, and that it results in much more high rates of positive outcomes with regards to relationships, self image, emotional health and the one really important thing is that the act of self excludeing itself, and this bleeds into the policy area, seems to be one of the most important aspects of self exclusion. The act of stepping forward and saying I have a problem. I am going to agree to take personal responsibility is a very very important concept and we should leverage that.

So critical design elements. When we start talking about self exclusion policy what should we do? An attention to detail during the application process is in my mind critical. Because we know that the act of self excluding is one of the seminal events, we need to take full advantage of it and make sure, and this is where a law enforcement policy comes to understand, and I take this from community-oriented policing.

Whenever you have clearly communicated expectations and responsibilities, no one should be upset when later they have consequences because of them. So when self excluders sign up, they need to be absolutely crystal clear that the responsibility to stay away from the casino is theirs. We're going to help them. We're going to give them some tools to help them, but it's their responsibility to stay away. Which means you need highly trained personnel that are administering this process, that are well trained, and that they explain all the treatment options. In fact, they should have the opportunity to see a counselor on site. When that has been afforded them and the one site that was done in Canada, 15 percent of the people took

advantage of the opportunity to see a counselor right when they signed up, as opposed to the three percent of the total gambler population. So people with identified gambling problems, only three percent of them take advantage of treatment versus 15 percent of the self excluders when they were offered that opportunity when they first signed up.

You should have protections for the gambler that I have already talked about where you block them from the marketing lists and give them those tools. There should be consequences should they choose not to engage. Should they choose not to fulfill their promise to stay away. Forms and recordkeeping are critical. There's some good examples of things out there, but you really need to pay close attention to data collection procedures so that you can do follow-up analysis to see whether it's done well.

You should be able to limit your liability, pay attention to little details like a lot of these people aren't going to have English as their first language so you should have interpreters on hand to make sure the language barriers are met. And then a reentry program which

is a new concept that has been introduced in Kansas. So that most of the programs now, which I think is a good idea are not lifetime bans. I think the research has shown that the minimum time period should be 18 months to two years because people that are in the program longer tend to do better, but you should allow people the option of getting out.

Most people just allow them to get out. Kansas has introduced this concept that before you get out you go through a day-long class of a self assessment and responsible behavior counseling, and we're finding that is very effective as well. I am going to skip this last part so we can go to Mark.

But one of the things the last slide is intended for is the Missouri program is I think sixth fold the largest in the country, and most of that is attributed to the fact that it was heavily heavily promoted. So education and outreach and a good marketing program are essential. Missouri, I think at last count had 17,000 people in the program. I think the next closest is somewhere around four. Thank you very much.

MARK VANDER LANDEN: All right. Good

afternoon. My name is Mark Vander Linden. As Kathy said, I am the Executive Officer of the Office of Problem Gambling Treatment and Prevention at the Iowa Department of Public Health. I really appreciate the opportunity to address you. You're taking the right steps to take a look at these issues early on, and it should be applauded, and I think that you will see the fruits of it.

My perspective is really two fold. From a state level in that I'm a sole state authority on problem gambling, treatment and prevention issues for the state. I oversee treatment, prevention, research, evaluation, marketing, workforce development, and so it allows me this sort of broad view of problem gambling and the different issues that need to be addressed.

On the national level I represent the Association of Problem Gambling Service Administrators as their Board President. So I'm able to see what's happening in other states, what's effective, what level of support is being provided and what that level of support being provided affords. I'm also on the Board of the National Center for Responsible Gaming and support

the work that they do.

I think it's important for you to know that I don't take a stance that is either for nor against gambling, like many here. I think that that, as I will point out in a few minutes, really allows me to work on developing much broader partnerships. Really our goal is two, is to mitigate the harms. That includes preventing whenever possible. Providing quality treatment and supporting persons that are in recovery from problem gambling, and at the same time recognizing that the gaming in the state, gaming across the country brings with it potential economic as well as entertainment benefits.

I'm going to cover three sort of general topics. One is partnerships. Two, I'm going to talk about kind of the continuum of care we have in Iowa and why that continuum of care is important, and third, I'm going to talk a little bit about our marketing strategy that we use in the State of Iowa, and what results that we've had over a sustained period.

First partnerships. Again, I have read the acts of establishing expanded gambling in the

Commonwealth. It's impressive. I have been following it over time as well, just watching the development of it. It seems incredibly thoughtful and it really does bridge this gap between how do we respond to problem gambling, compulsive gambling, however you want to term it, as well as allowing expanded gambling within Massachusetts.

Really I think that you have certain pieces of it that will place you at the forefront in the country. You will lead the path. I love the idea of onsite space for counseling services, employee training and problem gambling identification, your extensive efforts to deter under age gamblers, creating a subcommittee on addictions allowing for the Mass. Council and the Department of Public Health, creating a public health. All of these are amazing steps that you have taken, and I think will become kind of a new standard across the country.

You know, they are a great blue print and at the same time it's important to understand that its effectiveness will be judged by the relationships that are built, especially in terms of how the Commission, how the casinos that will

evolve relate with public, the Department of Public Health, the Massachusetts Council on Compulsive Gambling and other health and human service providers within the community.

I think that it's easy, and this is from my personal experience. It's easy for our treatment providers across the state to see gaming as some type of -- there is a tension between gaming and treatment prevention providers, seeing them as a barrier to their success and vice versa. Many of the casinos that we have worked with have expressed a similar feeling of it's difficult to get in a rhythm of a relationship with the treatment providers that are in their area, despite the fact that we have rules in Iowa as well that are intended to bring those two entities together in a partnership.

It's been a struggle, but at the same time I do really believe that that partnership is essential to the success of a casino within the community. Casinos within a community are dependent upon their reputation to be good stewards within the community, to extend themselves and make sure that they are addressing, they are doing

charity work, that they are addressing problem gambling, preventing problem gambling as it arises, and I think this is what needs to be held onto in these relationships.

Both parties, both are treatment prevention providers as well as the gaming industries including lotteries are reliant upon each other for their success. You know, really it's a win-win situation. It's a win for our treatment and prevention providers because they are going, to be quite honest that's where at least in part a lot of gamblers are.

When we take a look at our help line numbers, a vast majority of the people are citing the casinos as where they have been referred to the 1-800-BETSOFF number from, and that's powerful considering the extensive marketing campaign that we have. And for the casinos, it's an important partnership because we are out there providing treatment, serving individuals that have been hurt by their gambling behavior, providing treatment services, doing education that continues to allow casinos, lottery, any gaming option within the community to remain in a positive light, and I

think that I have seen that when our casinos come up every four years on referendum to see if they want to continue their license. There is an overwhelming support for the casinos, and I do credit in part our providers for expanding that reputation.

A couple of examples, I think these are somewhat anecdotal, but I think significant in highlighting some of the partnerships that have been held. I think that National Problem Gamble Awareness Week and National Responsive Gambling Awareness Week are two excellent examples of where the gaming industry as well as treatment prevention providers can come together to highlight what our risks and responsibilities of gambling and what help is available within the community.

Every year that we do this we see a bump in the number of calls that come into our help line. Partly because the casinos and the lotteries take that week and dedicate a certain portion of their funding or their marketing to highlight responsible gaming or problem gambling issues.

Another example, a few years ago we hosted a forum. It invited individuals of all

levels from the casinos. It invited our treatment prevention providers as well as our Iowa Gaming Commission, your counterparts, the Iowa Lottery to come together for a day to talk about problems in disordered gambling, as well as come up with what is an effective training curriculum look like for casino employees, and recognition that nobody is the ultimate authority, that we all are authorities in our own right, and that any type of effective training program really needs to take that into consideration.

The outcome of it was actually a vastly different training curriculum that is continued to be used today than what it was previously. The individuals that are on the gaming floor bring their experience of problem and pathological gambling and what face it shows at and how to respond as much as our treatment providers bring to the table for that. It was fascinating day with an ongoing and sustained result. You know, when we brought people to the same table, we found out that really there wasn't any sort of dividing line in the sand.

The issue of self exclusion came up and

had been a relatively hot topic in Iowa at the time whether or not we should move from a lifetime self exclusion to a limited ban self exclusion, and by and large there was no distinction between where a person from the gaming or casino industry were coming from as well as our treatment providers. It was truly a mixed bag.

Okay. So another example I think, and this is kind of on a more national level, the National Center for Responsible Gaming. They have a mission to help individuals and families affected by problem gambling disorders by supporting research on pathological need gambling, encouraging the application of research findings to improve prevention, diagnostic, intervention and treatment strategies, as well as advanced public education about gambling disorders and responsible gaming. This is funded and hold by the American Gambling Association.

An example of an excellent resource that is truly in partnership and by and large there isn't any other national funding streams for problem gambling research. They have taken the lead on that and continue to lead the way. I'm

glad to see that Massachusetts is considering research as one of its priorities with funding. It's needed, not just for Massachusetts but it's desperately needed for the country.

Okay. Next I want to talk about the continuum of services. The basis of an effective public health approach can be summed up by a popular motto with a substance abuse and mental health services administration, kind of a federal body. Prevention works. Treatment is effective and people recover. Prevention, treatment and recovery support, and this is by and large how we built our services in the State of Iowa.

Prevention first. It only makes sense. If we can help people avoid the problematic gambling behaviors that result in harm to themselves, their families and their communities, then we should do it absolutely. Let evidence guide these prevention strategies. SAMHSA has done an excellent job of developing prevention strategies that we've easily used in Iowa to provide prevention services.

The Massachusetts Council on Compulsive Gambling has a model program for the nation, and I

think that can only be expanded and enhanced as time comes. It includes kind of some of the following components.

One, develop a plan that provides basic public information to the general public. Two, employee education program of the risks and responsibilities for targeted and at risk groups. A side note to that, last fall the Department of Public Health, the office that I work in released a study of gambling behaviors and attitudes of adult Iowans. Much supported by what Marlene was saying earlier, the study found that 13 percent of adult Iowans, 16.6 males and 17.4 percent of -- I'm sorry. 17.4 percent of adults have experienced at least one problem gambling symptom during the last 12 months. That's one problem gambling symptom during the last twelve months.

These problem gambling symptoms can be anything from spending more than one intended during a gambling outing. It can be experiencing regret or shame about one's gambling or betting decisions. Admittedly not necessarily on a single occasion life changing. Probably these individuals are not going to seek out treatment but at the same

time definitely risky gambling behavior. Employing a public education program about the risks and responsibilities of gambling for at-risk groups is an essential component of a public education campaign. These are the targets. We absolutely want to target the one to five percent of compulsive gamblers, assure that they have the appropriate tools, that treatment is available, but we also have a large percentage of adults out there that can use some basic education about risks and responsibilities about gambling.

A third key component to this is helping key individuals including casino employees, including health care providers, including other human service professionals, understand compulsive gambling and able to identify problem gambling behavior. How does this happen? It happens in a number of different ways. It happens from a community or a grass roots level. It happens from the state level. It happens from a policy level, but regardless there needs to be steps put into place so that we can continue to inform these individuals, these key persons that encounter problems with pathological gamblers to equip them

with the information they need.

Support community activities to provide alternative forms of entertainment to gambling. We see higher rates of problems of pathological gambling when you see communities that have very limited forms of entertainment options to them. We have -- there is a large number, there are 20 casinos in the State of Iowa. I think that typically when you see a casino as a larger part of the entire picture of the community, you encounter more problems that are connected to that. When the casino is one form of entertainment and one form of entertainment option out of a whole menu of different entertainment options, you see a much healthier community. Part of that is common sense and part of that we have actually seen.

Fifth, create policies that assist problem gamblers and contain gambling as a form of entertainment. Look at these as policy issues. How can we continue to address problem gambling, promote responsible gambling at a policy level. Again, this happens at a number of different levels from the community, from a business level, a community level, a state level.

Okay, now going onto the continuum of care talking about treatment. Quality treatment for problem gamblers and the people in their lives. Emphasizing the people in their lives is an essential pillar to the continuum of care.

So conservatively roughly one percent of the persons from Massachusetts are compulsive gamblers. It may not seem like a large number, but it's thousands of individuals with lives that are devastated by gambling, and they need help right now.

The number of people that have been affected by the ripple effect of these problem gamblers, again referring back to a study that we did in Iowa last year, that was released last fall, 22 percent of all adult Iowans, 34 percent of those who had at least one problem gambling behavior said that they had been negatively affected by the gambler's behavior of a family member, friend or coworker. One percent, one to five percent affecting a much larger circle of individuals within the state. And again, I think that's support for the idea that yes, we need to provide quality successful treatment for the individual

problem gambler, but we also need to provide treatment access to the people that are in their lives that are also negatively affected.

Quality treatment means that it's provided by well trained, well qualified, compassionate people. It's accessible. It's affordable and it's convenient. If you take any of one of those out of there, I think that you will see a significant dip in the number of people who are accessing treatment. We have paid a lot of attention to that. It's got to be accessible. It's got to be affordable, and it's got to be right there for them in order for people to access treatment. As a result, we see a larger number of people accessing treatment in the State of Iowa than you do on a national level. We see a much higher number than the three percent. It's closer to five percent.

Okay. Effective treatment changes lives, and it actually has saved lives. Follow-up studies in Iowa have shown huge improvements in people's lives who access treatment. It is effective. It goes back to the saying treatment is effective. 86 percent of those who seek treatment in the State

of Iowa state that their gambling behavior is much less compared to when they entered treatment. Other significant findings show reduced debt, higher rates of employment, better overall social functioning. And when an individual's health improves, it improves the overall health of the community benefitting not just the individual, not just the community, but everybody that's involved with that including gaming.

Finally recovery support. Whether the treatment or other recovery paths, people recover and their efforts need to be supported. Gambler's Anonymous is a wonderful resource, but not the only way people seek recovery support. Other options need to be available, and those options need to be client driven, client selected and flexible.

This past year in Iowa we opened up a menu of services called recovery support services. It includes financial counseling. It includes rental assistance. It includes life coaching. It includes providing reimbursement for gym memberships. When an individual, you take away the primary form of entertainment for a person, you leave a big hole in their lives, and you can talk

so much about what are the other entertainment options but at a certain point it helps to have resources at your hands when you're providing services. It's a trial basis, but we have seen people take advantage of it. We continue to see the number of individuals accessing recovery support services go up.

Peer recovery coaching. These are individuals that may be in recovery, may not be in recovery but are there to help individuals in early recovery and sustained recovery on their journey, on their recovery journey. It's having incredible success within the substance abuse arena. Persons in recovery from substance abuse shows tremendous potential I think for persons recovering from problem and pathological gambling.

Okay. Just as there is no one path to recovery, there is also no one path to recover, there is no one path in recovery, and I think that's the essence of recovery support services. It's the essence of recognizing that we need to provide continued support for people in recovery. We don't want to see -- we recognize that relapse, that people will relapse and continue gambling, but

we also recognize that we want to provide as much support as we possibly can to them while they are in recovery. It makes good sense and it makes good financial sense.

Finally, I want to talk about marketing. I consider our marketing strategy kind of a cornerstone in our primary prevention efforts in the State of Iowa. For the last 25 years we have had a sustained marketing campaign, with a formula that includes providing information about how to access treatment, what are the signs and symptoms of problem gambling, and how it affects concerned persons. This has been consistent. It's been rolled out in different ways. It's been rolled out in probably 15 different ways over the last 25 years. We have rolled it out to all 99 counties in the State of Iowa in at least two different forms. It can be television. It can be broadcast television. It can be cable television, newspaper. We always try to have a billboard near a casino or as close to a casino as we possible can, but the results of it, again referring back to the study that we released last year, I think generally indicate that we have a state where its citizens

are better informed about problem gambling, can more easily talk about the issue, have wide backing of state-funded efforts to address problem gambling, and have broad awareness of how to access the services available. 90 percent of adult Iowans said that they are aware of the problem gambling help line, 1-800-BETSOFF, 90 percent. I don't know of another help line that has a broader awareness.

Two thirds of the adults said that they are extremely or moderately confident that they would recognize the signs that a family or family member has a gambling problem. 85 percent said it's important to provide public funding to make problem gambling treatment available. 91 percent support public funding for educating youth about the risks of gambling. 85 percent support public funding to inform adults about problem gambling and the problems that it can cause.

Not surprisingly, sustained and successful marketing campaigns aren't cheap. Just for your reference in the State of Iowa about four years ago we were spending roughly $1.1 million per year in the State of Iowa on this campaign. We have a quarter of that right now to continue that

campaign. It's significantly impacted our ability to reach the entire State of Iowa. We have adapted. We have adjusted, and at times we have used different forms of media to try to get the message out, but it impacts the number of people that are calling 1-800-BETSOFF.

I think if I have one final recommendation it would be see a marketing campaign as a form of primary prevention. Don't see it as an expendable cost when the budget becomes tighter. It really does make a difference in getting the information out about problem gambling.

Thank you. That basically covers it. I really appreciate your time. I do have to leave in about ten minutes and would love to take any questions if you have any. I will also leave my business cards in the back. If you have any questions, feel free to contact me that way.

CHAIRMAN CROSBY: Mark, what's the overall budget of your agency? You talked about the advertising budget. What's the whole?

MARK VANDER LINDEN: The overall budget coming in the fiscal year that starts this week, perhaps next Sunday will be $3.1 million.

CHAIRMAN CROSBY: Are there other sources or is that essentially the entire prevention and treatment budget for the state?

MARK VANDER LINDEN: It's the entire, it's the whole budget for all the services that I described, prevention services, treatment services. We do a small amount of research. We do evaluation. Our marketing campaign that is right at $220,000 this year workforce development.

CHAIRMAN CROSBY: How big is Iowa?

MARK VANDER LINDEN: We are three million people.

CHAIRMAN CROSBY: By the way, I grew up in Iowa City. Good country.

COMMISSIONER STEBBINS: The Chairman helped me answer my first question. My second question is, do you have a formal relationship with the regulatory body in Iowa?

MARK VANDER LINDEN: I think, and they may tell you differently, I have a great relationship with our regulatory body in Iowa. We have an advisory committee where we have representation from the Iowa Gaming Association, Iowa casinos, the Iowa Racing and Gaming Commission

and the Iowa Lottery, all of whom are fantastic supporters of the program and provide some valuable input and open doors. Actually when it came time to begin to host some of these trainings, to look at funding for regional conferences, all have stepped forward in really important ways.

COMMISSIONER STEBBINS: You said you're also responsible for research. Knowing that Massachusetts is starting at a baseline, two or three suggestions from you as the key research that we need to go out and collect as good baseline information to go back and look at in years three, four, five, ten, 15, 20.

MARK VANDER LANDEN: I found that the study that we released last fall has been invaluable to me. It's been really valuable as I talk about what does the picture of gambling look like in Iowa. Certainly prevalence is important, but you can get a general sense of what the prevalences, that there has been a number of studies done, but what are lower level forms of problem gambling behavior. Who are our at risk population? Why are people gambling? How are people gambling? What are the myths they believe

about gambling I think are all very important questions.

Again, I'll leave my card at the back and I can forward you a copy of the study that I'm referencing. This fall we're going to begin taking a look at doing a similar study, but looking specifically at college gambling. College gambling as well as decisions these students, these persons made during their adolescent years regarding gambling behaviors.

CHAIRMAN CROSBY: Thank you very much. That was great.

CHRISTINE REILLY: Good afternoon. Can you hear me? I want to thank the Commission for this opportunity to talk to you about challenges facing efforts to reduce gambling-related harms in the Commonwealth. I am Christine Reilly. I am Senior Research Director for the National Center for Responsible Gaming, the only national organization in the U.S. dedicated to funding peer-reviewed research and science-based education on gambling disorders and youth gambling.

The NCRG was founded in 1996 to fill the void in scientific research on gambling addiction.

Before the NCRG, the state of the research was partly because of the lack of funding was very low quality. In 1999 the National Academy of Sciences had a committee do a review, and they criticized the quality and credibility of the existing body of research, and recommended that future research be held to a higher standard.

For example, there was no consensus about rate of prevalence of the disorder. No treatment standard. No understanding of the neurobiology of gambling addiction, and the diagnostic code that was based not on empirical evidence but on the observations of clinicians who were treating problem gamblers. And since 12 to 15 percent, only 12 to 15 percent of people with gambling problems seek treatment, as you can tell if you just go by who is in treatment, you're not going to get a representative sense of the problem.

Many studies were plagued by poor research design, and in this vacuum arose a number of biased or advocacy-motivated studies conducted without regard to objective scientific standards. So from the beginning we have been committed to reversing this trend and establishing a foundation of

science-based research.

So we stepped in to fill this void by funneling the largest amount of money to the field and establishing a review structure that insures the highest quality of research. Since 1996, the commercial gaming industry has contributed 22 million dollars to NCRG. From day one we have modelled our grants program on the National Institutes of Health. First we wanted to insure that our funds were awarded to the highest quality research. Second, it allowed us to build a stringent firewall between the main source of NCRG funding, the gaming industry and the research. Third, using the NIH's policies and procedures sent a strong message to the scientific community that NCRG was committed to the highest quality of research. That enabled us to attract leading institutions to apply to us for funding including Harvard Medical School, Yale University, Johns Hopkins, CalTech, Mass. General, Washington University and many other outstanding institutions.

In practical terms, our grant-making process is shaped and monitored by a scientific advisory board, a group of leading independent

scientists in the field of addictions who volunteer their time to insure the integrity of NCRG-funded research. Proposals submitted to the NCRG are evaluated by independent peer reviewers who also have expertise in this area, and most of the time experience with NIH review panels. Their evaluations are guided by the NIH criteria for scientific merit, and are then reviewed by the scientific advisory board which makes the final decisions about grants awarded.

The most important part of this process is that neither the NCRG Board of Directors nor the donors have any influence over the grant-making process. In fact our grant agreement stipulates that NCRG is not allowed to see the final research findings until published in a peer-reviewed journal.

Publishing a refereed journal provides the final firewall. If NCRG was supporting low quality or biased research, our grantees would not be published in these journals, many of which are some of the most competitive publications in science. An additional stamp of approval comes in the form of NCRG grantees receiving subsequent

support from the NIH for studies piloted with NCRG funds. So thanks in part to the NCRG, the field has burgeoned over the past 16 years. In fact, a study from Harvard has noted that one third of all the gambling studies released during the past century were published between 1999 and 2003. The NCRG played a major factor in this growth by funding research that's produced more than 200 publications in peer-reviewed journals, many of them the highest impact journals in the field. NCRG research has been cited in peer-reviewed publications 11,000 times demonstrating the impact of our funding, and a number of our researchers have leveraged our money for millions in federal dollars to continue the research.

We are especially proud that NCRG funding has contributed to a number of firsts in the field and resulted in seminal work. We have funded the first reliable estimates of the prevalence of the disorder in the U.S. Harvard's estimate of approximately one percent of the adult population has been verified by independent studies such as the National Comorbidity Survey replication which is the landmark study of mental health in

America, and the review by the National Academy of Sciences.

We supported the first effort to frame gambling as a public health issue, the first study demonstrating the safety and efficacy of the drug Naltrexone in the treatment for gambling disorders, the first national study of college gambling including an analysis of school policies on gambling. The first study demonstrating that the neuro pathways in the brain that are activated by anticipating the hit of cocaine also lit up when anticipating winning money. This is the study at Mass General that Debi LaPlante referred to. This is important because it does suggest the shared neurobiology of different addictive disorders.

We funded some of the first studies demonstrating the role that genetics play in the development of the disorder, and finally, we also helped fund the first study of the health risks of casino employees. We believe it's important for the Commission to understand this background because many of the challenges you face in developing and implementing harm-reduction programs are rooted in the fact that this field is still

emerging and is currently where the study of alcoholism and drug abuse stood about 40 years ago.

So we offer the following recommendations based on our 16 years of experience with launching a field of scientific research and translating that research for use in practical applications.

First and foremost, it's important to distinguish between science and the gray literature. In this Internet age, the public access to health information has expanded dramatically which is a good thing. However, the sea of information presents a major challenge. How does the public distinguish between sound science and studies that lack scientific rigor. Because the field of gambling studies is young, there remains a great deal of what's called the gray literature, studies not published in peer-reviewed journals. While all research deserves a measure of scientific skepticism, unpublished research is particularly suspect.

I'm quoting from the editorial board for the Journal of Gambling Studies. Without any critical review of the scientific merit of a study,

unpublished research represents little more than opinion. Public policy must be driven by the best available peer-reviewed research. Otherwise, you risk developing policies and programs that may be ineffective or worse unsafe. Remember that even with the best of intentions, prevention and treatment, for example, can be effective, ineffective or even harmful.

Second, use a public health approach. We helped fund the thinking that went into this at the Division on Addictions at Harvard Medical School. They have enabled us, Doctors Corn and Shaffer have enabled us to understand gambling disorders within a public health framework, and here are some of the principles that you should keep in mind.

Developing policies on the basis of the highest quality peer-reviewed scientific research is the first and foremost principle in public health. It also requires a balanced approach that takes into consideration both the costs and benefits of gambling. The costs would be problem gambling, but the benefit might be senior citizens who go to casinos to spend their time and see their

friends and so on, but they don't have a problem, it's probably a benefit because it's giving them something to do.

Public health approach requires sensitivity to the needs of potentially vulnerable populations such as young people and some minorities, and it involves a proactive approach emphasizing prevention and harm reduction.

Third, we encourage you in your research funding to follow the NIH, and we hope that our experience in establishing the grants program can be a useful resource. State governments that support research often fail to use qualified, independent scientists to help develop RFP's and review applications for scientific merit. We encourage you to take advantage of the model of peer review established by the NIH, the federal agencies that are the premiere funders of science in the U.S.

Another essential aspects of the grant-making process is the importance of conflict of interest. We have adapted the stringent policies of the NIH that address not just real conflicts but the appearance of conflict as well.

Research investigators, your applicants, must be assured that the process of grant making is fair, objective and rigorous. Furthermore, preserving the confidentiality of information contained in proposals is also a vital concern to investigators.

So we encourage you to convey to grant applicants the importance of publishing their research findings in peer-reviewed journals in addition to any reporting that you ask them to do. Scientists have an ethical obligation to their own community and to the public to publish their findings. Research intended to help Massachusetts might also be applicable to the country at large and even have international applications. In this way your research program could make an important contribution to the science of gambling disorders.

For example, when Harvard Medical School evaluated the Iowa gambling treatment program, the investigators issued a report for the state government but then they went on to publish several aspects of the study in peer-reviewed journal.

Four, encourage science-based employee training. We agree that educating gaming employees is a priority of any responsible gaming program.

We believe that a science-based program constantly updated to reflect the latest research is the best approach to educating people about a misunderstood topic that is layered with outdated ideas.

The NCRG and the Division on Addictions at Cambridge Health Alliance collaborated to create EMERGE, the Executive Management and Employee Responsible Gaming Education Program. It reflects the latest thinking about addiction and gambling disorders, and also provides information and resources for employees who might be concerned about their own gambling. EMERGE is available to gaming operators as an online media-rich program available 24/7 or through an in-person train-the-trainer's workshop.

Five, in terms of responsible gaming, we recommend you take a look at the Reno model. When understanding what constitutes responsible gaming, it's important to look to science to guide our efforts. In 2004 the Journal of Gambling Studies published a paper providing a scientific framework and strategic agenda for community-based responsible gaming efforts.

Let me just mention a few of the

principles that might be especially relevant to your work. The key stakeholders in the field of gambling, that would include consumers, gaming industry operators, health care providers, community groups, government regulators and public health agencies should collaborate whenever possible. We have great models in Iowa and Missouri that can help you figure out what kind of collaboration you would like to foster. Any plan to reduce the incidence and prevalence of gambling related harms should be monitored and evaluated using scientific methods.

For example, we now have research indicating that self exclusion appears to be a safe and promising intervention. Research should continue to focus on developing and testing instruments that will permit more accurate referral, clinical evaluation and treatment matching.

I will stop here to mention we talked about encouraging alcohol and drug counselors to do more screening for gambling disorders because even though most of these people with gambling problems don't come for treatment, the finding is that they

do go to treatment for other things. So the brief biosocial gambling screen developed by Sarah, Debi and colleagues at Harvard is the three questions, and it's based on a study of 43,000 people, and those are the three questions they determined are most likely to identify a person with a problem. And so we took the three questions and put it in a little magnet and we mailed it nationally to a whole range of alcohol and drug counselors to remind them that it is important to screen for gambling disorders. We would be happy to do the same in Massachusetts. We did it for members of the Addiction Science Association, for the NADAP which is the National Association for Drug and Alcohol Providers and social workers.

So I think there are some creative things that we can do to get the word out, because I think alcohol and drug counselors are not familiar with gambling issues and probably feel very overwhelmed and we wanted to bridge that gap.

Now any responsible gaming program should rest on two fundamental principles. The ultimate decision to gamble resides with the individual and represents a choice. To properly make this

decision, individuals must have the opportunity to be informed consumers. Brochures explaining the odds and how slot machines work are examples of promoting informed decisions by customers.

Finally, unjustified intrusion is likely not the way to promote responsible gambling. For example, player reactions to time limits forced on their gaming session might increase excessive behaviors. Remember that the best intentioned interventions might be side swiped by the law of unintended consequences.

In closing, I want to extend to the Commission an invitation to use the science-based resources of the NCRG to help develop programs and policies. Part of our mission is to translate research into practical applications. A few examples of these resources include our workshops for clinicians, free webinars, brochures that help the public understand how to address gambling with their children, and a website dedicated to addressing gambling and gambling-related harms on college campuses.

Additionally, the NCRG staff responsible for the research program is based in Beverly,

Massachusetts, and is always available for consultations and assistance. Thank you again for this opportunity.

SARAH NELSON: Good afternoon or I should say good evening. I want to thank Chairman Crosby and members of the Commission for the invitation to be here today. I thank you all for taking the time to learn about these important issues.

I'm going to talk today about applying a public health approach to responsible gaming efforts and applying an empirically-driven scientific approach to evaluating those efforts. I will focus particularly on casino self exclusion programs, and some of the research we have actually done with Missouri on those programs. I'd like to begin with a few examples of harmonization techniques not taken directly from gambling.

First air bags. In the 1990's air bags became a mandatory safety device in most cars. These devices are effective and certainly save lives, but research has also shown that they can cause injury and even kill small children. Those research findings have led to specific recommendations and new safety standards for air

bags.

Another example, the U.S. has a minimum drinking age of 21 to protect youth from the harms of alcohol. Evidence suggests that this has steeply reduced drinking and driving fatalities among the young adults, but there is also some speculation that this limit might contribute to binge drinking and irresponsible behavior among young adults once they do start drinking.

Finally the campaign to reduce skin cancer. It's been hugely successful. The vast majority of the population is now aware of the risks of sun exposure, and many apply sun screen religiously, particularly to their children. However, it can be argued that an unanticipated consequence of that campaign has been an increasing incidence of Vitamin D deficiencies among the recent generation due in part to lack of sun exposure.

In all of these cases, regulations, interventions and safety devices which in most cases are very effective harmonization techniques, also have unanticipated consequences. Only through empirical research can we learn about the efficacy

and side effects of these techniques and improve them, and the same is true about gambling programs and responsible gambling interventions.

Researchers who study the impact of gambling on health and well being often focus on individual risk for addiction, but decisions about gambling expansion and regulation are based on debates and assumptions about costs and benefits to whole communities and impact on vulnerable groups. A public health approach to research examines the distributions and determinants of phenomena across populations. A public health approach to prevention and intervention uses that research to inform decisions about whom to target and how.

This figure adapted from Corn and Shaffer shows how gambling regulations and interventions can selectively target the different groups that we know exist. On the left side, primary prevention efforts such as health promotion and awareness efforts can target those who do not yet gamble. In the middle and also the largest section, secondary prevention efforts related to harm reduction and some forms of treatment can target healthy gamblers. Primary and secondary

prevention efforts can also have an effect on unhealthy gamblers, but tertiary prevention for these gamblers, in other words targeted treatment, involves these targeted intervention and treatment efforts directed specifically at people with gambling problems.

Research on the distribution of individuals within each of these groups, those targeted by primary, secondary and tertiary prevention, and people's natural progression in and out of these groups and in and out of problems can inform how much effort ought to be devoted to each of these categories in terms of our interventions.

It's important to note that techniques to make gambling safer cannot just be evaluated by their ability to reduce problem gambling. A public health approach recognizes the need to reduce problem gambling among vulnerable groups, but also recognizes the rights of individuals and the importance of not imposing unjustified restrictions on the majority of the gamblers who do not experience problems as a result of their gambling.

More shortly, and this quote is attributable to Dr. Norman Zinberg. "Bad laws punish many people

and deter few. Good laws punish few people and prevent many."

We use this public health approach as a framework in our work with casinos to develop responsible-gaming programs. The primary objective of a responsible-gaming framework is to prevent and reduce harm associated with gambling in general, and excessive gambling in particular while respecting the rights of individuals who safely engage in recreational gambling.

The principles of responsible-gambling programs ought to include the following: Commit to preventing and reducing gambling-related harms; work corroboratively with fellow key stakeholders; identify common short and long-term priorities; use scientific evidence to guide policy; and monitor the impact of installed policies.

Returning now to the examples I provided initially. A guiding principle of medical ethics is to do no harm. Most people think of this principle in terms of somatic medicine. For example, doctors often only offer untested treatments to people who are in extremely poor health and out of conventional treatment options,

but in behavioral health many treatment systems offer patients well intentioned but untested treatment plans. Unfortunately, untested treatments for both somatic and behavioral health can pose significant individual and public health concerns.

Once a public health approach is adopted, a scientific approach is necessary to insure that policies, interventions or treatments are accomplishing what they seek to accomplish. Specific to gambling, interventions, whatever their intentions, can decrease gambling-related problems, can increase gambling-related problems, can have no effect on gambling-related problems at all, can influence problems indirectly through other factors and can have unanticipated consequences.

Currently how policymakers understand gambling and disordered gambling determines the policies they develop, and often this understanding rests upon public and private opinions, media sensationalism and perceived threats to public welfare. Insufficient resources and infrastructure often prevent follow-up examination of the impact of policies and interventions. Consequently, the

efficacy of these policies and interventions remains unknown. Gambling policies would benefit if the policy-making process were science based. We need science to tell us whether policies and interventions do what we think they do. Good intentions do not always insure good outcomes.

Specific to gambling interventions, I have a couple of examples of possibilities of intended and unintended consequences of harm minimization strategies. Some of these are adapted from a paper by Bernhardt and Preston, and Kevin mentioned I think one of these as well.

The first is maximum bet limit. This is on slot machine play. In other words, only allow patrons to wager a certain amount. The anticipated consequence would be less expenditure per turn, less money lost. A potential unanticipated consequence would be longer play to make up for the smaller limits. Slowing the real speed on slot machines has been done. The anticipated consequence is that play will be slowed making gambling less problematic. The potential unanticipated consequence is that people will start playing multiple machines to make up for the slow

speeds.

An entry fee for casinos. This is actually done in Singapore. Residents have to pay a certain amount upfront simply to get into the casino. The anticipated consequence would be to deter frequent visits to the casino by residents. The potential unanticipated consequence will be you deter healthy gamblers, and those with gambling problems still gamble and end up spending more.

And finally screening for self excluders. I don't know if this is in practice anywhere, but I know it was discussed that you require people who are signing up for a self exclusion program to go through some kind of screening or counseling when they sign up. The purpose is to facilitate entry into treatment. The unanticipated consequences that you might deter people with problems who would otherwise use the self exclusion program if they didn't have to jump through extra hoops.

None of these examples are meant to imply that these are bad policies. More that we might not fully understand their effects if we don't study them and study them at length. Of the studies that

have been done evaluating gambling interventions and policies, most are cross sectional meaning they take information at one point in time and they are based on gambler's opinions about how harmonization techniques have affected them. Ideally research on gambling policy and interventions needs to be prospective. You want to follow a sample before and after a technique's implementation. Otherwise, we won't be able to tease apart cause and effect.

This figure here shows the steps needed to evaluate and improve responsible gambling programs. The first step obviously is to develop and then implement the program. The next is to develop an outcome-monitoring system, and the next step is to assess the penetration and impact of the program among both patrons and employees, analyze the outcomes and then recommend and implement changes according to the research findings. This is not a point-in-time evaluation, but a continuous monitoring of the program and its effects across time.

As Kevin has mentioned, compared to policy, research proceeds at about the pace of a directionally challenged snail, but it's crucial to

set up the monitoring system in advance and the ability to assess these outcomes so that you can evaluate the program once research does catch up with policy.

So I want to change gears quickly and just share with you a little bit of information about our research on casino self exclusion programs which can be one key component of a responsible gambling program devoted to assisting those with gambling problems. I'm not going to go over the history too much since Kevin touched on it.

The first gambling self exclusion program was in 1989 in Canada, and Missouri had the first statewide self exclusion program here in the states in '94. In a self exclusion program individuals enter into an agreement with the casino banning them from entering the casino for a specified period. Some programs are state, province or company wide. Others are restricted to a single casino. Some programs allow people to ban themselves only for life. Others for a few years. Some casinos enforce that ban with legal actions. Others simply escort self excluders out of the casino, and some policies include forfeiture of

winnings, although you don't get your losses back.

So at the Division we conducted a study of participants in Missouri's statewide self exclusion program who enrolled between 1997 and 2003. This is some of the research that Kevin referenced. This is one of the first studies to assess long-term self exclusion experiences and outcomes. Missouri's self exclusion program was created by the Missouri Gaming Commission in 1996. Applicants to the program add themselves to something called the List of Disassociated Persons, and at the time it was for life, although that has changed, and each enrollee assumes responsibility for remaining off casino property. If an enrolled person returns to a casino, he or she can be arrested and charged with trespassing.

Our study included two phases. In the first we examined the distribution of self excluders across space and time. This figure shows the distribution across time. In Missouri enrollments increased across time and then leveled off demonstrating a potential exposure and adaptation effect, and this is part of what Dr. LaPlante spoke about earlier.

This figure shows the distribution across space. The casinos, you can see they are marked by small yellow dots, and as you can see self excluders are clustered around casinos. This could indicate the people who lived closer to the casinos are more likely to experience problems although other explanations are possible.

In the second phase of the study we conducted interviews with self excluders seven to ten years after they enrolled in the program. Again, it's important to note that the program involved a lifetime ban at the time. More than 5,000 people enrolled during that time, and we randomly targeted 419 of those self excluders for interviews. Only 169 of those 419 had working phone numbers on the list we got, and we completed interviews with 113 of those 169.

Participants were 45 percent male, average age of 45 at enrollment, 81 percent Caucasian. Prior to entering the self exclusion program, 109 participants gambled at Missouri casinos, basically 96 percent. I guess the other four percent signed up proactively. After enrollment when we did our follow-up, only nine

reported that they had gambled in Missouri casinos after that enrollment, and importantly the proportion visiting out-of-state casinos did not increase.

28 or 25 percent reported that at the time that they enrolled, they quit all gambling. 18 percent quit casino gambling and 58 percent did not quit gambling. About half of those who quit did report returning to gambling at some time within those seven to ten years after they enrolled. However, they all reported gambling less than before.

Participants also importantly reported fewer gambling problems in the past six months than prior to self exclusion. Enrollment, that's among both people who were abstinent and those who were not.

In terms of enforcement, 18 percent or 18 participants or 16 percent attempted to enter Missouri casinos after enrolling. One reported close to 400 attempted entries. The other 17 tried to enter an average of 4.7 times. About 50 percent entered at some point without being caught, and 56 percent were caught at least once. One was fined. One was arrested. Seven reported

experiencing no consequences other than being asked to leave, and one received a citation and had to take a class.

When we ask respondents about their satisfaction with the program, 68 percent reported being fully satisfied with the self exclusion program in Missouri. Some of the 32 percent who were dissatisfied provided reasons. The primary reasons was the permanence of the ban. Other reasons were that the program was not explained adequately upon signup. They thought staff implementing the program was rude. Program made gambling worse. Still easy to get into casinos, and able to go to other states. Those last four only a couple of people per reason.

On this graph all you have to focus on is that second line that's highlighted, so don't worry about looking at all of it. More than 50 percent of participants reported receiving some form of mental health treatment at some point, and close to 40 percent indicated receiving gambling specific treatment. As the figure shows, gambling treatment was the most frequent received specific treatment among participants, and Gambler's Anonymous was the

most popular gambling treatment among those. Importantly this gambling treatment was more likely to occur after self exclusion than before it. This suggests that self exclusion might be serving as a sort of gateway for treatment entry.

Specific conclusions about self exclusion programs. They do appear to have promise. Our study and the other studies that have been done do find outcomes in terms of reducing gambling problems, reducing gambling behavior. Their effectiveness may be due to their providing a straightforward, first step for at-risk gamblers to begin to address their problems. So again, the very active enrolling may be the strongest part of the intervention. It's a way to start having awareness of the problem and potentially seeking treatment beyond that. We really need more longitudinal and perspective research to determine long-term outcomes.

Areas of improvement. If, and I highlight the if here, if enforcement is a priority more stringent measures are needed to identify and prevent self excluders from entering casinos. Obtain better contact information and maintain

better records of enrollees to facilitate research, and increase program enforcement and communication with enrollees.

When we did our study, the list we received and were able to work with, only about half of those people still had those same phone numbers, same contact information. It hadn't been updated since they enrolled, even though it was a lifetime ban. So for purposes of enforcement, and also research and monitoring your program, keeping that contact information up to date is important.

And finally, thinking about the length of the self exclusion ban and trying to couch that within the most recent research and empirical work is important in terms of self exclusion satisfaction, and just keeping abreast of the empirical evidence in terms of what works best.

More generally, self exclusion and other responsible gambling resources are only helpful if people can access them easily. One of my colleagues goes around the world and studies different self exclusion programs. He said he heard about one. Everything he heard about it was absolutely perfect. They did everything right.

They had all the right tools, and finally he thought to ask how many people have signed up. Zero. So unless there is some kind of getting the message out and bringing people into that program, you can have all the tools in the world and it's not going to work.

So responsible gambling programs and policies may work best if they are framed as a set of tools available to individuals experiencing problems. In terms of self exclusion, it really seems that getting rid of as many barriers as possible is the most important thing. You don't want to make people jump through hoops in order to take this first step. It's a first step to start to recognize the problem, and then you want to offer as many resources as possible in terms of treatment and programs so that people can access those when they are ready. It's important to increase the visibility of these programs and remove any barriers, and finally I didn't talk about this aspect of our research, but within a venue, all employees, not just floor staff, need to be trained in the principles and practices of these programs. A lot of the work at the Division that

we've done has also been around employee training programs, and really changing the culture within a casino so that more and more people are aware of this issue.

Kathy asked me to mention the other things that we could talk about given unlimited time. So again, we have done work at the Division on casino employee training programs, responsible gambling programs, and gambling behaviors and problems among casino employees. These are just some additional resources. Thank you.

KATHLEEN SCANLAN: Well, we are about half an hour behind time so are you willing to do some questions or are you done?

CHAIRMAN CROSBY: I think we are close to done but we have questions.

COMMISSIONER STEBBINS: I have one question on self exclusion. I mean a lot of the success goes to how the program is set up. We've heard stories of one casino where you could go and sign up for self exclusion but you actually had to walk through the gaming floor to get to where the self exclusion signup was, so it seemed to defeat the purpose. Are there any best practice

suggestions for self exclusion program? I mean on-line, in person? I mean what would be the best tact?

KEVIN MULLALLY: I think on-line would be difficult but my suggestion would be to look at it like you would a retail service, and that is to provide as many different opportunities for access as possible. I do think that a live person needs to be there. I think it's also helpful and I think research supports this, that to offer them, not make it mandatory mind you, but have the availability of counseling on site at the time that you sign up I think is a good feature. But for some people, the casino is the appropriate place to have the ability to sign up so I don't think that I would discard that on its face. I understand the criticisms. If that's the only way to access it, I can see where that would deter some people. On the other hand, I think some people, they might hit rock bottom then. That might be the only opportunity you get to have them take advantage of that and the big thing is to have well-educated people administering it so it's an informed choice. And I can't agree more with Debi that -- with Sarah

I mean that everyone at the venue, both Gaming Commission staff so just because you're an auditor or just because you're an administrative person that happens to be located in the facility doesn't mean you don't need to be educated about the programs and offerings that are available, and the same thing goes for the casino personnel.

SARAH NELSON: I think you also need to recognize that self exclusion is not treatment in itself. So it's the first step for recognizing problems. So again, all the resources that you can throw at them to make it available to people who do take that first step. Research shows that at least 15 percent of those folks will take advantage of on-site counseling, will take advantage of other possibilities and possible ways to enter into treatment.

KEVIN MULLALLY: The nice thing about the limited research that's been done, not to sound like the A-Team, but I like it when a plan comes together. The original purpose, even though there was no research available at the time, was to have a platform for somebody to step forward and acknowledge they have a problem and take personal

responsibility for it and have it serve as a pipeline to treatment, have it serve as a way to funnel people into the treatment program, and the early research indicates that those things are true. So again, I couldn't be a bigger fan to what Sarah said that you should have researched-base policy. Sometimes you have to make some educated guesses too.

COMMISSIONER MCHUGH: We have heard an awful lot of very helpful information about the research-based strategies for helping people help themselves with these addictions, but in Jodie and Scott's stories this morning, there was also a piece of the casino behavior that built on problems that people were having, and we haven't had much talk about that today as a way of incentivizing casino employees to look for and help people deal with the problems that are manifest during the course of their gaming experiences. As you said consequences are helpful.

Are there any models that the Commission can look at to help the casino-training programs have the bite that they need to have in order to be effective? Civil liability is a blunt instrument,

but we have a very active in Massachusetts and across the country civil liability program for bars that over serve people, and if somebody is helped to drive a casino, I mean to drive a slot machine into the family fortune, civil liability for that might be an incentivizing mechanism for helping people detect the problems earlier. I wonder if you have any thoughts on that.

KEVIN P. MULLALLY: It was touched on earlier, and I think it's important to recognize how this product and like many addictive things that people get addicted to affect different people differently. I mean casino gambling is an entertainment experience, and part of what makes it entertaining is they sell it as something that's fun where you can lose your inhibitions and you know, can make you feel good about yourself. For most of the population that does not have negative consequences. They are able to enjoy it as an entertainment option, just like the beer industry tries to sell Budweiser. You're out with friends. You all have the perfect bodies and a six pack and women love you and life is wonderful, and for most people that's what drinking a Budweiser is, but for

some you can't drink a Budweiser. You've got to drink 20 of them. So there's that aspect of it.

You know, you start saying okay, you shouldn't offer them free hotel rooms. Well, that's part of what makes it entertaining for most people. That's part of what they like about it. So the problem I have with starting to train casino personnel. You had two experts up here saying sometimes we don't know. Clinicians don't know, you know. Part of the problem is what we found out when we started adding gambling screens to alcohol and drug abuse people, is that we have been treating them for alcohol problems for years, and what we didn't realize is the underlying problem was a gambling problem. They became an alcoholic to anesthetize themselves for a gambling problem. Once we found out about the gambling and treated them for the gambling, the alcohol went away.

So you're dealing with in many instances many different mental health issues coming together. There is high percentages of comorbidity. Even with the people that were up here today, they said they have more than one addiction here. So we have many things to treat.

It gets really complicated. It's like going into a hospital and saying a cafeteria worker needs to diagnose somebody for medical issues. It's really difficult. I'll let the people that study this for a living problem give a more articulate answer than I did, but from a public policy standpoint that's what would scare me.

CHRISTINE REILLY: I remind you of what Dr. LaPlante said earlier about the difficulty of identifying someone with a problem, and here is the other side of it. In our training program, we try to equip, to make them aware of the issues and try to equip them in case somebody asks for help. But we don't encourage people to just approach somebody who looks like they are having a problem. The reason for that is one, it's almost impossible. You can't tell by looking at somebody if they have a problem, and two, what if the person doesn't have a problem. You obviously are upsetting a customer. And three, what if they don't have a problem but they are the worried well who tend to hear about a disease and assume they have it. There are a lot of people like that, and then four, if you do approach someone who has a problem, I mean being

found out could create a crisis for that person, and is the gaming employee really the best person to be relating to that person at that point in time. So we tend to err on the side of caution. I don't know, do you want to add to that?

SARAH NELSON: I wouldn't disagree with anything Chris just said, but I think we are moving toward a time where we can do a better job of at least predicting who might run into problems. So Internet gambling research, because you can monitor every single key stroke and every single behavior is moving to a point where you can at least look at somebody and give them a message, hey, your behavior looks like that of about 50 percent of people who go on to develop problems, and I would argue that it's very very important how you phrase that message because we are nowhere near having the kind of predictive accuracy where you can identify somebody and say you have a problem for all the reasons Chris mentioned, but we can provide more and more tools and they can be more and more targeted as we learn more. So we can target anybody who is slightly at risk and just have a simpler message that says hey, here is some

resources in case you run into any issues.

You can target somebody who you even know more clearer is likely to have a gambling problem with a more forceful message. That's within the realm of Internet gambling where we have a lot more data at our fingertips. You can think about it in terms of if you have player cards and slot machines moving in that direction potentially.

CHAIRMAN CROSBY: Chris, what's the size of the NCRG budget? How much money do you fund?

CHRISTINE REILLY: A little bit over a million a year. Most of the money goes for research but a portion of it does go to educational activities.

CHAIRMAN CROSBY: Do you have to re raise it every year or does everybody --

CHRISTINE REILLY: We get long-term commitments from companies and that seems to give us stability. Right now they are at the end of their five years and we are now going to companies and getting three to five-year pledges for the future.

CHAIRMAN CROSBY: All right. Your 17,000 people on that list sounds like a material

percentage of problem gamblers. That's five percent of 3.4 million, so what is the market? It sounds like you've really got a strategy that identifies really a substantial portion of the problem.

KEVIN P. MULLALLY: It's interesting because the markets because of St. Louis and Kansas City, obviously the two largest metropolitan areas, the St. Louis metro area is about four million people and Kansas City is about 2.1 maybe. So the population of the state isn't really reflective of the market size. And then you go down to the boot hill of Missouri and you're also going into Illinois, Arkansas and Tennessee. In the northern regions you're going into Iowa and Illinois. So the market size is much more significant than the state population, but you're right. Now you have got to remember that's 17,000 people since 1995, and if you followed Debi's bell curve, it has dropped. The public health model couldn't be better represented by the Missouri self exclusion numbers. It definitely is a lot of data that shows adaptation. The public has adapted over time. We hit 15,000 before I -- we were near 14,000 before I

left, and I left as executive director in 2006. So in the last six years they have only added about 3,000 people so it went like this and then.

CHAIRMAN CROSBY: Anybody else? I think we are about done. Are you finished Kathy?

KATHLEEN SCANLAN: I'm finished unless anybody from this panel or this morning's panel wants to just say anything else that we needed to cover today that we didn't get to cover. Just quickly, one or two words. Okay Chris?

KEVIN P. MULLALLY: Commissioner Stebbins, I think, asked about formal relationships between the Council and the Commission. I couldn't encourage you more to form what I call an alliance of stakeholders where you have the Council, the Commission, the industry association. I assume you will have some type of state association. The Department of Mental Health, a representative from the education community so you can reach out to young people, the corrections department so you can develop programs in your prisons.

I can give you a list of some common stakeholders, but those programs have been very effective. I think we had the first one in

Missouri. Kansas has done one. Maryland has done one. Arizona has done one. I think Iowa has them. It allows you to send one coherent message.

Everybody uses their own budgets and you have a set of bylaws, but no one can make you spend your own money. The lottery is the other one that's in there. Everybody uses their own resources, but it's a coordinated effort so you have one voice one message and things don't get confusing.

CHAIRMAN CROSBY: That list will be really helpful. That's great. I just want to thank Kathy Scanlan. I want to thank Wayne Burton and Cathy Anderson still here. The North Shore Community College, thank you all for coming. Thank you for our panelists second and first. Each time we have one of these, this is our fourth educational forum, I think we walk away swamped by thinking oh my God, what a lot of work we have to do, but this was a great session, troubling provocative, interesting and we will look forward to picking up the ball from your hand off and going to work. So thank you all very much for coming.

We did set up a Commission meeting

that we could have right afterwards as a formal public meeting to talk about this, and I think we need to decide amongst ourselves whether do we want to do that? I think after the community mitigation meeting we really had a feeling there was some immediate stuff we wanted to talk about. What's the consensus?

COMMISSIONER MCHUGH: I think we need to talk about it, but I'm not sure we need to talk about it right now.

CHAIRMAN CROSBY: All in favor? Okay, I think we are going to forego. I think we are getting tired. Thank you all very much. It was a really great event.

(Adjourned at 5:17 p.m.)

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