Final Report
A qualitative study of programs for problem gambling in the correctional population using interviews with experts in the field.

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Any good idea attributed to our expert is from their knowledge and experience; any errors should be attributed to the authors of this project.

Abstract

Criminal behaviour is one of the more troubling issues associated with problem gambling. Over the past 5 years we have been conducting research on gambling at numerous correctional institutions throughout Ontario. Our results suggest that prevalence rates of problem gambling in the adult offender population are 5 to 10 times higher than those found in the general population. The majority of offenders who report pathological gambling also report that their criminal histories and gambling pathologies are linked (65%). In our previous research, we found that more than half of those who gambled problematically before incarceration continue to do so while incarcerated. An examination of offender files suggests that most offenders with gambling problems are not identified by the correctional system as having a gambling problem and do not receive any specific intervention for the disorder. The plan of this study was to determine what efforts have been directed at this population in Ontario and around the world to deal with gambling problems. The study consisted of two major components. The first component was a review of published literature on addressing problem gambling within correctional populations. The second component was a series of interviews with experts in the field who have: (1) carried out interventions for problem gamblers in the correctional population, (2) have been involved with problem gambling treatment, (3) are familiar with programming for corrections populations, or (4) work in a policy or decision making capacity related to the correctional system. The goals of this study were first to discover what programs have been tried in the past and, second, to determine what programs are feasible for this population.

In this project we attempted to describe the situation as it currently exists in Ontario and in other jurisdictions with respect to treatment for problem gambling for offenders. The published literature on dealing with problem gambling in correctional populations is remarkably small. However, we uncovered a small number of programs that are administered by specific treatment agencies for particular settings. There is no system wide service currently available. There is a clear need for programming for this population and an apparent desire for programming among the population. On the other hand the participants are most likely to respond positively to a voluntary program than a mandatory program. Also, there are some good reasons why the program should be carried out by an outside agency. In particular because of stigma and confidentiality issues, an outside agency would be in a better position to offer services that are accepted by the offenders. Institutions have generally been very supportive of efforts for this population but there are still barriers to programming include difficulty dealing with institutional movement issues (lock downs, security, problems obtaining with temporary absences). Another issue is the lack of awareness of the issue of problem gambling in the criminal justice system including judges, lawyers, wardens, corrections workers, and parole officers.

Keywords: problem gambling, offenders, treatment, criminal behaviour, qualitative research

Rationale & Literature Review

One of the most troubling aspects of problem gambling is the link between excessive gambling and crime. In the general population the prevalence of pathological gambling in Canada is roughly 1% with an additional 2% to 3% having subclinical gambling problems (e.g., Cox, Yu, Afifi, & Ladouceur, 2005; Ferris and Wynne 2001; Park, et al., 2010; Room et al. 1999; Rush, Bassani, Urbanoski & Castel, 2008; Shaffer et al. 1999; Wiebe et al. 2001, 2006). Though problem gamblers are more likely to be male (Rush et al., 2008), some research indicates that males and females are equally likely to develop a problem with electronic gambling machines (Abbott & McKenna, 2005; Urbanoski & Rush, 2006).

With respect to offenders, Williams, Royston, and Hagen (2005) completed a review of studies examining gambling and problem gambling within forensic populations and found that the prevalence for both males and females ranged from 17% to 60%, with an average of around 33% across the samples (Williams et al., 2005). Williams et al., (2005) point out that prevalence rates found in correctional samples are the highest of any population studied to-date. Our recent studies (Turner, et al., 2007, 2009, 2011) of offenders in Ontario have found that about 25% have either a moderate or severe gambling problems. According to the Problem Gambling Severity Index of the Canadian Problem Gambling Index (CPGI/PGSI), 8.8% of the offenders had a severe gambling problem; 8 times that of the general population (Turner et al., 2011). Turner et al. (2007, 2011) also found that gambling within correctional institutions is common, even though it is a prohibited activity. Turner et al (2007, 2009) found that 38% of the offenders reported gambling while in prison. Turner, et al., (2011) have recently replicated these findings at 34%. In interviews, many of the offenders reported being caught in a cycle of gambling, debt, crime, followed by more gambling. One participant told us that "gambling lead to debt, debt lead to crime, and around it goes" (Turner, et al., 2009).

In addition, Turner et al., (2011) found that females had a slightly higher rate of problem gambling prior to incarceration than males. Much less research exists on the prevalence of problem gambling among female offenders, however. Abbott and McKenna (2005) studied 94 female offenders in New Zealand and found prevalence estimates of 23 to 35% for problem gambling and 13% for pathological gambling, with 28% reporting gambling in prison. Williams et al. (2005) found that, compared to male offenders, women reported lower levels of problem gambling prior to incarceration (11% for females vs. 33% for males) and less participation in gambling activities during incarceration (26% vs. 50%). In our recent study (Turner et al., 2011) we interviewed a small sample of female offenders (n = 41) in Ontario. According to the CPGI/PGSI, female offenders were somewhat more likely to have severe gambling problems prior to incarceration than their male counterparts (14.6% vs. 8.2%). However, during incarceration, severe problem gambling rates were lower for females (0.0% vs. 4.8%). Game specific problems may explain the lower rate of institutional gambling. Males most often reported problems with card games (36%), whereas females most often reported having problems with slot machines (45%). Cards are available in prison while slot machines are not. Women also remarked that there were few opportunities to wager inside on games that are available (e.g., cards) as there is very little interest from other offenders in doing so (Turner, et al., 2011).

Co-morbidity

Problem gamblers demonstrate significantly higher rates of depression, anxiety, ADHD, and other mental disorders than the general population (Desai & Potenza, 2008; Martins, Ghandour, Lee & Storr, 2010; Rush et al., 2008; Smart & Ferris, 1996; Turner, Jain, Spence, &

Zangeneh, 2008; Turner, Zangeneh, & Littman-Sharp, 2006). Problem gambling (PG) and substance use disorder (SUD) are also strongly associated (Petry, Stinson, & Grant, 2005). Based on a review of the literature, Spunt et al. (1998) estimate that PG among SUDs is four to ten times that found in the general population. In fact, the two afflictions overlap remarkably on risk factors, etiology, and symptoms (Petry, 2006; Potenza: 2006). The causal relationship between mental disorders and problem gambling is unclear. Hodgins and el-Guebaly (2010) found that co-occurring mental disorders interfere with treatment efficacy for problem gambling. Similarly, offenders demonstrate higher rates of depression, anxiety, ADHD, and substance abuse problems than the general population (Blocher, Henkel, Retz, Retz-Junginger, Thome, & Rosler, 2001; Boe & Vuong, 2002; Dalteg, Gustafsson, & Levander, 1998; Motiuk & Porporino, 1991; Rasmussen & Gillberg, 2000; Roy, 2001). It is important to find out if problem gambling among offenders should be dealt with as part of an integrated program, as a separate problem, or if PG could be integrated into existing programs. For example, would having more than one program that covers similar issues such as coping skills or relapse prevention be an unnecessary duplication that stretches limited resources?

Crime and Gambling

Several studies have reported high rates of gambling-related criminal activity amongst problem gamblers (Blaszczynski & Silove, 1996; Blaszczynski, McConaghy, & Frankova, 1989; Brown, 1987) and, in particular, have noted a strong relationship between gambling and crime within correctional samples (Abbott & McKenna, 2005; Abbott et al., 2005; Bellringer, 1986; Lahn & Grabosky, 2003; Meyer & Stadler, 1999; Turner et al., 2009). From a clinical perspective, it is also worth noting that pathological gamblers with a record of recent gambling-related crime have been found to manifest more severe gambling disorder symptoms than those with no recent gambling-related illegal behaviour (Ledgerwood, Weinstock, Morasco & Petry, 2007). A study by Ledgerwood et al. (2007) compared the clinical features and treatment prognoses of pathological gamblers who either had recent gambling related illegal behaviour with those without illegal behaviour. In total, 63 gamblers who reported illegal behaviour were compared to 168 who did not. South Oaks Gambling Screen (SOGS) scores (Lesieur & Blume, 1993) were greater among those with illegal behaviour than those without ($p < .001$). Perrone, Jansons, and Morrison (2013) report that repeat offending is a significant feature of problem gambling-related offending.

A recent study by May-Chahal, Wilson, Humphreys and Anderson (2012) used a questionnaire to study problem gambling within two medium security English prisons (one male, one female). 27.8% of men and 18.1% of women were identified as medium-risk and problem gamblers. 13.4% of male offenders and 7.2% of female offenders claimed to have committed at least one crime either to finance gambling or to pay off debts (this makes for 23.6% male and 17.6% of female gamblers). Of all offenders, 5.4% of males and 3% of females stated that their current offence was related to gambling.

Williams, Royston, and Hagen (2005) completed a review of studies examining gambling and problem gambling within forensic populations and found that the prevalence for both males and females ranged from 17% to 60%, with an average of around 33% across the samples (Williams et al., 2005). As noted above, Williams et al., (2005) found that the prevalence of problem gambling in correctional samples is the highest of any population studied to date. Our own studies have confirmed their findings in Ontario (Turner, et al., 2007, 2009, 2011, 2012). In

particular they found that the prevalence of problem gambling was roughly 8 times that of the general population (Turner et al., 2011).

For both correctional and clinical samples, the most commonly reported offences are "income-producing" ones such as theft, fraud, counterfeiting, and embezzlement (Turner, et al., 2009, in press; Smith, Wynne, & Hartnagel, 2003). For example, the Australian Institute of Criminology found that 15% of all cases of serious fraud reported in 1998 and 1999 had gambling as the primary motivation (Sakurai & Smith, 2003). A study by Smith, Wynne, and Hartnagel (2003) of records from the Edmonton Police Service estimated that 27% of counterfeiting reports were gambling-related. Turner, Preston, Saunders, and McAvoy (2009) found a significant relationship among convicted offenders between the number of income producing offences and the level of problematic gambling. In addition, the majority (65%) of severe problem gamblers reported that their criminal activity was the result of the need for money to gamble or to pay off gambling debts. However, some investigators have noted that a portion of pathological gamblers have also committed violent crimes (Griffiths, Parke, & Parke, 2005; Lahn & Grabosky, 2003; Parke & Griffiths, 2005a; Parke & Griffiths, 2005b; Smith et al., 2003; Turner, et al., 2009, in press).

Within prison populations, problem gambling may be associated with an increased risk of escape, suicide, debt-related institutional violence, and disciplinary problems (Walters, 2005; Zinger & Wichmann, 1999). These risks have important implications for institutional security (Williams et al., 2005). In addition, the high rate of relapse to gambling problems, the co-morbidity with various mental disorders, and the link between gambling debts and crime have implications for rehabilitation and parole. The primary focus in this project is programming for offenders who commit a criminal offence as a result of their gambling problem. However, gambling may be a recidivism risk even for offenders whose gambling problems were not directly related to their criminal activity.

Williams (2009) has discussed assorted pressures that drive many inmates to gamble. According to Williams (2009) sex offenders – who have low status in prison and are at risk for assault – often gamble as a means to become more accepted by other inmates (see also: Williams & Hinton, 2006). Female inmates, often separated from their children and dealing with abuse issues, might gamble to escape or even to acquire psychotropic medications from other inmates (Williams, 2009). McAvoy and Spirgen (2012) have discussed the role gambling can play in the underground economies of prisons. In all, gambling seems to be attractive as an outlet to relieve boredom or to forget one's problems, and assorted pressures and situational factors endemic to prison culture can also induce inmates to gamble (Williams, 2009).

Research on offenders in Canada and elsewhere suggests a considerable need for offender-specific treatments. However, limited effort appears to have been expended to that end. Still, a small number of programs were found in the research literature. For example, Marotta (2007) described a program offered in Oregon that consisted of a six-session psycho-educational problem gambling program presented in small groups. Similarly, in Canada, Nixon, Leigh, and Nowatszky (2006) have delivered a six-session gambling awareness program to incarcerated provincial offenders in Alberta. These programs are described in more detail in the literature review.

Research Questions

This study is a combination of a review of the literature on problem gambling programming for offenders as well as a interview study of expert[1] perceptions of the state of programming for PG among offenders. Data was collected from semi-structured interviews, either in person, over the phone, or by email depending on the location of the expert. Through triangulation of various perspectives we hoped to gain a thorough understanding of the state of the art of programming for problem gambling and make recommendations about what services are needed. The research was guided by the following questions:

(1) What programs have been run for offender populations inside correctional institutions? Were the clients male or female or transgendered? What programs have been run at different security levels?

(2) What programs have been run for offender populations outside of correctional institutions?

(3) What evidence is there for the success of these programs? For example, was the program evaluated and through what lens was it evaluated?

(4) Do these programs meet the needs of the problem gamblers they serve?

(5) What gaps (if any) are there in the current system for the treatment of offenders?

(6) Would offenders be resistant to these programs if they were introduced in Ontario?

(7) What is the relationship between gambling and SUD?

(8) Should problem gambling programs be integrated with drug, alcohol or mental health programs?

(9) What are the perceptions of use of community services and what would providers recommend to ensure continuity of care? For example, how to encourage referrals to community groups from the Federal and Provincial correctional systems.

(10) What gender differences need to be taken into consideration when setting up programs for offenders with gambling problems?

Methodolody

The questions stated above guided our initial exploration, but the questions were adapted as the study progressed. The length of the interviews varied greatly and the focus differed depending on the participant. Also, some questions were customized for the specific program depending on whether it took place inside or outside a correctional institution. In addition, by asking each respondent if there are any other questions or additional information we should have asked, we extended our knowledge of the issues. The closer connection made possible through face to face qualitative interviews has been shown to be especially useful when dealing with marginalized segments, be they addicts, inmates or problem gamblers (Adler, 1990, Atkinson & Flint, 2001; Faugier, & Sargeant, 1997; Griffiths, Gossop, Powis, & Strang, 1993).

Participants

The participants for this study are experts in the correctional field who have developed or provided interventions for correctional populations. Some of this information was obtained through the published literature. However, information on many programs aimed at this population is not publically available. By interviewing these experts directly about their experiences with these programs we learned about what has been successful and what did not

[1] Note we are using the term expert instead of key informant because informant is considered a problematic word with correctional populations.

work. The sampling strategy was purposive because that is an efficient manner of focusing the study on a particular population. Purposive sampling is a non-random type of sampling often used in qualitative research that involves seeking out participants for a specific purpose tied directly to the objectives of the study. According to Sandelowski (1995) purposive sampling is one way a researcher can reduce the minimum number of sampling units required within the confines of a single research project, but still produce credible and clinically useful findings.

We interviewed 14 experts who have provided us with information about dealing with problem gambling in a correctional setting. Some experts were recruited through contacts that we already knew. Other participants were recruited using a snowball technique. The experts provided us with insights into the need for programming at different stages through the correctional system (e.g., before incarceration, during incarceration, after release), and helped to highlight experiences and opportunities that might be used in the development of programs for this population.

Procedure

The method used to collect data for this study was semi-structured interviews. We already knew of a number of people engaged in problem gambling programming in Ontario. We interviewed these people as experts to determine the specific approaches they have used, their advantages and limitations, and to obtain their views on dealing effectively with problem gamblers in the correctional system. Examples of such experts include Judge Mark Farrell who presides over America's first gambling court and Chris Myers who provides an intensive gambling-specific program to offenders serving federal sentences in Ontario.

Data Analysis

Data analysis began with transcription of the interviews. Interviews were analyzed immediately and used to generate more focused approaches to collection and subsequent analysis. Since we had no way of knowing, for example, what the major gaps in PG services are, and also no way of knowing which services had proven effective, it was incumbent upon us to learn as the study progressed. In addition, given the heterogeneity of the participants, different questions were asked to different participants. A lead researcher (NT) then summarized the content of each interview in terms of key points and then distributed these summaries (along with the transcripts) to SM and PF to ensure that the initial summary was an accurate reflection of the participants' opinion on the topic. Given that the experts spoke directly to the issues, the data analysis was quite straight-forward. There were no hidden meanings in their transcriptions that needed to be uncovered. The summaries appear below in the results section. From these summarizes we extracted common themes that were discussed in multiple interviews dealing with each research question. This summary of the interviews is provided near the end of the results section and organized in terms of the interview questions. We discuss convergent and divergent views on each topic.

Results

Literature Review of Correctional Interventions

Several programs have been developed for problem gambling among correctional populations. Studies have identified a need for institutional screening and treatment (Jones, 1989; Lahn, 2005; Marshall et al., 1999; Powis, 2002; Sullivan, Brown & Skinner, 2008). The literature review is structured in terms of screening, diversion, mutual aid fellowships, and treatment and prevention.

Screening

Sullivan, Brown and Skinner (2008) have tested screens for prison-specific issues, and discuss testing as well as implementation by the New Zealand Department of Corrections. Specifically, these authors discuss the Eight Screen, a brief tool originally designed for family doctors. They tested this, the Eight Screen South Oaks and the DSM-IV criteria on one hundred medium security inmates. They concluded that the Eight Screen is easy to administer with limited training. The authors claim that its adoption in New Zealand should improve the identification of developing as well as established pathological gamblers. This, along with education programs to raise awareness and promote help-seeking, could help to reduce recidivism among prison populations (Sullivan, Brown, & Skinner, 2008).

Lahn (2005) has discussed some US programs dealing with problem gambling and crime. Nevada and Arizona, for example, have initiated training of correctional staff to screen for problem gamblers (Lahn, 2005; see also: Arizona Council on Compulsive Gambling, 2002), both for inmates and those having been released (Powell, 2001).

Diversion: Problem Solving courts

Another option for problem gamblers in the correctional system involves diverting offenders with gambling problems from the criminal justice system into a special gambling court (Lahn, 2005; Rose, 2003; State of Louisiana, 2003). Currently no such gambling court exists in Canada. However, gambling treatment courts could be modeled after a more general practice of problem solving courts where the offenders with psychiatric problems such as substance abuse are redirected away from the prisons and into a therapeutic situation. Drug Treatment Courts (DTCs) have been described as therapeutic courts or problem solving courts, and are the model upon which gambling treatment courts are based. In place of a formal, traditional application of law, the main objective is rehabilitation rather than punishment. With all types of problem solving courts, the system is amenable to disease conceptions of maladaptive behaviours, and social (environmental) issues are given more attention (Cooper, 2003; Nolan, 2002). It would seem that this has not been specific to drug use. In a review of problem solving courts in Canada, Slinger and Roesch (2010) discuss mental health courts, community courts as well as drug treatment courts (see also: Peters et al., 2012).

The first DTC appeared in Dade County, Florida in 1989 (Wiseman, 2005). According to Public Safety Canada (2010) there are now 17,000 drug treatment courts worldwide, not just in the US but also in Canada, Europe and Australia. The first DTC outside the US was opened in Toronto in 1998 (Public Safety Canada, 2007; Werb et al. 2007), with another one to follow in Vancouver's Lower East Side in 2001 (Somers et al. 2012). A gambling court could be rolled out in a similar manner or affiliated with drug treatment courts.

Latimer et al. (2006) conducted a meta-analysis of 54 studies involving 66 DTCs, and concluded that recidivism was reduced by 14%. Another review by Public Safety Canada (2009) estimated that recidivism was reduced by 8%. Chandler, Fletcher and Volkow (2009) have discussed therapeutic alternatives to incarceration, including drug courts. Designed to "provide a bridge between drug treatment and adjudication" (p. 189), the authors claim that every dollar spent on drug courts saves about four dollars in incarceration costs. They report that drug courts graduates have one half the re-arrest rates of those found in matched samples. Drug treatment courts are not without their critics (e.g., Cooper, 2007; Dannerback et al. 2006; Alemi, Haack and Nemes, 2004; Wolfe et al, 2004). In addition, they are not equally effective for all groups.

For example, Butzin, Saum and Scarpitti (2002) found that factors such as employment, race, education, and frequency of drug use affected the rate of success of the program. Marlowe et al., (2005) point out that compliance typically hinges on the perceived certainty of being detected. This issue is a particular problem for a gambling court because of the lack of any clearly defined measure of compliance (e.g., no urine screen).

Currently there is only one problem solving court that is specifically focused on problem gamblers. This program is located in Buffalo New York and is run by Judge Farrell. We contacted the Judge and discuss his program in more detail below.

Mutual aid fellowships (Gamblers anonymous)

Correctional facilities in Canada encourage mutual aid fellowships such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) to run within the facilities. Similar groups for gamblers could operate in Canadian correctional facilities. Founded in the 1950s, or by some accounts earlier than that (Browne, 1994), Gamblers Anonymous (GA) is a mutual aid fellowship modeled after Alcoholics Anonymous (AA) and utilizes a 12 Step approach similar to AA. GA now holds meetings in most North American communities, and to a lesser degree has established itself worldwide. Similar to AA, GA groups are peer support groups made up of a fellowship of individuals who try to assist each other to cease gambling or to remain abstinent in the long term. Gamblers Anonymous views problem gambling as a compulsion, or a type of illness, and promotes total abstinence from gambling as the only form of recovery. GA offers a unique recovery culture that in many ways distinguishes it from fellowships such as AA and NA (Ferentzy, Skinner & Antze, 2010). The most glaring difference involves the crippling financial difficulties many gamblers face: GA devotes much (sometimes all) of its time to counselling members on challenges involving financial and legal considerations (Ferentzy, Skinner & Antze, 2006). GA differs from formal treatment in that it involves peer support rather than professional intervention, yet the goals are similar: help members stop gambling and deal with character traits, such as self-centredness, which purportedly cause the excessive gambling (Custer & Milt, 1985). Perrone et al., (2013) note that there have been very few research studies formally evaluating the efficacy of GA except a few studies that included "a small sample of Gamblers Anonymous clients in their research" (Perrone, et al., 2013, p. 34). Ledgerwood et al. (2007) noted that offenders in their study responded better to CBT in conjunction with Gamblers Anonymous than to an exclusive referral to Gamblers Anonymous. Nonetheless, this is an option for problem gamblers in correctional facilities that should be explored.

Treatment and Prevention

Perrone et al., (2013) reported that in Australia there is a lack of awareness in the criminal justice system of problem gambling as an issue, and inadequate screening for problem gamblers in offender populations. Turner et al., (2009; 2012) also found a general lack of awareness of the issue in Canadian institutions. Furthermore, the vast majority of problem gambling treatment research and evaluation studies have focused on community-based problem gambling services and very little attention has been directed towards evaluating problem gambling treatment offered to offender populations (Perrone et al., 2013). Perrone et al., (2013) go on to note that within the correctional environment, problem gambling treatment services remain largely undocumented and unevaluated. Evaluation studies that have been conducted are often based on participant self-reports of satisfaction. Nonetheless, we have managed to uncover information on a few problem gambling treatment services that have been offered to offenders.

Availability of problem gambling services for offenders is largely haphazard. If the offenders are lucky, a program facilitator or psychologist, often from outside of the institution, may start a program in prison. Most often, however, the offenders have little access to programs for gambling problems. In Utica, New York (Powell, 2001) for example, the Gambling Information and Counselling Services (GICS) provides group sessions in one New York State correctional institution. This involves a ten-week module for inmates who have been identified as problem gamblers. According to Powell (2001), this was the only service of its kind in the New York State correctional system. The staff consisted of two New York State Certified Social Workers (Powell, 2001).

In terms of treatment modality, programs are typically modelled after those used with non-correctional populations (Perrone et al., 2013). As noted above Ledgerwood et al. (2007) compared treatment outcomes of problem gamblers with or without a recent criminal history. They reported that pathological gamblers with a record of recent gambling-related illegal behaviour manifest more severe gambling disorder symptoms and report greater gambling debt than those without recent illegal behaviour. It is also clinically significant that offenders in that study responded better to CBT in conjunction with Gamblers Anonymous than to an exclusive referral to Gamblers Anonymous. After a baseline interview, clients were referred either to GA, GA in conjunction with a CBT workbook, or GA referrals coupled with eight sessions of individual CBT. The CBT workbook covered the same topics as the CBT sessions: "discovering triggers, functional analysis, pleasant activities, self-management planning, coping with craving and urges, assertiveness and gambling-refusal skills, irrational thinking, and coping with lapses" (p. 296). Gamblers who reported illegal behaviour were more likely to meet ASPD criteria. SOGS scores did decrease from baseline to follow-up ($p < .001$). Also, overall SOGS scores were significantly higher among those with illegal behaviour and those without ($p < .001$). Nonetheless pathological gamblers with gambling-related illegal behaviours improved at a similar rate to those without gambling-related illegal behaviour. However, the authors conclude that more intensive treatment may be warranted for individuals with gambling-related illegal behaviour because they demonstrated greater gambling problem severity throughout treatment and follow-up (Ledgerwood et al., 2007).

Consistent with the findings of general population studies, CBT models also demonstrate positive outcomes for correctional populations (O'Connor et al. 2000). O'Conner et al. (2000) endorse a biopsychosocial model of gambling. While they do favour CBT, they offer a greater focus on behaviour, and consider stimulus response conditioning as central to the problem itself. After reviewing case studies of CBT, they concluded: "These case studies provide tentative support for applying general behavioural techniques to gamblers" (O'Conner et al, 2000, p. 17). Here, the behavioural (e.g., substitute behaviours) is emphasized more strongly than the cognitive, which of course is not ignored. Cognitive restructuring – notably aimed at erroneous beliefs – is also endorsed (p. 22).

In Oregon, incarcerated female offenders have been offered a six-session psycho-educational problem gambling program presented in small groups. Marotta (2007) set out to assess the rates of problem gambling among Oregon's incarcerated females. The SOGS was used to assess gambling problems. According to the study 38% of the offenders were problem or pathological gamblers of which 27% were probable pathological gamblers according to the SOGS (5 +). Of the sample, 12% reported crimes related to gambling but only 3% had previously received help for problem gambling. As with other studies, Marotta (2007) found that a large proportion of incarcerated persons have a history of a gambling problem, and that

problem gambling appears to be a risk factor for re-incarceration.

Marotta (2007) examined the demand for problem gambling services, then developed, implemented and evaluated an intervention for offenders. The intervention program was adapted from a self-help manual developed in Alberta called "Becoming a Winner: A Gambling Self-Help Manual" (Hodgins & Makarchuk, 2003). The program was a self-change guide utilizing cognitive-behavioural techniques and consisted of six 90 minute small-group psycho-educational classes. The results of his evaluation showed a significant improvement in knowledge and attitudes about gambling, including a greater awareness that treatment is available. Marotta (2007) also had positive feedback from the participants. For example: one participant was reported to say "I am so grateful this program has come to Coffee Creek – I need it desperately" (p. 14). At a six month follow-up 45 participants were contacted. Of these 64%, reported they had set goals regarding reducing or eliminating their problem gambling, and 97% were said to endorse the program as helpful. Only slightly over 12% reported current problems with gambling. At intake, the majority of the participants scored in the pathological range of the SOGS, but after 6 months only a small number of the participants still scored in the pathological range. This effect was also sustained after over a year with only slightly more than 10% of the participants in the pathological range. These findings suggest that problem gambling interventions in prisons can be implemented and that the "Oregon GEAR Corrections approach appears promising as a prevention strategy for incarcerated persons close to release" (Marotta, 2007, p. 24). However, there were still challenges to success of the program including cultural conflicts (between offenders themselves, and between offenders and the agency), logistical considerations when working within a facility and a high attrition rate which may have effected the results. Marotta (2007) also points out that his program often gets problem gamblers out of their denial, and how problem gambling in prisons can be reduced dramatically with the right kind of treatment. This might be significant given one of Marotta's (2007) claims: "Problem gamblers are notorious for not seeking treatment" (p. 2).

There are a number of gambling-specific programs that have been offered in specific localities, but very few of these programs have been formally evaluated (or the evaluations are not publically available) (Perrone, et al., 2013). For example, in Victoria, Australia, inmates identified as problem gamblers are directed to educational and counselling services (Lahn, 2005; Victorian Government, 2003). Yet there has been no formal outcome evaluation for those who accessed these services (Lahn, 2005). Similarly, Minnesota offers education and counselling, including telephone services, Gamblers Anonymous meetings and both in-house and outsourced awareness programs (Perrone, et al., 2013).

Perrone, et al., (2013) identify a number of other programs that have been implemented. In Auckland, New Zealand, Brown et al. (2002) designed and developed a brief (60 minutes) group-based interactive, educational intervention for incarcerated problem gamblers with follow-up one-on-one problem gambling counselling on request. The program was designed to minimise problem gambling related harm, with a specific focus on increasing cognitive dissonance between current and preferred gambling behaviour through the use of motivational interviewing. The idea was to shift participants from pre-contemplative to contemplative stages. The program was evaluated, and the results indicated that 58% of the participants (n=49) had not experienced a change in cognitive dissonance between current and preferred gambling behaviour states. The researchers report that the program was successful at addressing the gambling issues experienced by participants, but did not positively motivate them to seek further treatment.

Perrone et al., (2013) also describe the Breaking Even program (Relationships Australia, 2004) in South Australia which had as its goal reducing the likelihood of offenders engaging in problem gambling both in prison or after release (Relationships Australia 2004: 23). However, Perrone et al. (2013) note that the efficacy of the program could not really be evaluated because of the small sample size (13 completers) and lack of methodological rigor.

Perrone et al., (2013) also describe a program within the Victorian correctional services system called Gambler's Help, which includes problem gambling counselling, problem gambling financial counselling and community education, as well as Gamblers Anonymous. The services offered by Gambler's Help agencies are outlined in full in Chapter 5 of Perrone, et al.'s (2013) report. The most comprehensively documented and longest standing program identified is the *'Inside Out'* program. However, as with many similar programs it has only been evaluated using evaluation forms distributed to the participants, and the results of these self-evaluations are not public so the program's effectiveness cannot be assessed. Similarly, no formal evaluation of the GA groups has been conducted for this particular context.

A recent study by May-Chahal et al. (2012) in England studied problem gambling rates among offenders. They set up a voluntary treatment program, but have as yet not published any evaluation study of their project. The offenders themselves were said to be very supportive of the study "and several entered the voluntary intervention programme offered to them" (p. 383). While the program itself is not discussed, May-Chahal et al (2012) recommend that more could be done to help offenders with PG.

The only thoroughly evaluated program we have uncovered in the peer reviewed literature was one offered in Lethbridge Alberta Canada. Nixon, Leigh, and Nowatszky (2006) have delivered a six-session gambling awareness program to incarcerated provincial offenders in Alberta. Marotta (2007) also presents some evaluation data for a program in Oregon, but the full details of that study were not published. Based on pre and post program evaluation measures, they found a significant increase in awareness of problem gambling and in the degree of negative attitudes toward high-risk gambling following completion of their program. We contacted the authors of this study and will discuss their program in more detail in the results section.

Turner et al., (2011) uncovered two institutional programs and one instance of an integrated module for non-custodial offenders in Ontario. We contacted the people who ran these particular programs for more information for the current study, and these programs are discussed in more detail in the results section.

Interview Results

Gambling treatment court

One option for problem gamblers in the correctional system involves diverting offenders with gambling problems from the criminal justice system into a special gambling court (Lahn, 2005; Rose, 2003; State of Louisiana, 2003). Mark Farrell founded the first Gambling Treatment Court (GTC) in the United States (the Amherst Drug Treatment Court). To describe his program we have relied on a literature review of publications about this program, summarized information from a PowerPoint presentation about his program given in Toronto in 2011, and performed a brief interview with Judge Farrell himself.

With therapeutic courts, or problem solving courts, the model and approach are different from traditional settings. According to Rose:

> "Judge Farrell is the first to apply this "therapeutic justice" model to gamblers. The program may sound touchy-feely, but that is not how it is run. Defendants have to first plead guilty and waive all constitutional rights, including the right to plea-bargain. If they make it through the program, all charges are dropped. But, if they miss a weekly therapy session, they go to jail for a week. If they miss a court appearance or violate the terms of their contracts with the Gambling Court, they are returned to regular criminal court and go to prison for a felony" (Rose, 2003).

The judge's goal is the best interest of the offender as well as the best interests of society. Typically the court would accept a disease-based model of the condition (i.e., drugs, alcohol, gambling, mental health) and thus view the case as a health problem that can be dealt with through treatment, rather than as a criminal case. The judge manages the process through the court as team leader. The various members of the team – including prosecutorial and defense team members – work together rather than in adversarial roles (Farrell, 2011).

The Gambling Treatment Court (GTC) is said to be innovative and progressive (Farrell, 2011). A key objective is "understanding the interface of the compulsive gambler with the criminal justice system" (Farrell, 2011, #4). The gambler's criminal activity, descriptive characteristics and co-morbidity issues (notably regarding drugs and alcohol) must all be taken into account. Specifically, Gambling Treatment Courts require judicial awareness of issues regarding DSM IV symptoms for pathological gambling and the many implications of comorbidity. The old – or traditional – way of punishing is described by Farrell (2011) as unenlightened, involving societal as well as judicial insensitivity to the gambler's situation. Therapeutic treatment courts are diversionary rather than reliant upon traditional legal processing. Above all, this new kind of court relies upon teamwork: supplanting the traditional, adversarial rapport between defense council and prosecutors, the judge treats all parties (including the gambler) as part of a team designed to help overcome the addictive behaviour(s) that led to the person's arrest.

Planning and implementation involve the identification of potential outpatient facilities, training and education of court staff, and a non-adversarial, contract-based approach to rehabilitation. A "progressive interface" with the judicial system must include input from experts, as well as a flexible and realistic approach to each gambler's situation. Given that comorbidity can mask or complicate a diagnosis as well as someone's prospects for improvement, the entire addictive cycle (involving gambling, possibly other behaviours, and

perhaps drugs and alcohol) is taken into account as are issues such as age, history of domestic violence, and any or all risk factors for illegal behaviours.

While in a traditional, adversarial system a prosecutor would try to prevent the use of compulsive gambling as a plea element, in the GTC the prosecutor is on the same "side" as the defense council and, hopefully, the gambler is on the same side as well. The traditional approach involves a simplistic (and harsh) conception of "law and order," whereas with GTC the judge is also a social worker, and the court a proactive agent of change (Farrell, 2011). Prosecutorial involvement with the therapeutic team (i.e. diversion) and judicial adoption of therapeutic protocol makes for systemic cooperation. So the defense council has a new role: zealous advocate, but within a team setting.

The defendant is motivated to make progress by means of regular monitoring, accountability, and a thorough system of psychosocial support – all throughout a process that lasts at least one year. Judicial discretion is key; with light sanctions at first, but gradual severity for noncompliance. The length of the process will increase with noncompliance, as will the possibility of incarceration – meaning essentially that when all else fails, traditional punitive sanctions are invoked.

At arraignment the following things are considered: (1) Indicia of problem gambler, (2) Type of criminal activity, (3) Past criminal record, (4) Psychosocial characteristics, (5) Drug, alcohol, mental health issues, (6) Financial/debt status, and (7) Reports from family, colleagues, or employers.

A full screening assessment of the client is completed within 2 weeks. The defense counsel and district attorney then negotiate on the Plea which results in a Pre-plea or Post-plea diversion to Gambling Court, if appropriate. The defendant then begins an individualized, contractual, judicially monitored problem gambling recovery program. As mentioned, the Amherst Gambling Treatment Court requires a minimum 1-year duration for pathological gambling defendants. Throughout the course of the program, the defendant is mandated to return to court regularly to assess progress in treatment. If the defendant is non-compliant with the treatment program, the Judge can apply sanctions including (1) Warnings and admonishments in open court, (2) Demotion to earlier program phases, (3) Increased frequency of court appearances, (4) Confinement in the courtroom or jury box, (5) Increased monitoring and/or treatment intensity, (6) Fines, (7) Required community service or work programs, (8) Escalating periods of jail confinement, (9) Termination from the program and reinstatement of regular court processing, (10) Incarceration.

The gambling treatment court run by Judge Farrell has encountered a number of difficulties and challenges. In order to run a gambling court, the court must understand the gambler and some of the difficulties involved in running such a court. The court needs to be aware of the cyclical nature of addiction and that relapse is common. A relapse may be a setback, but the court must use some leniency in dealing with it (Farrell, 2011). One major problem is the challenge of identification. In drug courts, cases often involve drug use, but with gambling court the behaviour itself is often legal so there will be few cases where the addiction itself leads to court. Rather, the court case would occur as a secondary consequence of gambling (e.g., drunk driving after a night gambling). Another problem is that lack of a urine screening makes it difficult to monitor progress (Farrell, 2011). Screening for those presenting with multiple addictive issues is important because co-occurring disorders mask or complicate diagnosis. The court needs to be flexible, take risks, and use common sense and realism.

Finally, acceptance by parties concerned – and society at large – has not always been forthcoming. Gambling was not officially included in the statutory language in diversionary legislation; thus "gambling intervention – is the lost stepchild" of problem solving courts (Farrell, 2011). Additional problems occur from judicial "myopia" and mandatory sentencing guidelines that restrict a judge's ability to use discretion. Plus, in many jurisdictions there are no systemic treatment avenues or relationships with treatment facilities. A final concern: ongoing resistance from defense councils can be a problem for GTCs, so improved communication with defense counsels is a pressing need.

Gambling awareness and prevention

Another program, The Gambling Awareness and Prevention Project, was developed and evaluated by Nixon, Leigh and Nowatzki (2006). The program was offered at Lethbridge Correctional Centre, which is a provincial facility in Alberta. The institution is a multi-level site with multiple levels of security. It houses both male and female offenders and accommodates both remanded (awaiting trial/sentencing) and sentenced provincial offenders. Funding for the program was from the Alberta Problem Gambling Research Council (AADAC), community initiatives program (Alberta). Upon completion the clients were offered a certificate of completion, referrals to other programs and services including GA, and programs offered by AADAC. A list of services available, e.g., AADAC, GA, with contact information was also provided to each client.

Nixon et al., (2006) described the development, implementation, and evaluation of a psycho-educational gambling program for prison inmates that focused on awareness of gambling and problem gambling, reducing cognitive distortions, and changing attitudes towards gambling (attempting to lead to a more realistic and negative perspective). In addition to information obtained from the paper, we also interviewed Gordon Leigh about his program. According to Gordon Leigh, the program was developed over the course of several years running group therapy for problem gamblers who were prison inmates. Similar programs were delivered in the community. The approach was the use of brief counselling. The program was run by Gordon for 5 years targeting gambling problems, and then was "subsequently modified by others… to become a generalized program along with other addictions." The program was delivered from 2002 to 2004 through collaboration between the Lethbridge John Howard Society, a prominent prisoner rehabilitation agency that delivers addiction recovery programs inside prisons, and the Addictions Counselling Faculty of the School of Health Sciences at the University of Lethbridge.

The program was mostly for males within the institution, but about half of the clients were females in the community. The program is utilized by prison inmates and community members. For the correctional evaluation sample, a total of 71 inmates completed the baseline questionnaires. There were 46 males (64.8%) and 25 females (35.2%). For the follow-up 49 of the 71 individuals (69%) completed follow-up questionnaires (Nixon, et al., 2006). The only gender specific issues that needed to be taken into account were in terms of the examples of causation (e.g., what factor lead to problem gambling for individuals), and the gender of group leaders (e.g., women might be more comfortable with a female facilitator because of female-specific issues that might be raised in the group). Otherwise the programs were the same for male and female clients.

In order to recruit participants for the program, a notice was posted in the Living Units along with self-referral sign-up sheet. The participants could also be referred by case workers. In the community, the participants were made aware of the program through advertisement and self-referral.

For the evaluation sample, recruitment for the program was voluntary and was accomplished by placing a notice in each living unit of the Centre giving details of the program and the start date, along with the sign-up process. This was the same process for requesting a service, namely filling out an inmate request form to be placed on the program list. There was no pre-screening involved in determining who might participate in the program, since the program was designed with both prevention and gambling awareness in mind. There was no exclusion criteria applied. Prior to commencement of the program baseline evaluative screens and instruments (e.g., CPGI/PGSI, cognitive errors in gambling, attitudes towards gambling and the ability to calculate gambling odds) were administered.

According to GL the program consisted of 6 sessions of high intensity. The group leaders followed a manual to ensure consistency. The goals of the Gambling Awareness and Prevention Project were to develop and implement a program that would educate prison populations. In addition, a study was conducted to evaluate the degree to which the program altered the participants' attitudes, knowledge, and behaviour (Nixon, et al., 2006). The program was delivered on six separate occasions over a 15-month period (2002–2004) at the Centre. Inmates registered voluntarily for the program. In order to evaluate the program, participants were surveyed at the beginning and end of each series using a combination of problem gambling instruments to measure any changes in their awareness of problem gambling, attitudes towards gambling, odds (math) calculation skills, cognitive skills, and behaviour. According to Nixon et al., (2006) the participants were issued a workbook organized into six sections that included subtopics for each session. The sessions were highly interactive and used a Socratic method of instruction whereby the group leader asked questions to elicit answers from participants, who would respond with information from their own knowledge and experience of gambling. When the participants did not answer, the facilitator would provide the information to the group. The clients also used a workbook to work on lessons. All communication (spoken and written) was at the grade 8 to 10 level so as to be understandable by all participants. Technical terms were replaced with more familiar terms where possible to aid understanding. For instance, the term "cognitive distortion" would be replaced by wording such as "mistaken thinking." The discussion and answers were written on a chalkboard, and the group members wrote down the information in the relevant sections of their workbooks. According to Nixon, et al., (2006) individual group members could tailor the information and its emphasis to their own particular experiences, circumstances, needs, and plans. This gave group members a sense of ownership to the answers and solutions they personally developed in response to group activities. They were able to record this information in their workbooks for future use. In addition, the workbook contained factual and technical information about gambling and problem gambling of which group members might not previously have been aware (e.g., an explanation of the progressive nature of gambling addiction).

A pre- post-test design was used for the evaluation (Nixon, et al., 2006). Nixon, et al., (2006) reports that there was a significant increase in cognitive error recognition, and that the clients attitudes towards gambling became significantly more negative. Past-year frequency of gambling decreased, but the change did not reach significance. They did not find any significant differences in math skill score, CPGI/PGSI scores, or past-year SOGS score. The results indicated that a program of this kind can be effective for inmate populations, particularly in changing attitudes towards gambling. A longer program that is more clinically oriented may be required to impact gambling problems. In addition post program interviews were used to better understand the relationship between the offenders gambling and their criminal behaviour. GL

reports that the program is very successful in terms of delivery, and somewhat successful in terms of results.

According to GL, the offenders were not resistant to the program. In fact they welcomed the program, perhaps because it was voluntary. The main barriers to the program were the structure of prison program schedule and general lack of acceptance of the need for a program in prison with the senior management and policy makers in Alberta. This is largely because "gambling is not illegal and so the record of convictions does not show gambling as a problem." Instead the conviction would be for example: "for fraud, drug related etc."

GL indicated that the programs and services for offenders were not meeting the needs of offenders with gambling problems. The main gaps in services included a lack of screening for gambling problems on intake or prior to prison entry as part of the sentencing assessment (as it is with alcohol and drugs). The lack of gambling programs available in institutions, especially at the federal level, is also a problem.

When we asked if problem gambling programs should be integrated with substance use, GL endorsed both *somewhat integrated* and *dealt with separately.* This is because "some inmates have compound problems involving other addictions" as well as gambling. GL also endorsed the integration of problem gambling and mental health programming.

ADAPT (group program for provincial offenders)

Turner et al., (2011) discovered an institutional gambling program offered to female provincial offenders in Ontario at the Vanier Correctional facility in Milton. The program is offered by a treatment agency in the Halton Region called ADAPT. In addition, we found that ADAPT also runs a program for males at the Maplehurst correctional facility in Milton, Ontario. ADAPT is a free and confidential community treatment agency that provides assessment, counselling, and group and educational services for alcohol, drug and gambling related issues. Families of those affected are also welcome. Branch offices are located in Burlington, Oakville, Milton, Georgetown and Acton. We contacted Kristyn Inglis (KI) and Rachael Grier (RG) who run the ADAPT program for offenders. The funding for this program is provided by the Ontario Ministry of Health and Long Term Care, as part of the work of the ADAPT problem gambling program.

The program is entirely voluntary and presented in the form of a four-session psycho-educational awareness program for female offenders at the Vanier Correctional Facility for Women (provincial) and for male offenders at the Maplehurst Correctional Facility. According to KI, this ADAPT program has been running a 4-week psycho-education program at both institutions for over 5 years. This program initially was specifically for problem gamblers (or people that wanted to learn about problem gambling), but became a joint problem gambling and substance abuse program last year due to low attendance.

According to RG, "the 4 week sessions needed to be independent enough from each other that if clients started in week 1 or 3, the acceptance of the presented material wouldn't change. As well, the material has evolved over time to support and encourage discussion and relevant sharing among group members" – especially with the women at Vanier.

According to KI, the programs in the male and female facilities are very similar. "What might differ is the discussion that is brought up by the clients." For example, the "female group members sometimes discusses stigma related to their addiction and being a woman in jail; or being a woman with these types of issues and also being a mother." Gender differences are

therefore taken into account in response to issues brought up by the clients, rather than through any inherent differences in the programs for male and female clients.

The program is utilized by any male or female individual concerned about their own gambling or substance use, or who may have concerns about the gambling or substance use of someone close to them. They can sign up for the program at their facility. The female group is open so anyone can attend at any time, while the men's group is sign up only and there is usually a waiting list. Offenders attend the group each week for 4 consecutive weeks, listen to the material presented and join in-group discussions if willing. If they miss a week, they can try to make it up next time it comes around. After completing the 4 sessions they receive a certificate.

We asked if the offenders were typically resistant to the program or if they had been when it was first established. According to KI, "No, they are usually interested in whatever groups are provided for their learning, and they are not required to attend. The men's group tends to discuss less than the women's group, but that is not always the case." The voluntary nature of the group ensures that the participants do not resist the program. RG added that "as well, on the men's side there is less time offered for the program therefore it is more didactic than the women's group."

The overall approach is information sharing that is respectful to the setting and the client's past, present and possible future. At Vanier (for females) a 4 session program is offered once a week. Each session runs up to 1.5 hours and includes weekly handouts for clients to follow along with the facilitator, use of a white board as well as a video. Week One focuses on identifying addiction, how it happens to some people, myths and stigmas regarding "addicts,," and similarities and differences between problem gamblers and substance abusers. For Week Two, they look at the progression of addiction, negative consequences, motivations for change, addiction and the brain as well as a video about problem gambling to further demonstrate commonalities between gambling and substance abuse. Week Three addresses family impact, relationships, communication, and recovery needs. Finally Week Four is about relapse prevention, supporting and maintaining change, urges and triggers, and coping skills.

The length of the Maplehurst group ranges from 30 to 75 minutes depending on the environment. The program set up is similar, but the program is more of a teaching group rather than a discussion group. Handouts are given for the 4 week cycle. Fewer material resources are available at the Maplehurst site. For example there is no video equipment or whiteboard available. Participation is always encouraged in both groups, which can involve adding to the information shared as well as to open a forum for support and empathy. This occurs more at Vanier than Maplehurst.

In addition, we asked if the clients are offered anything upon completion of the program such as aftercare, or any ongoing monitoring. According to KI, "in the women's facility they could be offered continued individual counselling, but the men's facility is more difficult to work with and does not allow this at this time. Clients could also be provided with information about agencies in their home community for when they leave the correctional facility."

The program has never been formally evaluated, yet is considered somewhat successful. According to KI, they have "made recent content changes" to the "psycho-educational groups." In addition they are working with the volunteer coordinators to ensure they are available at the most accessible time for clients who wish to participate in the program (i.e. change of day, time, range).

In addition, we asked what specific barriers (structural, financial, participant) that the program faced which have (or could have) limited its potential. According to KI, "The program

has been limited by support of the correctional facilities. Sometimes it can be difficult getting in to do the program; sometimes all the clients that have signed up have not been brought in by the guards to group; sometimes clients aren't permitted to attend because of other programming. We also have had difficulty in the past with our client numbers, especially when it was just a group about problem gambling. There were not enough clients to continuously run."

On the topic of factors that have been critical to the overall success and continuation of this program, KI commented that "we have received support from some staff at the correctional facilities that have helped us continue our programs at times. As well, we receive positive feedback from the group members."

KI also commented that "there is no consistency with regards to what supports are offered" to problem gamblers across the system. The biggest gaps in the current system are a lack of regular individual and group counselling for offenders.

When asked if problem gambling programs should be integrated with substance use or other programs or be treated separately, they noted that the program is open to both problem gamblers and substance abusers. KI commented that problem gambling and substance use programs should be "somewhat integrated." They have found that a large number of clients have concerns about their substance use and problem gambling. "In addition, it is also helpful to make clients aware of the risk involved in substitution. We have found group counselling to be effective within the offender population when integrated." Thus a somewhat integrated program seems to meet the needs of clients.

KAIROS (group program during parole).

Previously an independent agency and now a program of the Youth Diversion Program, KAIROS is a Kingston-based community outreach rehabilitation program for young people and for provincial probation clients. KAIROS offers assistance to those with alcohol or other drug use concerns, those with gambling related problems, and to the families of clients. Services include assessment, counselling, consultation, and public education, along with a specialized problem gambling program for youth. Outreach extends to elementary and secondary schools, young offender facilities, and adult detention centres in Frontenac and North Frontenac Counties.

Betsy Schmidt (BS) was asked to participate in our research study because of her long-standing involvement with KAIROS' community based SUD program, which offers education and counselling to provincial offenders in the Kingston and Frontenac areas. BS has provided SUD & PG supportive services to provincial offenders inside and outside of prison for over 20 years. For the past 12 years, she has been co-ordinator and lead facilitator of a 5 session psycho-educational program for male offenders on probation. The program, only available in Kingston, is presented to those offenders identified by their Probation Officer (PO) as having had substance use and/or gambling problems related to their offence(s). BS has a significant amount of clinical experience and insight into the treatment and needs of provincial offenders with substance use and gambling problems.

Like most other interview participants, BS felt that the current programs do not meet the needs of offenders with gambling problems. One problem is that institutional programs that served as part of "community corrections,", and which were intended to help offenders with their reintegration by providing information about services in their home communities, have not been continually funded. This makes it more difficult for offenders to receive a referral to community treatment prior to their release, and thus they typically end up spending more time in prison if problem gambling treatment is a condition of their probation.

BS suggested that, for the population they serve, problem gambling services work best as part of an integrated program. The group they run is a 5 week program, but it is more of an educational program than a self-help group and is not aimed at people who have serious problems. BS has been involved with the program for 12 years. The target population for their program is "pre-contemplators," who may have been ordered by a judge to have drug/alcohol treatment in cases where their offence involved substance use. Entry decisions for the program are determined by the facilitators "in conjunction with the PO [Parole officer]," who have discretion to decide what program will serve an individual offender's needs. Unless there is a compelling reason for individual counselling, offenders in the KAIROS program participate in group sessions with 6-10 others. According to BS, inclusion in the group depends on the qualities the person has, "such as just being able to sit still. Some people shouldn't be in a group."

The program runs once a week, 90 minutes per session, for 5 consecutive weeks. Typically it is presented near the end of the workday in order to accommodate those who are employed. Whenever possible, mandatory meetings with a PO are scheduled just before group sessions to further assist offenders with their travel and work arrangements, and to further encourage program attendance. The general approach to the program is described as "low key, not a lot to fill out, and no homework." The approach used is cognitive-behavioral and educational. While the program is not actually geared for people who cannot read or write, BS indicates that illiteracy is not a barrier: "If a client says they can't read or write, we will help them with what little paper there is. Some offenders get the notion that because its education they have to write notes, but that's not the case." BS says that some offenders also "come in thinking they have to pour their heart out in the group, but relax when told the group is not self-help and they don't need to say anything about themselves." BS stressed the importance of continuing to run the program in such a way that "offenders are treated fairly and, if they do not wish to talk, they are not forced to."

Parole Officers have insisted that offenders not be allowed to miss any of the 5 sessions, as it would represent a significant portion of the entire program. Those who must miss a group session for legitimate reasons are required to make it up at an individual appointment in order to complete the program. For each client, a letter is prepared for the PO indicating whether the offender ultimately completed the program. After the program has been completed, offenders are given contact information for KAIROS and other community resources, "so they can continue to discuss…[by] either phone or make an appointment here or at Options for Change [another community service for SUD/PG]." BS estimates that 90% of the people who complete their program thank them for running the group and that "the evaluations are all pretty positive." For the evaluations they are asked what they thought about the content of the group, the quality, the information and the facilitators, but the program has not been formally evaluated.

Primary support for the program comes from the Ontario Ministry of Community Safety and Correctional Services, which provides funds to serve community clients in the area, including those in the 5 week program. Probation & Parole services in Kingston provides a board room for the group sessions, which according to BS, has lead to "better attendance than having it at our office."

As far as limitations to the KAIROS program as it currently runs, BS did not mention any specific concerns other than "a need for better [informational] DVDs. Newer DVDs aren't easy to get and they are expensive. And you cannot screen them before buying." It is important to note that the program serves only male offenders currently on probation. BS believes the

program could be adapted for women, but there are specific issues that would need to be addressed relating to childcare, food, and transportation. She believes the content would need to be reshaped for some issues and that in addition it would be better to run during the day for those women with school aged children. BS noted that the program had been tried in a provincial detention centre once but the transition of inmates in and out was too disruptive. Other barriers in that setting included the perception that "some guards were supportive, but others were not" and that "sometimes there would be a delay of perhaps 45 minutes [to organize the session] because something else was going on at the jail."

BS listed a number of things that she felt were critical to the overall success of the program including (1) the style of the program, (2) the ease of referrals for probation officers, and (3) quality of the facilitators.

In addition we interviewed CC, who also works for KAIROS, and presents the gambling information and awareness module imbedded within the program. CC is the problem gambling specialist at KAIROS and, as such, is the lead in outreach for problem gambling education and clinical services. Within the module presented, CC provides facts to the offenders about the real risks and rewards of gambling involvement, information on how to identify problematic gambling, and leads discussions on how gambling is viewed by individuals within the group and across society in general.

In the program, facilitators present a PowerPoint presentation about "process addictions," which includes compulsive gambling. They then explore the various venues in Ontario in which sanctioned gambling can take place. CC examines some of the myths and distorted beliefs about gambling, including notions of "luck," chance, and probability. For instance, CC pointed out that, among the participants, "some believe they are poker stars, and they think they know more than others about the game and about what they are doing within it." Finally, suggestions around responsible gambling and harm reduction are provided and discussed. CC also noted that "participants are expected to complete the CPGI problem gambling screening questionnaire and are encouraged to take part in the conversation." The content of the presentation is largely "guided by problemgambling.ca as well as the responsible gambling council's DVD." CC also stressed that the presentation tries to remain neutral about the decision to gamble. Offenders are encouraged to contact CC "for a more in-depth review of their gambling" if they have any concerns. No formal evaluation of the gambling module was mentioned.

Like BS, her colleague at KAIROS, CC feels that while current PG programs do not meet the needs of the provincial correctional population, the approach to integrating PG awareness in existing SUD programs does have value. It was noted, however, that "some participants have actually complained to POs about having to listen to the gambling material when they are there for substance abuse." While acknowledging that their groups are currently "male only," CC believes the content could be offered to female offenders, though "it would probably focus more on emotions and the impact of gambling on the family." As far as support for the program, CC simply pointed out that "Probation continues to fund it so they must be pleased with what they see and the feedback they are getting."

Chris Myers treatment program

Chris Myers (CM) was asked to participate in this study because he has been running a program for problem gambling offenders in the Kingston area for several years. CM has worked with addiction clients for over 20 years and has been offering the gambling specific program for offenders for 8 years. His interview was a particularly rich source of information about the issue.

When asked if current programs meet the needs of offenders, CM answered "only somewhat," explaining that "not enough awareness of the problem" exists among offenders, institutional staff, or within the assessment process itself when offenders first arrive in federal custody. He noted that there are considerable gaps throughout the correctional system that hamper identification and treatment of problem gambling, with the single biggest factor being a general lack of awareness about the nature of problem gambling. CM noted that, among offenders and staff alike, problem gambling is typically viewed as "a weakness of will" rather than as a serious compulsive behaviour in need of structured intervention. This viewpoint may interfere with the willingness to recognize problem gambling when it exists and limit the types of strategies considered when the issue is identified. For offenders, CM noted a stigma attached to problem gambling that keeps them from coming forward, stating that it is a "taboo subject, they don't talk about." For example, CM mentioned one man who "thought other people would make fun of him for his gambling problem," which illustrates a common "fear of shame and embarrassment that I think a lot of the offenders feel before they realize...it's creating a number of problems." When the problem is acknowledged, the continued belief that "I can just say no, I can just stop" may further delay their entry into treatment.

Regarding staff response to gambling, CM indicated that it varies quite a bit, from "turning a blind eye" to active discouragement, depending on the role of the person (e.g. security, case management, programs, etc.) and the type of institution. According to CM, most staff view the offenders not as problem gamblers, but rather as "fraud artists, bank robbers, or just criminals." CM makes an effort to educate "the parole officers, and program officers, to look at what's behind" the criminal activity by simply asking the offender if they are committing "fraud to facilitate their gambling." On the security side of the equation, CM noted that at one institution security staff are now routinely "breaking up the [card] tables because there has been some dramatic consequences," including beatings, stabbings, and increased requests for protective custody related to gambling debts. This, along with a steady increase in referrals, suggests that staff and offenders at the institutions CM visits are becoming more aware of problem gambling as a serious issue.

Based on his 20 years of experience working with substance abusers, including the past 8 years working almost exclusively with gamblers, CM stated that problem gambling needs to be dealt with separately rather than as an integrated module within other programs. He asserted that "There is a significant difference, there are some similarities of course, but there is significant difference working with substance abusers and problem gamblers…and the treatment is quite different." CM has seen the integrated approach tried in other contexts, specifically with PG clients in a substance use group in the community, and ultimately concluded: "In my honest opinion, I don't think it works well. I think there needs to be separation. It all comes back to their emotions and core beliefs, and the issues underlying the behaviours….there are different techniques for those."

CM notes that people enter his program by a variety of means. For example, word of mouth from previous participants often leads to self-referrals. Entry based on referrals from program and parole officers is quite common as well. CM also noted that, in several cases, offenders who were approved for transfer to minimum security had been sent to Frontenac specifically to access his program. On one occasion he was contacted directly from the assessment unit about sending an offender to his program but, in that particular case, there was a problem because the offender was approved only for high security incarceration. They managed to solve the problem, however, when CM agreed to visit that individual at his institution.

As Kingston no longer includes a federal institution for female offenders, CM runs the program exclusively for men, though he believes it could be adapted for women with "a bit of tailoring." As part of his program, he includes "a lot of gender information…talking about how the person is cultured as a male" but recognizes that that the same approach "could be formatted specifically for females." With females, CM indicated that he would probably "start looking at emotions more," or perhaps in a different way. In his words, with "a male offender, as opposed to a female offender, there is quite a difference in how they express their emotions and work through those emotions." CM suggested that the content might also change to reflect gender differences in terms of the type of games preferred, indicating that in his experience "men are more apt to be risk takers and involve themselves in…sports betting, card playing, stocks, high risk sort of things…as opposed to slot machines and bingo." CM also noted that those "stereotypes are being challenged," as he now sees male offenders who are more often describing themselves as "slot junkies."

CM provided us with several insights into the process of developing and implementing a program inside. We learned, for example, about the history of how problem gambling intervention began within CSC in the Ontario Region. According to CM, Frontenac Institution had "been a supporter of a problem gambling program for a number of years. One of the reasons was that one of the offenders there had significant charges against him, fraud related charges. He was looking for specific problem gambling counselling, and at that time there was nothing offered in any of the institutions." As a result, one of the program officers contacted Options for Change and spoke with CM, who then "did a fair amount of work with the institution. I did some blitzes campaigning about problem gambling and some awareness programs…a 5 session awareness program. The more awareness, the more visual we were in the institution, the more people started coming forward and the POs started calling us" to make referrals. This "awareness campaign" ultimately led to the program that was adopted at Frontenac.

The program has received no direct financial support from CSC but CM points out that "the program managers in corrections helped me with the logistics of getting offenders there." This includes posting information in living areas and on the Teledon system[2] to advertise the program, making arrangements for CM to evaluate those who come forward, and organizing presentations to program and parole officers to ensure they know about the services he provides. In addition, they "send out passes [to attend each group session], help with photocopying, putting participant manuals together…and supply us with a room."

With regard to the development of content and structure of the program, CM said: "I have done a fair bit of research across North America and Europe looking for studies, research, best practice, evidence based material for offenders…[it's] very limited." With just one applied research article to guide him, CM contacted the authors to ask about the content of a PG program they had studied, which was briefly offered to provincial offenders in Lethbridge, Alberta. He also spoke with the facilitators at ADAPT in Oakville, who had been presenting PG awareness sessions to provincial offenders in Milton, Ontario. In addition, CM asked the offenders he had been seeing in individual counselling about "what would be helpful," utilized feedback from brief "psycho-educational sessions" he had conducted previously with offenders, and considered

[2] The Teledon is the "in-house" TV channel that announces upcoming institutional activities, social programs, and employment opportunities, etc. Outside program providers and researchers often use Teledon to raise awareness of their activities among the offenders and to assist with recruitment.

some common "cognitive distortions" found among offenders which seemed to correlate to their gambling. Finally, CM "looked at different treatment centers" in terms of what they were offering and started revising materials he had gathered to "tailor it to an offender population." CM considers the program to be a "work in progress" and notes that the content and structure have "evolved over time. The first one I ran at Frontenac was 8 sessions, and now it's 16."

To date, CM has presented the program to offenders at two minimum and one medium security institution. However, the "awareness campaigns," primarily targeting staff to educate them about identifying gambling problems within the offender population, have taken place at all security levels and at several other institutions. As CM and many others have pointed out, very few offenders are identified as problem gamblers by the courts so he focused his educational efforts on staff who have considerable offender contact after sentencing. CM says that, on occasion, the "offender admits to it at the court procedure, and then it's a straight forward referral" but typically clients are directed to him after being "identified from discussion with their program or parole officers regarding the crime."

The program itself, which generally begins with 6-12 participants, runs for 16 sessions of about 2 hrs each. CM initially ran the groups once per week but, in recent groups, has switched to running it twice a week in order to offset disruptions that typically seem to occur. For instance, unpredictable institutional shut downs, along with unannounced staff training days and other factors, once turned a planned 16 week program at a medium security institution into a 27 week "exercise in frustration management" for both CM and the participants. "Ideally" says CM, "it would be nice to run like day treatment…21 days consecutive."

When they get started, "One of the things I do, the very first day, is develop a confidentiality contract with them." CM asserts that this initial process of "developing that contract and discussing what it means…developing that trust," is absolutely critical to the continued functioning of each group he works with. When asked to describe the "contract," CM explained:

> They generate what that means. I certainly guide them through it but it is more or less "what is said here, stays here," but we really break that down. I spend a couple hours developing that contract and we look at consequences. So if an offender breaches those, what does that look like? What does that mean for that offender? And we get a consensus rule of what will take place if there is a breach of confidentiality. If it comes back to the group that there was discussion on the outside of what was said, then there would be consequences. I have it all on a flip chart and say "now you know A-Z what could take place, what this all means. I also ask "How do we make this group as safe as possible for you? What would this look like?" And then I develop a contract, duplicate it, they get a copy and I get a copy.

CM indicated that, while it has not yet had to be enforced, the participants almost always decide on "immediate expulsion" as the major consequence of any serious breach of confidentiality within the group. The process appears to be quite productive as well, as CM points out: "I've heard from offenders after the group, or during the group, that it's been effective because they haven't heard things out in the population. It made them feel safe, that they could talk about what was going on." Trust is not easily established within this population but CM points out that most initial scepticism "dissipates over time" and eventually "they do trust each other, as much as they can, and trust the facilitator."

Following the initial "trust building" session, CM notes that subsequent sessions include the following activities:

- Reviewing behavioural models to understand their gambling behaviour, including the Custer model of Compulsive Gambling and Prochaska and DiClemente's Stages of Change.
- Examining development of PG, including individual pathways to problem gambling and the continued cycling of thoughts, feelings, and behaviours that perpetuate gambling.
- Examining distorted thoughts related to gambling, including those about odds and probability, skills versus chance, influencing outcomes, superstitious behaviours, etc.
- Discussions about real and perceived value of money, the nature of one's relationship with it, what it means to have/not have money, judgements about self worth related to money.
- Understanding stress, its effects, and how the individual typically responds to it.
- Open discussion about difficulties within the prison environment and challenging cultural expectations about acceptable means of managing conflict inside.
- Relaxation therapy including progressive muscle relaxation, meditation, and mindfulness.
- Exploration of emotions, including their purpose, beliefs about them, and how to manage them. Management techniques include "surfing" emotions, "body scanning" to determine how they experience emotion physically, and reviewing previous maladaptive responses in order to improve outcomes.
- Discussing the issue of dishonesty, with self and others, and the role it plays in complicating our lives.
- Looking at imbalances across different areas of their lives, and exploring ways of getting their lives back into balance.
- A guest speaker presenting information on bankruptcy, credit counselling, budgeting, and management of debt and credit.

Upon completion of each group, a written progress report is prepared and addressed to the participants and their parole officers, including the results from various "outcome measures." Within that documentation, CM also notes whether the participant "needs further treatment and follow up." For instance, CM points out that "A number of fellows from minimum security have gone to the inpatient program in Windsor. When they're eligible for unescorted temporary absences, they are able to stay at St. Leonard's [halfway house] and attend the inpatient program as a day treatment." He also makes referrals to services in the community they are returning to and supplies them with the 1-800 number for the problem gambling helpline in Ontario. According to CM, having offenders contact gambling counsellors in their community, prior to release, makes them much less anxious about accessing the service and "more receptive, as opposed to being forced there by their PO."

According to CM, the program has been formally evaluated by the program manager at Options for Change, who audits all of the work he does. To evaluate program effectiveness, they rely on offender OQ-30.1 outcome measures (Carepaths, 2013), which is the same instrument used to provide feedback to participants about change. CM reports "When we look at individuals filling out the OQ30.1, seeing some movement in that gives me concrete information that this has been beneficial for them on the whole." The participants themselves also complete an overall evaluation of the program, including feedback and measures concerning content, structure, facilitator effectiveness, and presentation materials used.

There are, of course, other ways to determine the program's "success". For example, CM appreciates "seeing the offender from when they first come in to when they leave, the comfort level of discussing some things they have probably never said out loud with other people, especially in a jail setting." CM also receives positive feedback from parole and program officers, but ultimately considers their "willingness to make referrals" as a better measure of his success. The relationship with parole officers in particular has developed over time and is now branching out to areas of discussion that include other "process behaviours" such as shoplifting. Finally, CM noted another positive indicator of acceptance of the program within corrections when one offender applied for early release and was told by the parole board "We will grant you parole, but you have to finish the gambling program first."

As with most other interviewees, CM mentioned some important barriers to providing programs to offenders. For instance, he discussed how having to schedule his program time around CSC core programs and other mandated activities can be a challenge. As an example, at one institution the offenders were expected to either be in school or working during the day, so the only option there for CM was an evening program "so that the fellows weren't losing pay." His program schedule once conflicted with a popular skills training program as well, a welding course, in which case he had to postpone his start date in order to accommodate the offenders. Another challenge has been a lack of dedicated space for his program at institutions. On one occasion, he was provided with a room that shared by 8 different social program groups and, as a result, found that "people were coming in and out of there all of the time." This caused a great deal of disruption and conflict due to confidentiality concerns and, ultimately CM suggests, revealed the extent to which some correctional staff fail to appreciate the importance of confidentiality.

According to CM, one factor that is critical to the success of a program inside is "developing good relationships with everyone you encounter when you walk into an institution" especially security staff who have the power to affect facilitator and offender movement inside. As CM likes to say, "You pick your battles," and he generally tries to remain quite flexible, except in situations that interfere with the "emotional safety" of his groups. CM suggests that success has also come from reviewing a great deal of research on problem gambling, particularly as it relates to offenders, and from disseminating the information throughout institutions to raise awareness of the issue and to encourage "buy in" about its importance at all levels. CM also believes that, ultimately, in order for the program to succeed throughout corrections it might need official adoption by CSC as one of their "core programs," which includes a lengthy evaluative process along with "formal agreements" to fund such a program. At present, however, that possibility seems a long way off.

As a final thought, CM stated:

> My belief is that these fellows are going to get out [so] I think effective treatment for them is essential. They need to have this. If the gambling isn't treated appropriately, the individuals are going to go back out, commit the same crimes, and come back into the same situations ... costing tax payers more and more money.

Parole

We also interviewed a parole officer with Correctional Service of Canada (CSC), Joanne Tyo-White (JTW), who works at a minimum security Federal institution preparing offenders for release. She typically meets offenders when they first arrive at the institution, interviews them to

determine which programs they are suitable for, ensures they have access to the programs needed for completion of their correctional plan, and prepares offenders and their accompanying paperwork prior to parole board hearings.

JTW provided many important insights into the difficulties of dealing with problem gambling offenders during their incarceration. According to JTW, problem gambling is a common problem inside. She noted that problem gambling is occasionally mentioned in the offender file or is brought up by an offender during the interview, but most times there is little or no indication that a problem is present. With one offender, for example, the only indication of a gambling problem was that "he stated during a parole board hearing that he liked to go to the casino and spend time with his girlfriend." Only after further questioning during the hearing was it revealed that he had an outstanding gambling debt of $10,000.

JTW reported that when an offender presents with, or is otherwise discovered to have, a gambling problem she does not have access to a *CSC-run* program designed for problem gamblers. She noted her good fortune, however, to have other options including: a problem gambling program for offenders run by CM (see below) at the institution, the outpatient service Options for Change in the local community for problem gambling [also run by CM], psychologists on staff at CSC, and a community maintenance program designed for offenders who have been in programs for substance abuse. JTW has also utilized a residential program in Windsor for problem gamblers, which has allowed some offenders to stay there during the program and others to access it on a day treatment basis while staying at a halfway house. In one case, JTW had an offender who had a limited ability to communicate in English. She managed to make arrangements with an outpatient treatment service in Toronto that could deal with a particular language group over the phone and the person received counselling via the telephone in her office.

For obvious reasons, JTW's preferred method of dealing with offenders with gambling problems is to refer them to see CM for a complete assessment. Ideally they would be placed directly into his program, but that "depends on release timing, availability of the service, and individual factors" according to JTW. A recurring theme in her interview was a desire to avoid "burning resources by over using them." Psychologists are generally available, for instance, but JTW would prefer to use psychological services for more difficult cases that require more intensive therapy (e.g., depression). Gambling, on the other hand, "could be dealt with using more specialized services for addictions, or possibly through existing programming." One of the big problems with relying on programs outside of CSC is that they are only accessible to offenders who are eligible for an escorted temporary absence (ETA). Thus, offenders who have been charged with gambling related offences in prison may not be eligible

JTW indicated that she would still prefer to have a dedicated program as part of CSC and is a strong believer that CSC should develop its own programming for problem gambling. When asked if it could be integrated into other CSC programs, she said that it was "probably a good idea to integrate it into existing programs, especially if you're worried about costs" and acknowledged a view of gambling as "similar to other addictions." In addition, one of the indicators she's experienced with problem gambling offenders is "involvement in drug dealing." That is, gamblers getting involved in the drug market in order to fund their gambling. In other cases though, the primary criminogenic factor is problem gambling itself and the offender is not involved with substances. JTW feels that, in those cases "trying to shoe horn them into a substance use [program]… might actually make things worse." It was her opinion that "those who also have substance abuse problems could definitely benefit from an integrated program."

Privacy was raised as a concern for problem gambling programs for offenders. Clients not involved with the criminal justice system can expect a high degree of confidentiality when working with a therapist (with some specific exceptions). The expectation of privacy is greatly diminished for offenders seeking similar help. For example, in most cases, the Parole Officer receives a detailed report from the therapist, which is then presented to the parole board for consideration during hearings. Despite a reduced expectation of privacy, JTW does not think that concerns about confidentiality are sufficient to deter most offenders with gambling problems from accessing available programs. She notes that she has not experienced any resistance on the issue from offenders she has dealt with and points out that "gambling problems are less of an embarrassment to talk about with a therapist than say a sex offence." Overall, JTW reported little resistance from offenders about their involvement in gambling treatment services, with the exception of "those in denial who don't want *any* services."

Based on her experience, JTW indicated that problem gamblers were somewhat different from the general correctional population, suggesting they are typically "non-problematic offenders, very compliant. The ones that I've dealt with, they come from a very pro-social background." Such offenders would reasonably be expected to do well in treatment programs and JTW provided us with an informal evaluation of CM's program. In her opinion, based on feedback from participants, their subsequent progress in their correctional plans, and her own dealings with CM, she has found it to be "very successful" for those clients sent to the program. Indeed, each offender that she referred to CM's program has had a "positive outcome and was successfully paroled."

In addition we met with a number of parole officers in Toronto to discuss problem gambling. Some parole officers reported having encountered problem gamblers and not really knowing how to deal with the condition. However, our discussion with parole officers suggested that many other parole officers are not really aware of the issue of problem gambling, not sure how to deal with it, and are unaware of the services available in the community. Another major issue that was brought up was the problem of how to effectively monitor clients for compliance to orders not to gamble without a urine test.

Programming Officer

Another perspective we sought out was from a programming officer Vicky Garrett (VG). VG was asked to participate in the study because of her extensive correctional experience and familiarity with CM's program. She has been with CSC for 21 years, initially as a Correctional Officer and then moving into the role of Program Officer. She has delivered all of the CSC "core" correctional programs, with the exception of Sex Offender Programs, and has facilitated programs at all levels of security. VG is also a Regional Trainer and, as such, spends a good portion of her time completing quality reviews on Correctional Programs Officers. VG provided logistical assistance to CM when he first started the gambling program at Frontenac Institution and has also worked with several of the offenders who completed that program.

VG agrees that federal offenders are not generally well serviced with respect to gambling concerns, and was surprised to learn that CM's program is entirely unique in Canada. When asked about the possibility of integrating problem gambling interventions with existing CSC programs, VG's opinion was that it "might not be that bad of an idea." For instance, she reported having an offender who just graduated from her family violence program who was a bookmaker, but not a problem gambler. In such cases i.e. where gambling involvement exists, but not problem gambling, VG believes that "an integrated program might be good." In fact, VG

reported that CSC core programs are already moving toward an "integrated program model," in which fewer distinct correctional programs will exist. This approach takes the shared principles and general content found across several CSC programs, and creates a singular program designed to address multiple issues. That process is just beginning within CSC, however, so VG indicated that "the jury's out for the time being" on whether this proves to be an effective overall approach or not. Though initially opposed to the idea, VG stated that "if you look at the integrated skills approach and self-management planning, and the fact that most of the programs are cognitive based treatment," it has potential to be successful.

With respect to her views regarding the effectiveness of CM's stand-alone program at Frontenac, VG stated simply "I see success in the fact that parole officers continually refer. They would not refer if they did not see value." Offenders enter the program via self-referral or are referred via parole and program officers when there is an indication of need. VG reports that, so far, none of the offenders or staff she has dealt with had any complaints about the program and, in fact, spoke very highly of CM and the program. According to VG, "Some other programs you might get complaints, but not CM's. His reputation [with offenders] has helped him build rapport."

Managers of Institutional Programs

Janice Saunders (JS) is currently the manager of Institutional Programs at Collins Bay Institution and was a correctional Program Officer when CM first presented there. JS provided support to CM's program by means of organizing passes for inmates to attend his program and arranging space. JS was interviewed because of her assistance with logistical matters at Collins Bay Institution, when CM first presented his program at the institution. Collins Bay is a *medium* security federal institution and, unlike minimum security sites like FI, presents considerable challenges due to security concerns, institutional routines, and restrictions on inmate movement. These factors can greatly limit the capacity to provide "social" (i.e. non-core) programs, as well as potentially impacting their effectiveness, due to various disruptions (e.g. lockdown) to planning, presentation, and participation of such programs. JS had experience presenting programs within the constraints and changing environment of a higher security institution and, as such, provided valuable insights regarding various logistical considerations at CBI.

JS did not think that corrections adequately dealt with offenders with gambling problems, and that intervention was mostly "hit and miss." At CBI they rely on CM coming in and providing a program. Even then, if an offender is not at the right place at the right time and does not know how to access the information, his needs would go unmet. In addition, she said that they "don't do enough to identify at intake to who might have a problem and who needs an intervention. I think we are skimming the surface…and even at that, barely. They do not routinely assess for problem gambling. I can't remember in the number of years I have been in corrections…seeing many, if any, correctional plans that identify problem gambling as an issue." JS suggested that programs for problem gambling and substance abuse "need to be treated separately." JS believes that the stigma attached to problem gambling is a reason that the problem is concealed. This would be a problem in a mixed or integrated group, but not a gambling specific group ("a safe environment").

However, JS said that corrections will offer an Integrated Correctional Program Model (ICPM) in the very near future, one that deals with many issues related to impulse control. It is currently be piloted in two regions. JS indicated she has heard good things about this new approach. She notes that "even though with some of the research I have read on gambling they

see that the brain activity is similar to that of substance abusers…I still think that there are enough differences. Even within substance abuse, people who just use alcohol can't relate to guys who use cocaine…guys want to be able to relate."

She also mentioned that there are so "few forms of entertainment in an institution" and gambling is one of them. But "a number of guys with impulsivity issues - thrill seekers - need constant stimulation...those sorts of things, the poker games and the betting games that go on in the units." It was the opinion of JS that "Somebody might come into prison without a gambling problem but be released with one….and so that educational module I think could at least raise awareness."

JS thought that at intake, offenders need a "primer for inmates, to know when this might be getting out of hand" that would include the real possibility of spending their "entire sentence in segregation because they're in debt to other offenders."

According to JS most offenders get into the program at Collins by self-referral. Offenders put in a request and program staff let CM know when they have quite a few requests. In addition, they "canvas parole officers to see if there is any interest." There is also a lot of word of mouth about the program and notices sent to the offender through the Teledon system (see note 2).

JS noted a problem within CSC in that they revamped the selection criteria for correctional programs so that offenders who needed programming would get it, and others who did not need programs would not. "But it left this sort of purgatory for some of the offenders who feel, and they are not wrong for feeling this, that in order to be considered for any kind movement in their case, whether it's a transfer to lower security or a conditional release, they need to have achieved and accomplished something. So if we aren't offering them any correctional programs…and they are also not going to school because they completed high school on the street, they have nothing they can do here to demonstrate to their parole officer, case management team, or the parole board, on any change. I'm not the same bad guy who came in here." So sometimes they are eager to sign up for programs they don't need, just to show that they are doing something to improve their case.

In terms of resistance, JS is not aware of any. Typically with correctional programs, offenders who do not want a program will show it very openly. There may be people who think "no way I don't want anyone here to have any ammunition to use against me," but it would not come out in the open because the program is voluntary. The institution has never told program staff to offer services for PG. There is still a lack of recognition of problem gambling as a potential criminogenic factor.

In terms of success JS says that she has "heard guys say really really good things about it including guys who are "grateful because they really need it" and "thought it was really good." Yet it is difficult to measure because gambling was not measured at intake. In addition, she added that they do not know how many more problem gamblers developed it while in prison. In terms of barriers, she notes the "failure to identify at intake who might need the program," it puts too much responsibility for self-referral on the offenders themselves, "it's not taken as seriously right now." Not all parole officers are aware of problem gambling among offenders, and parole officers may not to be open to really reviewing their case load to identify potential participants; because at the end of the day it will not really change their recommendations. Also, the stigma and access to gambling activities inside prison present a challenge to creating behavioural change.

In terms of access to gambling, "we have all sorts of measures put in place to stop drugs from coming in because we know we have a number of drug addicts here, but we bring problem

gamblers in and there is a game going on in every unit, or in a guy's cell, or in the group room, or in the yard." JS agrees that some corrections workers turn a blind eye to the gambling. "We have a drug strategy; we don't have a formal strategy for dealing with that aspect of the underground economy in prisons." JS added that they underestimate "the number of problem gamblers that come in and we underestimate the extent that problem gambling contributes to their, not necessarily criminal behaviour, but their overall lack of satisfaction with their life…that might help sway them towards criminal lifestyle."

Beverly Pitcher (BP) was interviewed because of her role as a program manager within CSC and her involvement coordinating CM's program at the Frontenac and Collins Bay Institutions. BP has worked in federal corrections for close to 18 years and began her career as a Correctional Officer. She worked as a Parole Officer at various institutions and then trained as a correctional program officer, delivering substance abuse and cognitive skills programs to male federal offenders. She later became a Regional staff trainer in core correctional programs for both male and female offenders. For the past several years, BP has served as a Program Manager at various institutions and is now at Frontenac Institution. FI was the first CSC site to host CM's program. BP's current responsibilities include the coordination and management of "core" correctional programs, social programs, education, inmate employment and inmate pay at FI. BP also facilitates referrals to CM from CSC Parole Officers, in order to assist the identification of offenders who are in need of PG intervention.

Regarding the possibility of simply integrating PG intervention into existing core correctional programs, BP stated:

> "I suppose that would work for some fellows but, if you used a module about gambling on someone who had substance abuse, that would not apply to everyone in that one group. My preference would be one distinct group. Possibly a short information session would work but, a whole module, I am not sure that would apply to everyone. This could be based on my own experience, where I see programs based on one thing, but that's the way I visualize it, as a stand-alone program."

BP indicated that, at Frontenac, problem gambling offenders find their way to intervention in a "variety of ways." They get involved in the program there through (1) self-identification in response to posters put up by CM, (2) case management teams, particularly parole officers, when gambling was the problem that brought them to jail, (3) security staff where the offender has developed PG during incarceration, and (4) word of mouth from previous/current participants. However, she noted that because PG is not assessed at intake, most referrals to the PG program are ultimately initiated by the offenders themselves. It was her opinion that "Gambling is more socially acceptable, so it is safer to step up to the plate about that."

With regard to selection of participants for appropriate intervention, BP indicated that several possibilities exist at Frontenac: "There is a treatment and an educational program, so it is dependent on the needs of the offender. It's similar to the…low and high intensity needs that correctional programs target. I believe [CM] has done individual work as well. There is a challenge in that there may not be enough people with similar needs, so there could be a need for "modified" interventions." That idea suggests that perhaps some aspects of the gambling program (e.g. duration, intensity, group size, etc) could be changed, depending on overall demand and the needs of individual offenders at a given time. With respect to final decisions about program entry, BP noted that "Sometimes guys [want to] take the course just for the

information, or because it makes them look better to the national parole board. In the past guys have asked to take the course for these reasons but Chris screens everyone and generally includes only those who are PG."

BP mentioned another service utilized by offenders at Frontenac, the residential treatment program located in Windsor, though she noted some reservation: "We have sent some fellows, but I'm not sure if it meets the needs of CSC. We have had problems getting them there...and halfway houses [for offender accommodation during the program] are not easy to access." The obvious limitation with that resource is that only offenders who are approved for Unescorted Temporary Absences (UTAs) could attend such a program, and those permissions are not easily obtained.

BP did not comment on the content or structure of the PG program at Frontenac but was aware that, upon completion of the program, the offenders were given a certificate and that a short report documenting the offender's progress throughout the program was provided to their parole officer. It was unclear whether that report is posted in the offender's electronic file (OMS) for others to see (e.g. National Parole Board) or simply given to the PO to distribute as appropriate. BP was also aware that CM will meet with offenders and their parole officers after the program to discuss treatment progress and to assist with referrals.

In response to the question of resistance to the program, BP stated: "Definitely not from staff because, back to security, this is a significant issue for them. When there are debts there's violence. So I would say staff is very supportive." With regard to offenders, BP indicated they "probably show resistance, if they're not in agreement or in denial, but I cannot think of any particular cases. I know we see that with other programs, substance abuse for example, where they are minimizing the problem." BP also pointed out that, unlike CSC's core correctional programs, the PG program is not mandatory so participants can chose to ignore it if they wish.

The only potential barriers BP mentioned, related to running a PG program inside, were that "Depending where you are in corrections, sometimes having enough guys to run a group can cause problems" and "Structural barriers can cause problems, but we do not have those here." This speaks to the challenges of offering programs at the higher security institutions, where restricted inmate movement and routines regularly disrupt the provision of services. These issues typically don't exist at minimum security institutions like Frontenac, where "delivering programs is easier…everyone is more receptive and it's more conducive to finding support."

Regarding the question of whether the services currently available to CSC are adequate for problem gambling offenders, BP responded

> "there is absolutely a gap. Chris [Myers] is only one person providing services to a large organization in the Ontario region. One person cannot meet the needs of everyone. I see, on a regular basis, fellows that get missed at Frontenac. Chris has been unavailable on many occasions…[because] he was stretched too thin"

Having received informal feedback about the program at Frontenac from staff and offenders, BP stated: "Based on impressions, I would say it has been very successful. I have not heard negative feedback." According to BP, while "success can be measured many different ways," she was not aware of any formal evaluation of the PG program by CSC, which was viewed as a potential limitation to general acceptance within the organization. As she put it, "A big question is how are we going to use our resources? I am not confident that there was a ton of support in the past because it wasn't something that was formally recognized by CSC." Regardless of whether CSC

as a whole recognizes the program's merits, BP asserted that "Chris has established rapport with staff and gained credibility, so we continue to do our own thing. We see first-hand the benefit."

BP offered the following as the benefits of PG treatment for offenders: 1) information and education about PG for all of the offenders; 2) feedback regarding treatment gains and future considerations; 3) a sense of relief and gratitude for getting some specific assistance; 4) the possibility of lower rates of reoffending, especially among those where PG is an obvious criminogenic factor. For staff, especially parole officers, there is a sense of relief that there is a program to which to refer offenders. They also seem pleased that the issue is being addressed. In addition, the staff value CM as a crucial resource when they have questions about cases involving gambling, require individual assessments to determine treatment needs (e.g. low, moderate, or high intensity), or are looking for community services for the offender. As a final remark, BP stated: "I'm really pleased that we are making movement in this area…recognizing gambling as problematic and finally evaluating the behaviour itself."

Gamblers anonymous

Another option for problem gambling services for correctional populations is the use of Gamblers Anonymous (GA). GA originated in the 1950s, or by some accounts earlier than that (Browne, 1994). As noted above GA is a mutual aid fellowship based on Alcoholics Anonymous (AA) and the 12 Steps. GA now holds meetings in most North American communities, and to a lesser degree has established itself worldwide. Similar fellowships such as AA and NA groups regularly run groups inside prisons. We contacted Arnie Wexler (AW) for additional information about running GA groups for offenders.

According to AW, "lots of people are in jail because of gambling addictions." AW reports that he has testified for over "50 problem gamblers over the years" including 2 cases recently. AW told us that

> most lawyers don't know how to deal with gambling addiction in the courts and their egos won't let them learn about it." I get so many calls from compulsive gamblers and then their lawyers don't even want to talk to you. They think they have all the answers and in lots of cases won't let someone talk in court for their clients. And most judges don't understand the gambling addiction. The last 2 cases I was in court for one lady got 10 years the other got 17 years.

He added that most jails in the USA have AA and NA meetings but very few have GA meetings. He said that it is "hard to get them going in correctional institutions."

AW ran a GA group in a prison from 1972 to 1974 every Friday night in New York State. Then when he was executive director of the council on compulsive gambling of New Jersey, he started three groups. He added that "most gamblers who get out of jail are told [they] need to go to GA," but often parole officers do not follow up to ensure that this has happened. If the gambler attends GA, he/she will only attend until the end of the sentence and then they will not attend GA again "till the next time they are going to court again." Sometimes the offender will need to provide a document signed by a GA representative to show the parole officer that he/she attended a meeting or meetings. "Sometimes they come for a small part of the GA meeting to get it signed or they just sign any name to the paper without coming to GA meetings" at all.

We asked AW why there are so few GA groups in prisons. He agreed that stigma might be one answer. He added that it is hard to get GA meetings started in prisons. He said that he

thinks it is because “people look at other addictions and say those people are sick.” But they look at “gamblers and say they are bad people and crooks.” He noted that this is true for the general public, lawyers, judges, and the people running prisons. In addition, the popular belief is that all that is needed is to “tell gambler just stop and that will work.” Simply put, most people do not understand the reality of problem gambling as a mental disorder. This problem may even extend to the problem gamblers themselves.

AW noted that he has “never heard of a GA meeting started in a prison without the help of outside GA people getting it going.” He recommends that offenders who wish to get a group started, “need to get a GA contact from outside to get the ball rolling to start a GA meeting for them.” The group he ran in New York had 20-25 gamblers attending every week. Three of the attendees said they had just come for the donuts, but they came every week. Those attendance numbers suggest that that a group can be organized in correctional institutions and can attract a sufficient number of participants to make the group function.

We also asked him if, compared to other settings in the community, the offenders were reluctant to open up at the GA meeting. His answer was “not at all I heard some of the most unreal stories even guys talking about killing people for money to gamble.” However, some of the meetings had a prison guard present and then the inmates would not share much.

Investigations in Ontario also confirm that few GA programs have been run for offenders during incarceration.

Problem gambling counselling service

Most of the experts we contacted have worked within the correctional system. However, most problem gambling treatment occurs outside of the correctional system. Most often treatment services are run as part of the health care system, and the counselling is typically done by social workers or specialist addiction counsellors. To fill out our exploration of the treatment system we contacted a problem gambling counsellor who works for the Centre for Addiction and Mental Health (CAMH). The counsellor, who preferred to remain anonymous, based her responses on her professional experience working at CAMH for several years, but she cautioned us that it "does not mean this it is reflective of the outside society/community."

First we asked her about her experience dealing with problem gamblers with criminal histories. She told us that she has had clients with criminal histories as a consequence of gambling-related problems. For example, one client threatened to explode a casino in Ontario with a bomb due to his gambling losses. The client did not have any bombs and it was "just an empty threat." During treatment they found out that he was suffering from a bi-polar disorder, but had not been diagnosed or treated for it. Another client was mandated to seek treatment as part of his probation because he had stolen money from work and assaulted his wife physically. He had been so upset and angry over his losses and needed to come up with money so “he decided to steal money from his work.” Another client had committed fraud by writing checks then "depositing into his own account, then withdrawing money from his account." When the bank found out "he was charged with fraud."

She estimated that less than 30% of her clients had a criminal history. We also asked her about her experience with clients on probation. She responded that she had seen clients who were mandated to treatment by parole officers. She noted that they sometimes "request letters to be sent confirming clients attendance and admission to the program, sometimes they need to know how they are progressing in the program, how long is the length of the program for them, when will they be discharged."

We also asked her if there are any special considerations in dealing with problem gamblers with a criminal history. She responded that they "are treated like other clients in the program attending groups and individual sessions. We take every person's needs into consideration. For example, sometimes there are language barriers. Access to treatment site might be a problem therefore we do our best to accommodate their needs by providing interpreters free of charge or offer phone sessions at times, or refer them to our multilingual problem gambling services if it is a right fit" or to other services closer to their residential location. She told us she cannot think of "anything specific consideration that we do with regard to folks having been charged legally or having a criminal history." They do case management as needed, as well as linking the client to appropriate resources such as "employment counselling, referral to our team psychiatrist if necessary, linking them with other case managers in the community to help with allocating appropriate housing, employment, referral to appropriate internal and/or external mental health services, financial debt management counselling agencies and anything else that might help improve their lives for the better." And if they are not able to help the client, they make referrals either within CAMH or outside CAMH in the community as needed.

We also asked her about any gender considerations for clients with criminal histories. She noted that most clients are "males who have come to our services with a criminal background." One major difference she noted is that "males seem to have committed more aggressive violent crime, females tend to have committed less aggressive more hidden kind of illegal acts such as embezzlement from work or a bank, taking advantage of their partners' credit cards or banking information." She also noted that "males tend to go beyond their circle of family and friends to commit crimes but females tend to stay within their own immediate circle of family and friends."

We also contacted someone from the Windsor residential program to get their perspective on dealing with clients from correctional settings. According to their web site (Windsor Regional Hospital, 2013) the Windsor Regional Problem Gambling Services has been providing gambling specific treatment since 1994. It is funded through the Addictions Branch of the Ministry of Health and Long-Term Care. Their "services are designed to help those individuals who are experiencing gambling problems, as well as those family members and friends who are being affected by problem gambling." Their residential treatment services are available to residents across Ontario. According to their web site

> The residential program is a structured 21-day closed cycle. Program components include individual and group therapy, cognitive distortions, understanding anger, change and goal setting, stress reduction, defence mechanisms, meditation, recreation/exercise, identifying and understanding feelings, communication styles, relapse prevention, art therapy and spirituality.

In particular we asked them by email if clients from an offender population presented any special problems. The person responded that "I have asked staff to make comment on your questions. There was very little that suggested that there were any special issues with this population." He went on to say that as a rule there are no special problems. However, "those with more pronounced Personality Disorder can be disruptive due to quickness to raise voice, get defensive or avoid self-reflection." In addition, he noted that the "facility is non-medically staffed" so that arrangements have to be made for some medications (e.g., methadone) which can lead to some complications." In terms of how well prepared offender clients are for treatment,

he noted that offender clients are "not any more or less than other clients referred from our referent agencies." And finally in terms of whether the current system is meeting client needs adequately, he said that "There is no indication that the current system is not meeting their needs. Residential support received from local St. Leonard's Society probably contributes to this." Overall it appears that the residential treatment is a useful and successful part of the overall treatment picture for offenders with gambling problems.

Summary of Interview Results

In total we interviewed 14 people about programming for problem gambling. We summarized each interview for its key unique points, but also gathered together information that cuts across interviews. This section is organized roughly in terms of the questions asked (see Appendix 1) which are indicted in brackets after each title; p refers part of the questionnaire, and q refers to the specific question within each part.

The programs (part1 q 1 to 3).

Each program described was different. Table 1 displays some of the key differences between the programs. CM's program is comprehensive and focuses specifically on problem gambling from a cognitive behaviour point of view. The program in Lethbridge also focused specifically on gambling problems. In contrast, the KAIROS program run by CC and BS was more generally about addiction, rather than just gambling per se. In addition, it was designed to raise awareness and provide information rather than as treatment. Nonetheless it dealt with topics such as erroneous beliefs and distorted thinking. This was a 5 week program, running once per week, but only one half of one session dealt with gambling per se. The ADAPT program was originally planned to be only about gambling, but due to comorbidity and to increase attendance it was expanded to cover other issues such as alcohol and drugs. The program is now an integrated program that touches more on addictions in general.

The structure varies from program to program. Each program is quite different in nature. This is in part due to the different settings and different needs of the offenders. The reader is referred back to the individual programs for more details.

What guided the development of programs (e.g., framework)? (part1 q 4)

Obviously GA programs have their own twelve-step disease-oriented philosophy (see Ferentzy & Turner, 2013) based on their 60 years of experience as a mutual aid society. The gambling treatment court also uses a disease model of problem gambling along with aspects of a biopsychosocial approach to the disorder (e.g., risk factors, erroneous beliefs) and combines this with a unique problem solving court approach to criminal cases. Most of the other programs examined utilized some version of cognitive-behavioural therapy, but typically utilized an eclectic approach that is client centred.

A number of different sources of information were cited including videos from the Responsible Gambling Council of Ontario, and a screener from CAMH. The CAMH web site was also cited. For the overall approach consisted of information sharing**.** The program includes identifying addiction and dealing with myths and stigmas, motivations for change, addiction and the brain, family impact, relationships, communication, recovery needs and relapse prevention (e.g., coping skills).

The program developed in Lethbridge (Nixon, et al., 2006) appears to have influenced both the Oregon and Kingston programs.

What are they expected to do? (part1 q 6)

Different programs had different expectations. With CC, for example, the only requirements were to attend sessions and complete some questionnaires. Members were encouraged, but not required, to "take part in conversation." At the other extreme, participants in CM's group were required to complete a battery of questionnaires, participate in discussion throughout the program, and abide by a set of rules related to group conduct and confidentiality. Members of CM's program were also reminded that the more effort they made to participate, the more likely they were to derive some meaningful benefit from the program..

How long is your program / module? (part 1 q7)

Program lengths varied from 1 to 16 weeks, with the total time of presentation ranging from 45 minutes to 40 hours. ADAPT at Vanier is 4 weeks long, with a single 90 minute session per week. The Maplehurst program varies from 30 to 75 minutes depending on security situation at the time of the session. CM's program is 16 sessions long, with each session running for at least 2-1/2 hours. The KAIROS program is 5 sessions long, but gambling is only one half a 90 minute session so the total length is about 45 minutes. The program in Lethbridge consisted of 6 90-minute sessions of high intensity.

Sex of participants? (part 1 q 8)

Most of the programs were specially designed for males because they comprise the majority of offenders. However, the ADAPT program for provincial offenders has two versions: One specifically directed at male offenders (Maplehurst) and one for female offenders (Vanier). The program in Alberta was offered in a correctional facility and in the community. Both were open to males and females, but more females were included in the community program. The Gambling Court in Buffalo sees both male and female offenders.

Would it work for both male and female? Gender specific issues (part 1 q 8 & 9)

All of the participants noted that programs could be adapted for males or females, but noted a number of specific gender related issues that would need to be taken into account. For example, CC noted that with females she would focus more on emotional issues and the impact of gambling on the family. According to KI from ADAPT, the programs they run are very similar in both the male and female facilities. The main differences are reflected in the topics that are discussed in the group setting. For example, female group members sometimes discuss stigma related to their addiction and being a woman in jail; or being a woman with these types of issues and also being a mother. CM similarly noted that if the group were directed at females they would "start looking at emotions" and they would have to "work through those emotions in different ways as well." CM also noted differences in game preference.

BS noted that the program should not necessarily be of mixed gender. Specific needs for females, however, would need to be addressed such as childcare and transportation (e.g., bus passes to get to and from the program). For women with children a program offered during the day might work best. In addition she notes that some content would have to be reshaped to capture differences in experiences of women and men.

A counsellor we spoke to noted that there is an important difference in the type of offences committed by males and females. She noted that males often commit more aggressive

violent crime other extreme than females. In addition, male crimes are more likely to be outside of their circle of family and friends.

Who is utilizing the services / how do they get involved. (part 2 q1 & 2)

Answers to this question varied depending on the site. For example, CC noted that her program was aimed at male provincial offenders on probation and that it was "part of their order to take part in substance abuse." It was mandated for substance abuse, not for gambling per se. ADAPT, however, is open to offenders who sign up for the program at their facility. The women's group is open so anyone can attend at any time, while the men's group is sign up only and there is usually a waiting list.

According to BP, participants get involved in CM's program through (1) self-identification in response to posters put up by CM, (2) case management, (3) parole officer especially when it was the problem that brought them to jail, (4) referrals from security where the offender has been found gambling during incarceration, and (5) word of mouth. BP also noted that sometimes guys will try to get into a program just for the information, or because it makes them look better to the national parole board. According to JS word of mouth plays a key role.

Was there any resistance? (part 2, q3)

Most of the participants noted little resistance from anyone. This was largely because the programs were voluntary and the participants felt that they needed the programs and appreciated having them available. CC noted that in the past some participants with substance use disorders have complained to parole officers about the gambling content, feeling that it was not applicable to them. She noted that she has not heard complaints recently perhaps because the purpose of the program is explained to offenders. CC also noted that "some offenders see themselves as poker stars," and in their own minds they know exactly what they are doing. Another offender "was talking about quitting his job because he had won twice on the weekend." JTW reported having one offender who was initially in denial and not interested in any programming. KI said that the offenders who attend were usually interested in whatever groups were provided for their learning, and they were not required to attend. JS stated that she is not aware of any resistance, but that the program is voluntary. JS noted, however, that some offenders may not identify themselves or seek out help because they do not want anyone to have "any ammunition to use against" them.

Support for Program (part 2, q5)

Some programs get their financial support from provincial corrections or probation / parole services. Others get financial support through health care or from the judicial system (e.g., Gambling Court). In Canada there is almost nothing formal to fund programs and no long-term guarantees of funding.

Completion & Referral (part 2, q6 & 7))

Upon completion most programs offer some sort of certificate of completion and a report is sent to the offender's parole officer or directly to the parole board. Some programs provide an option for additional individual counselling, but most often the resources are so scarce that no additional support is available. Offenders who complete the treatment requirement for gambling court are released without any criminal record, but offenders who fail repeatedly to meet their

conditions can be returned to prison to serve their full sentences. BP for instance noted that upon completion of CM's program, the offenders are given a certificate and a short report is documented that goes to the parole officer and eventually to the parole board. CM provides the parole officers with a detailed report that shows the offender's progress and their scores on outcome measures. In addition, he refers them to additional community resources if needed.

Formally evaluated / Successful (part 3, q 1 to 4)

Most of the programs we examined have not been formally evaluated. Notable exceptions are the program in Lethbridge (Nixon, et al., 2006) and the one in Oregon (Marotta, 2007). However, some programs do hand out pre and post questionnaires to evaluate the program, but the evaluation is informal.

BS noted that to evaluate the program, they thought about the content of the group, the quality, the information and the facilitators. She estimates that 90% of the people thank them for running the group and the evaluations are "all pretty positive." The information is included in the annual report. The participants, however, judged their various programs as successful in terms of how the offenders improved according to the reports, and in terms of the success at getting parole. The programs were not evaluated in terms of changes in recidivism or gambling behaviour.

According to BP, CM's program has been evaluated based on the feedback and the program appears to be successful. She has not heard negative feedback about the program. The main benefits of the program are that it provides information and education for offenders, treatment gains, a sense of relief for the offenders that they are getting help, gratitude, and hopefully lower rates of reoffending. For staff there is a sense of relief from parole officers that the issue is being addressed. Similarly JS noted that it is difficult to measure the success of CM's program because gambling was not measured at intake. Nonetheless, she has heard many clients express gratitude for the program.

VG noted that, in her view, the fact that staff continued to refer offenders to the program is itself is a measure of success. Parole officers and programming staff would not waste their time with a program if they do not see any value in it. As similar comment was made by CC in that probation must be happy with the program because they keep funding it.

According to KI, the ADAPT program has never been formally evaluated.

Barriers (part 3, q 5 & 7)

CC did not feel there were any barriers to her program. For JTW one of the major barriers was that programs were not available in prison or not available at the offender's institution. She also noted limited resources for offenders with gambling problems and a desire not to "burn her resources." Similarly CM noted a reluctance to send too many clients to the Windsor program at the same time. Another problem is that some offenders do not qualify for escorted temporary absences and thus cannot access community-based PG programs. A third problem is that staff must escort clients on temporary leave from the prison; understaffing can mean that there is no one available to escort the offender to community-based treatment. She noted that programming is available outside of the institution but little programming is available for those currently institutionalized. This may make it harder for offenders with gambling problems to get parole if gambling related services are a condition of their parole. It was noted by one interview participant that ETA's might be used as an incentive for offenders to be more compliant with the rules in the prison in order to maintain their eligibility for ETAs. The person noted however that

ETAs are not *intended* to be used as an incentive, but sometimes do in fact serve in that capacity..

CM noted that conflict with other programs was a barrier for some offenders. For example, some of the men were taking a welding course at the same time as the gambling program was to run, so the gambling program was postponed. In addition, the program may conflict with work and therefore the offenders would lose pay if they participated.

VG noted that at Frontenac there were no barriers for CM, but for those offenders at other institutions, transportation was a problem. Consequently it would be good to have a standardized program at her institution rather than to have to either bring CM in or move the offenders around to accommodate their needs.

BS noted that sometimes the guards were not supportive and might go to get the person 45 minutes late. Other institutional issues such as a lock down might also be a problem. JTW, however, reported that institutional staff were in general quite happy to bring the offenders to programs for gambling because they view it as a serious issue associated with institutional violence. However, it was noted by CM that he had to spend time cultivating relationships with institutional staff in order to ensure their cooperation. VG confirmed that CM was well liked by the staff and that facilitated the smooth running of the program.

The ADAPT program has had some problems in the correctional facilities. Sometimes it was difficult getting in to do the program; sometimes all the clients who had signed up were not brought in by the guards to group; sometimes clients were not permitted to attend because of other programming. They also had some difficulty in the past with client numbers, especially when it was just a group about problem gambling. There were not enough clients to run the program continuously.

In terms of barriers, JS noted that the biggest barrier was a "failure to identify at intake who might need the program." In addition, she mentioned that they have no formal strategy within federal corrections for dealing with gambling.

Any factors that have contributed to success? (part 3, q 6)

BS listed several aspects that contribute to the success including the style of the program, the ease of making a referral for probation officers, the quality of facilitators, and being available on a regular basis so that the offenders feel comfortable reaching out.

CM noted the importance of cultivating relationships with staff such as parole officers and security staff. Success itself in dealing with the problem at hand contributed to the program's popularity. As VG said, the program is seen by staff as successful, otherwise they would not utilize the service.

According to KI, they have received support from some staff at the correctional facilities that has helped them continue the program. As well, they received positive feedback from the group members about the program.

Should PG programs be integrated with existing programs (e.g. SUD)? (part 3, q 8).

Opinion was mixed as to whether programming would best be handled as an integrated program or a separate program. VG expressed the view that some programming can be handled as an integrated program, and that they are trying some integration. An offender with a gambling problem who also has some other issue such as family violence would benefit from an integrated program. She also said the jury is out as to whether an integrated program is a good idea or not.

CC noted that an integrated program would work for a program that raised awareness of the

issue, but that for treatment a stand-alone program might be better. It would depend on the audience. For those with both drug and gambling issues, an integrated program works, but if not, separate programs would be better. One noted that people with drug problems sometimes complain about having to sit through the gambling sessions. BS also stated that her program works as an integrated program but it is aimed at pre-contemplators. BP noted that in terms of integration with SUD, it would work for some fellows, but her preference would be a distinct group; a stand-alone program. JS suggested that PG and SUD "need to be treated separately" in part because of stigma related to gambling. JS believes that the stigma attached to problem gambling is a reason that the problem is concealed. This would be a problem in a mixed or integrated group, but not a gambling specific group ("a safe environment"). In addition, guys want to be in groups where they can relate to each other. CM stated that based on his 20 years of experience providing treatment for people living with substance user and gambling disorders, that problem gambling needs to be treated separately and not as part of an integrated program. He argues that "there is significant difference" between these two groups.

KI noted that she would prefer a somewhat integrated program because they have found that a large number of clients have concerns about their substance use and problem gambling. In addition she noted that "It is also helpful to make clients aware of the risk involved in substitution. We have found group counselling to be effective within the offender population when integrated."

In terms of mental health CC said she does not know what the best practice would be. JTW noted that they have psychiatrists available for more serious mental health problems whereas gambling is better dealt with in a gambling-specific programs; gambling by itself does not require the services of a psychiatrist. BS noted that in one group they had to remove an offender from the session because he was actively hallucinating and needed more specialized mental health care.

Are current programs meeting needs? Are there gaps in service (part 3, q 9).

A common theme with of these interviews is that current programming for problem gambling does not adequately meet the needs of offenders. CC for example noted that "offenders are underserviced" and that often case managers just do not think about PG as an issue. VG noted that gambling "does come up within the different programs of self-management and financial management" but that there are "no core gambling programs." Several of the interviewees noted that CM's program meets the needs for offenders in the Kingston area, but is the only such program for federal offenders in Canada. If there are other similar services specifically targeting offenders in Ontario or in Canada, we have not yet uncovered them. According to BP, CM's program cannot meet the needs of everyone and his services are already "stretched too thin." The program that was available in Alberta has since been closed. There are other programs that may include a gambling component. For example, KAIROS and ADAPT have included gambling components, but they are not comprehensive programs that adequately deal with the issues. The program available in Guelph for provincial offenders is apparently unique. However, their service for males has a limited capacity. Judge Farrell's program in Buffalo is currently the only program in the world that deals specifically with problem gambling. JTW states that she would prefer having an in-house program available to deal with gambling problems rather than the current situation. KI noted a lack of regular individual and group counselling available for offenders. CM also noted a lack of awareness of the issue as a reason

for the gap, and that a sense of stigma on the part of the offenders also means that many are unwilling to come forward about their gambling.

Additional comments (part 3, p 10).

CM put a great deal of emphasis on the importance of honesty, openness and confidentiality for the success of his group. He cautioned however that some correctional staff can underestimate the importance of confidentiality (especially given the issue of stigma) so it is incumbent upon the facilitator to ensure that staff do not compromise it, even inadvertently.

Discussion

According to Perrone, et al., (2013) "the difficulties associated with establishing good practice in the problem gambling treatment field, both within and outside of correctional service environments, are well documented (p. 27)." The effectiveness of "most problem gambling treatment programs, service models and methods of delivery are either undocumented or poorly documented (p 27)." Perrone et al. (2013) mention that prison problem gambling treatment typically replicates community-based services, and employs the same modalities (e.g., CBT; see also Gambling Research Panel, 2003). Perone et al. (2013) point out one of the difficulties in assessing the best treatment is that program frameworks are typically eclectic and include behavioural and cognitive components. This makes it difficult to evaluate individual aspects of treatment that may be effective (p. 28). In addition, few programs have carried out systematic evaluations. The situation is further complicated by variability in the definitions of gambling problems, differences in measurements of treatment outcomes, and differences in research methodologies (Hodgins & Holub, 2007; Perrone, et al., 2013).

As a first step toward dealing with this problem in Ontario we set out to summarize the literature on dealing with problem gambling in correctional populations as it currently stands. In the literature review we discussed some of the papers we have uncovered. In addition we interviewed people who have worked with this population to see what advice we could obtain regarding programming for this population.

Questions that guided the research

In the methods section, we listed a number of questions that guided our research. Below we have listed each of these questions and summarized the results found from the literature review and interviews.

(1) What programs have been run for offender populations inside correctional institutions? Were the clients male or female or transgendered? What programs have been run at different security levels?

During the course of this investigation we uncovered a number of programs that have been offered to offenders with gambling problems. Programs have included (1) short information oriented sessions, (2) intensive group treatment programs, (3) gambling treatment court, (4) a short program (5 session) offered post release on addictions in general with a small component on gambling, (5) individual counselling either by a social worker or psychiatrist (but intended more for major psychiatric disorders), and (6) gamblers anonymous. Most of the programs we have found were been set up for minimum security or for provincial institutions. In all cases,

these programs were offered by people outside of the correctional institutions typically from treatment agencies.

Each of these programs is an important component of the continuity of care. Gambling court would be an ideal method of dealing with first-time offenders who had committed non-violent crimes related to gambling. The problem is that often offenders with severe gambling problems have committed financial crimes that may be considered too severe to be eligible for a problem solving court. Nonetheless such an option might reduce the number of offenders who go on to have long criminal careers. As noted by Turner et al., (in press) more than 20% of offenders have some level of gambling problems. The integrated information sessions that covered both substance abuse and gambling offered either before release (ADAPT) or post-release (e.g., KAIROS) are a good first step in raising awareness among offenders about the issues related to gambling and substance abuse. These programs may lead to referral to additional programs. Many gamblers simply do not know about problem gambling treatment services or even about the concept of problem gambling as a disease. Raising their awareness of both the problem and the availability of treatment may move some people from pre-contemplation to contemplation.

Intensive programs such as that offered by CM are a more ideal solution for severe problem gamblers. Individual counselling by either a social worker or psychiatrist can be important, but typically is only available for more severe cases such as those with a major depression. According to one interview participant, these resources are in limited supply and intended more for severe cases.

Mutual aid groups such as Gamblers Anonymous could play an important role for offenders who have gambling problems either before or after release. Gamblers Anonymous is not an optimal solution because it is run by non-professionals and has some beliefs (e.g., the necessity of hitting bottom) that can be counterproductive (Ferentzy & Turner, 2013). Nonetheless GA's major strength lies in its collective belief that PG can be overcome, a view that later research and testimonials of GA members seem to vindicate (Ferentzy, Skinner & Antze, 2006, 2009). In addition it is often a useful adjunct to therapy (Lesieur & Blume, 1991; Rosenthal, 1992; Petry, 2002). In addition, given that Gamblers Anonymous groups are free to attend, they would be particularly helpful in these difficult financial times. Currently this option is not being utilized in the correctional system. One possible reason is that the stigma associated with problem gambling may discourage offenders from participating in such groups. Offenders on probation or parole or those who are qualified for escorted (ETA) or unescorted temporary absences (UTA) may be able to attend a GA meeting in the community, but this would not be helpful to offenders in prisons or jails who do not qualify for ETAs or UTAs. Community based GA groups would not be an option for those in medium or maximum security. A better option would be to run groups within the institution. CSC allows AA and NA groups to run as “social programs” at most of the higher security institutions, which are generally attended during the evening. AW noted that it is difficult to get GA groups started in correctional facilities. Still, the attendance numbers reported by AW suggest that a group could be organized in correctional institutions and could attract a sufficient number of participants to make the group function effectively. However, the organization of AA and GA groups appears to require the efforts of a dedicated individual to get the programs going initially, and to keep the programs going. Perhaps both Federal and Ontario correctional authorities could play a role in providing some assistance to offenders who wish to be in or even start a GA program within an institution.

CSC does offer programming for offenders. In addition to educational and training programs, CSC offers a variety of programs including programs for general crime prevention, violence prevention, family violence prevention programs, substance abuse programs, sex offender programs, and community based correctional programs (Correctional Services of Canada, 2013). Currently there are no programs offered by CSC that are directed specifically at problem gamblers. CSC offers in house alcohol and drug abuse treatment programs to women (the Women Offender Substance Abuse Program - WOSAP), men (the National Substance Abuse Program -- NSAP), , and Aboriginal people (Aboriginal Offender Substance Abuse Program – AOSAP). These programs might take gamblers if they also have a substance abuse problem, but do not address problem gambling per se. "CSC provides a range of substance abuse programs for specific populations (men, women, Aboriginal, incarcerated, community), based on criminogenic risk, and need (various intensity levels) to best match offenders to the most appropriate programming. The primary objective of these programs "is to assist high need/high risk substance abusing offenders cope with life situations without resorting to drug and/or alcohol misuse that results in criminal behaviour" (Correctional Services of Canada, 2013).

(2) What programs have been run for offender populations outside of correctional institutions?

The gambling treatment court and the KAIROS program were both run outside of the institutional setting and specifically targeted problem gamblers who were offenders. The gambling treatment court is for diverting offenders prior to sentencing in order to keep them out of prison. Currently Buffalo, New York is the only community in the world that we know of that has a problem solving court that focuses on gambling problems. The KAIROS program is for community sentenced and post-release offenders during the period of probation. It is mainly focused on substance abuse, however, KAIROS in Kingston has added a half session on gambling problems that raises awareness of problem gambling and the availability of services for problem gambling.

Other services are also available to offenders, but not specifically for offenders. This includes services in the community during bail, probation, parole, or after release through the problem gambling treatment system including outpatient services throughout Ontario, and an inpatient service offered in Windsor.

(3) What evidence is there for the success of these programs? For example, was the program evaluated and through what lens was it evaluated.

Very few of the programs we examined have been evaluated formally. Notable exceptions are the small program in Oregon, and the program offered in Lethbridge. Most programs have some opinion based evaluations (e.g., was the program helpful), but only a small number of programs have been evaluated scientifically and even those did not firmly establish the long term effect of the program on re-offending or gambling.

(4) Do these programs meet the needs of the problem gamblers they serve?

A consensus from the interviews and the literature review is that the programs that have been offered do meet the needs of the offenders when available**,** but that the programs are simply

not available to most offenders with gambling problems. The program run by CM in Kingston, for example, appears to be the only program available in Ontario for Federal offenders with gambling problems. Furthermore, this program is only available to offenders who qualify for minimum security. Although CM had tried to offer the program to offenders at a medium security institution, he found that numerous disruptions and restrictive institutional routines made it impossible to present with any regularity. Offenders in maximum and medium security institutions then are currently unable to access gambling specific interventions. CM believes that, under the current arrangement to present his program solely at Frontenac Institution, he can service 3-4 times as many offenders due to greater logistical efficiency.

(5) What gaps (if any) are there in the current system for the treatment of offenders?

Offenders in federal maximum security prisons have no access to problem gambling services. As noted by Turner, et al. (in press) however, the highest rate of problem gambling amongst federal offenders was found in maximum security. This is a huge gap because the highest needs offenders are not being treated. In addition, services are very limited for provincial offenders and the sessions available are likely too few to have any overall effect. Services upon release are widely available from the standard problem gambling treatment service but there is little coordination between treatment agencies and people working in the criminal justice system. In meeting with parole officers we found that the parole officers were largely unaware of community services available for problem gamblers. There is thus a need for education on what is available in the community and to understand that this is an essential part of the offenders ability to successfully reintegrate.

It should be noted that the gap in service for offenders with gambling problems is not unique to Canada but appears to be a world-wide issue. In fact, offenders in Canada are much better off than those in many other countries in terms of having access to a variety of programs designed to deal with specific issues (Correctional Services of Canada, 2013). Ontario in particular is perhaps one of the better serviced areas for offenders with gambling problems because of the availability of specific treatment program in the Kingston area, as well as the programs available in Maplehurst and Vanier. The situation is far from ideal, but we are aware that steps are being taken to improve it. For example, in the autumn of 2012, we took part in a meeting between representatives of Toronto East Parole office and problem gambling counsellors and educators at CAMH. This meeting was organized at the request of the staff in the parole office. In addition, CM is in a discussion with CSC to expand his program as a pilot project to improve service for this population.

(6) Would offenders be resistant to these programs if they were introduced in Ontario?

The consensus from all participants is that most offenders with PG would welcome a program to deal with their gambling problem. It is likely, however, that they would prefer a more voluntary program rather than one that was mandated. The only resistance from problem gamblers that we heard about was from a particular individual who was required to seek out counselling as a condition of parole who was in denial about his gambling problem.

(7) What is the relationship between gambling and SUD?

Given the high rate of substance abuse amongst offenders and the high comorbidity between problem gambling and substance abuse it is likely that a large percentage of problem gamblers also have a problem with SUD. Several interviewees noted the high comorbidity between substance abuse and disordered gambling. One participant mentioned that she had encountered offenders who were sentenced for drug dealing, but who had gambling problems that led them to drug related criminal activities.

(8) Should problem gambling programs be integrated with drug, alcohol or mental health programs?

Opinions on this question were mixed with some interview participants voicing the opinion that an integrated program would be a good idea. In particular there are overlapping skills that both SUD and PG clients could benefit from. Two of the programs we discussed in this paper are in fact integrated programs that deal with both SUD and PG. However, several interview participants voiced the opinion that problem gambling services should be dealt with separately from SUD, rather than provided as part of an integrated program. The main reason offered was that problem gambling is more stigmatized than substance abuse. JS for example suggested that the stigma attached to problem gambling is a central reason that the problem is concealed. An integrated program would mean gamblers admitting to other offenders that they had a gambling problem. This could lead to stigmatization and potential victimization. For example, if other offenders know that a person has a weakness for gambling, he or she could be targeted for invitation to gambling activities, such as card games, that have been rigged (Turner, et al., 2011). Note however that BP somewhat contradicted the notion that PG is stigmatized when she noted that gambling is more socially acceptable than some other behaviours. This is true - gambling is more socially acceptable - but problem gambling is perhaps more stigmatized because it is viewed as a personal weakness rather than a disease. This would be potential problem in a mixed or integrated group, but not a gambling specific group ("a safe environment"). Another problem with an integrated group is that clients may not be happy with having to sit through information sessions that are not relevant to them. For example, people who only have a problem with gambling may not wish to listen to issues related only to drugs. Similarly those with drug problems may not wish to hear about gambling issues. However, the idea of an integrated program has gained traction in the federal system. It is more cost effective than having separate programs for every possible disorder and many of the treatments for problem behaviour and other problems (e.g., SUD) are similar (e.g., Cognitive Behavioural Therapy; teaching coping skills etc.). In addition, as many as 80% of offenders enter prison with SUD (Kunic & Grant, 2006; Weekes, Moser, & Langevin, 1999); coupling SUD treatment with PG would make sense and appeal to policy-makers who are concerned with fiscal restraint.

Some combination of the two might be feasible where joint sessions were conducted for common needs (e.g., coping skills, dealing with negative affect) and separate sessions were conducted for unique aspects of the addictions (e.g., the impact of drugs on their liver or the true odds of winning on a slot machine). In addition, combining programming for problem gambling with some other aspects of mental health (impulse control, stress management, etc.) which apply to a large number of offenders with more specialized services for specific needs would be a good model both clinically and economically.

(9) What are the perceptions of use of community services and what would providers recommend ensuring continuity of care? For example, how to encourage referrals to community groups from the Federal and Provincial correctional systems.

The respondents were aware of the importance of the continuity of care and made references to referrals to services in the local community after release. Our discussion with parole officers, however, suggested that many parole officers are not really aware of the issue of problem gambling and were unaware of the services available in the community. This points to a need for system-wide education on issues related to problem gambling. In their defense, however, parole officers rely on information gathered by others in the judicial system prior to ever meeting the offenders. If the right questions are not being asked then, there is little expectation that a gambling problem will be uncovered early on. As pointed out by several correctional staff, the fact that there is no systematic screening for problem gambling at intake also dramatically reduces the likelihood of identifying the issue when an offender begins to serve their sentence. Thus in order to solve this problem there is a need for screening for problem gambling in the institution and in the parole office. All of this underscores the importance of raising awareness about problem gambling *throughout* the judicial and correctional systems. In addition, many problem gamblers do not come forward for help, so the services that are available are often not utilized. In fact a majority of problem gamblers do not enter treatment (Dalton, Stover, Vanderlinden, & Turner, 2012). Staff at CAMH have recently taken steps to improve the awareness of parole officers of these services in the community. As noted above regarding question 5, in the autumn of 2012, we took part in a meeting between representatives of Toronto East Parole office and problem gambling counsellors and educators at CAMH. Another issue that came up in some interviews was a desire not to overuse particular resources (e.g., psychology, psychiatry, residential services). Greater awareness of the services that are available would be an important step forward for improving the access to treatment for the population.

(10) What gender differences need to be taken into consideration when setting up programs for offenders with gambling problems?

This study is a review of expert provider perceptions of the state of programming for PG among offenders. Most of the programs we examined were specially designed for male offenders because males make up the majority of offenders. However, the ADAPT program for provincial offenders has two versions: One specifically directed at male offenders (Maplehurst) and one for female offenders (Vanier). The program in Alberta was split between correctional facilities and the community. Both were open to males and females, but more females were included in the community program. The Gambling court in Buffalo sees both male and female offenders. Most of the respondents stated that the main difference between male and female clients had to do with the relative importance of emotional and family related issues. The male and female programs run by ADAPT for example are very similar. The main differences are in the topics discussed by the clients. The female group members sometimes discuss stigma related to their addiction and being a woman in jail; or being a woman with these types of issues and also being a mother. Pragmatic issues such as childcare and transportation (e.g., bus passes) may be important for female offenders. In summary, several respondents mentioned that a program for female offenders would be similar to a program for males, but might focus more on emotions

than a program for males. These aspects are already integrated into the SUD program for women at CSC.

Summary

This study revealed a number of programs that have been piloted in correctional institutions to address problem gambling. These programs took a variety of forms ranging from Gamblers Anonymous groups run by non-offenders, to integrating PG modules into existing substance use programs, to intensive and highly structured programs developed specifically for problem gamblers. Some offenders may have multiple service options, while others may have little access to services. The current situation is not, in general, meeting the needs of offenders with gambling problems. PG is not treated as a priority, and as there is no formal screening for problem gambling when offenders enter prison or jail. By consulting with experts we were able to determine some possible next steps in program development for this population. This will include additional studies of offenders and problem gamblers, as well as interviews with participants in the programs that we have identified in this study.

In addition, specific priorities for improving the current system need to be established. For example, one of the issues affecting whether offenders get the appropriate interventions they need, for any issues, is the duration of their sentence or length of detention. This is especially important for female offenders who typically serve shorter sentences than their male counterparts. Short sentences may mean that some offenders cannot participate in programs, so it is worth considering how to incorporate brief PG interventions along with community referrals for such offenders. Another issue to resolve is the need to increase the level of relative importance of PG programming within institutions, along with building connections between corrections and community organizations that already provide services. Building better and more informed referral systems within corrections would certainly be helpful in this regard. CM's program is perhaps an ideal scenario given the intensity and depth of the program and the quality of the triangular relationship CM has built between his program, the offenders, and CSC. Different approaches and solutions may well be required for other settings such as provincial correctional institutions. An issue that needs to be addressed is how to get services to those offenders who do not qualify for minimum security or for ETAs or UTAs at the minimum security level.

An important issue that came up in some of the interviews is that few offenders are identified currently by the system as having a gambling problem and that, as such, the scope of the problem is not known to many correctional workers. JTW for example noted that problem gambling is occasionally mentioned in the offender file or is brought up by an offender during the interview, but most times there is little or no indication that a problem is present. In our study of gambling problems amongst offenders (Turner, et al., 2009; Turner et al, 2012), we found that only a minority of offenders with gambling problems were identified has having a gambling problem by the offenders file. Thus while some offenders are identified by the system, it is likely that many slip through the system without addressing their gambling problem.

Another issue that needs to be dealt with is low attendance for voluntary programs. Offenders are likely to prefer voluntary programs; yet many offenders who have a gambling problem might not attend unless attendance was required. Programs for PG can be attractive to an offender who is nearing the time of the parole/probation hearing and wishes to show that he is working hard to qualify for release. This is because the parole/probation board looks for indications of change and growth. Offenders often want to show that they are trying to make

changes to improve their chances of parole or simply because they wish to reduce the boredom in prison. Some also recognize that they have a problem and need help. In these situations the offender is motivated to attend and may even welcome a mandatory program. However, the feedback we got from offenders was that they generally did not want mandatory programs (Turner, et al., 2007).

Chandler, Fletcher and Volkow (2009) have discussed this matter in terms of offenders with substance abuse issues. As noted above, a high portion of offenders have problems with substance abuse. Chandler et al. (2009) argue that addiction is a disease of the brain, with strong genetic components, these authors take issue with a punitive approach to addictions. These authors observe that, in most correctional settings, drug education is more commonly used than formal treatment itself. Thus, they argue for expanded treatment options for offenders with SUD.

One option they discuss is the use of the Drug Treatment Court or more generally problem solving courts (Chandler, et al., 2009). As noted above, expanding this idea to gambling has been tried in Buffalo and has been running for a number of years (Farrell, 2011; Rose, 2003). CAMH has been exploring this idea since 2011 (Turner, 2011 Feb; Teasell, & Turner, 2012 Feb). In February 2011 the PGIO at CAMH organized a Forum to bring together key stakeholders from the Ontario legal and problem gambling treatment systems to participate in a "Gambling Treatment Court Forum." The purpose of the forum was to explore and discuss the need for this initiative in Ontario, learn what other jurisdictions have done, and explore ways to create and/or incorporate gambling treatment court into existing diversion programs. The invitation list included stakeholders from the problem gambling treatment system, the legal system (which included, judges, crown and defense attorneys), and community agencies such as the Salvation Army, the John Howard Society and the Elizabeth Fry Society. In total, approximately 40 participants registered to attend. Judge Mark Farrell was the keynote speaker for the forum, with additional presentations from Nigel Turner (Turner, 2011 Feb), as well as presentations from crown attorneys, defence attorneys, Chris Myers from Kingston, and representatives of CAMH drug treatment court.

There was a great deal of interest generated in the topic, including interest expressed from judges in Windsor and Toronto. This presentation was followed up in 2012 with a presentation at the Drug Treatment Court Conference in 2012. Unfortunately, there were considerable challenges in convincing crown and defence attorneys about the the idea of a gambling treatment court. The largest barrier was the belief that there were not enough cases of offenders with gambling related offences that would benefit from such a program; a secondary barrier was a lack of monitoring tools equivalent to a urine test. Attorneys often asked how we could monitor someone on the program to know if they were gambling or not. In 2011 and 2012, CAMH continued to do presentations at conferences and attend meetings with stakeholders in an attempt to move this agenda forward, but was not able to secure a commitment from a court judge and crown and defence attorneys. So no program was started. Nonetheless, the idea of a gambling court should be given serious consideration as a means of effectively dealing with gambling problems in the criminal justice system.

This research project is only the first part of a more extensive examination of programming for problem gambling in the correctional system. It is our plan to expand on this topic in a subsequent study to explore what needs to be done for this population, and to develop recommendations for best practices for offenders who have gambling problems in correctional systems and in the community. A focus of the larger study would be the barriers that we will likely face in trying to set up a treatment program for offenders in the correctional system (from

offenders, the correctional system, the treatment system, for male offenders, for female offenders).

Conclusions

In this project we have attempted to describe the situation as it currently exists in Ontario and in other jurisdictions with respect to treatment for problem gambling for offenders. The published literature on dealing with problem gambling in correctional populations is remarkably small. In addition we uncovered a small number of programs that are administered by specific treatment agencies for particular settings. There is no system wide service currently available. There is a clear need for programming for this population and an apparent desire for programming among the population. On the other hand the participants are most likely to respond positively to a voluntary program than a mandatory program. Also, there are some good reasons why the program should be carried out by an outside agency. In particular because of stigma and confidentiality issues, an outside agency would be in a better position to offer services that are accepted by the offenders. Institutions have generally been very supportive of efforts for this population but there are still barriers to programming include difficulty dealing with institutional movement issues (lock downs, security, problems obtaining with temporary absences). Another issue is the lack of awareness of the issue of problem gambling in the criminal justice system including judges, lawyers, wardens, corrections workers, and parole officers.

Limitations

The method used in this study is qualitative. We included a relatively small sample of key experts which limits our ability to generalize. The main potential limitation involves researcher bias. Unwarranted assumptions can distort the interview process right at the start. Furthermore, researcher bias can affect the interpretation of qualitative results. The researchers are skilled in scrutinizing their own biases and letting the interview participant tell their own story. In addition, during the analysis, each of the researchers went through the data and helped summarize it. In addition, the interviews are reported in great detail and wherever possible the opinions of the interview participants are given in their own words. We also ensured accuracy by sending the summaries back to the interview participants for their review. No offenders were included in this analysis; however, we have interviewed a large number of offenders in our previous studies (Turner, et al., 2007; Turner et al., 2011). In addition, we were not able to recruit anyone in politics or upper level management in the correctional system or wardens.

Implications & Future Research

Recommendations

1) Increase awareness of the issue of problem gambling at all stages of the criminal justice system including judges, lawyers, corrections workers, and parole officers
2) Promote the possibility of problem solving courts for offenders with gambling problems
3) Assess problem gambling during intake so that the scope of the problem is more accurately understood in the correctional system. At the Federal level this could be accomplished by adding

a few questions to the Offender Intake Assessment (OIA; Motiuk, 1997) that is delivered at intake.

4) Train parole officers and other people who work in the correctional field to identify people with gambling problems and to deal with them appropriately, including referral to appropriate resources.
5) Increase availability of inpatient care for problem gamblers who are released from prison.
6) Encourage local treatment agencies to set up and run problem gambling services inside correctional facilities
7) Develop in house programs with CSC to raise awareness of problem gambling and treat problem gambling.

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Table 1
Overview of the programs discussed in this report.

Program	Sex	Setting	Sessions	Time (minutes)	Method	Orientation	Content	Evaluation
Gambling Court	M&F	Court	As needed		Problem solving court	Biopsychosocial / Disease model	PG	
Lethbridge	M&F	Provincial prison	6	540	Brief treatment	Cognitive / behavioral	PG	Nixon et al. (2006)
ADAPT	M&F	Provincial prison	4	360	Brief psycho-education	Cognitive / behavioral	PG + SUD	
OPTIONS	M	Federal min security	16	2400	Intense group treatment	Cognitive / behavioral	PG	
KAIROS	M	Parole	1 out of 5	45	Brief psycho-educational	Cognitive / behavioral	SUD + PG	
GA	M&F	Any	--		Mutual aid	Twelve step model	PG	
Oregon	F	US State prison	6	540	Brief treatment	Cognitive / behavioral	PG	Marotta (2007)

Appendix 1

Initial Interview Questions For Key informants.

Note that the interview questions were modified during the project. In addition, shorter questionnaires were used for some experts where the questions were more targeted to a specific small set of issues (e.g., Gambling Court, GA, outpatient treatment services, inpatient services.)

Part 1

1) What is the nature of your involvement with this program?
2) What initially led to an identified need for this type of program?
3) Which individuals and organizations would you identify as "key players" in the creation of this program
4) Were there any particular philosophies or principles or a theoretical framework that guided the development of this program?
5) What would you say were the primary goals in developing this program?
6) What did you (or others) think/hope/expect would happen as a result of this program being provided?
7) How long is the program?
8) What is the gender breakdown of the project?
9) In your opinion would this program work for both male or female participants? Are their gender specific issues that need to be taken into account.
10) Do you feel that current programs meet the needs of all offenders with PG? If so, why? If not, why?

Part 2

1) Who utilizes the services of this program (target population)?
2) How do offenders become involved with the program and what are they generally expected to do?
3) Are offenders typically resistant to your program or were they when it was first established? How have participant concerns been addressed over time? Is this program equally acceptable to males and females.
4) Can you please describe the program in terms of its length/structure, content/activities, level of participant involvement, and overall approach (e.g. education & prevention, cognitive-behavioural intervention, peer-supportive, corrective-coercive in nature, etc)?

5) Can you describe the primary sources of support for this program (i.e. funding/ administration, other capital resources, personnel, volunteer or in-kind assistance, etc)?
6) Are clients offered anything upon completion of the program such as aftercare, or any ongoing monitoring?
7) Is there any referral service for offenders for care after release?

Part 3

1) Has this program ever been formally evaluated? If so, how was this done and by whom?
2) What specific measures of success are you relying on (e.g. available data, recidivism or relapse rates, feedback from offenders and/or correctional staff, general impressions, etc.)?
3) How successful would you say the program has been overall?
4) Are there any changes you would like to make to your program?
5) What specific barriers (structural, financial, participant) have been faced by this program which have (or could have) limited its potential?
6) What factors would you say have been critical to the overall success and continuation of this program?
7) Could this program be adapted to other contexts in order to expand its reach? If so, where else could it potentially work and what might be required in order for it to succeed elsewhere (barriers, supports)?
8) Should problem gambling programs be integrated with substance use or other programs or should they be treated separately? Why or Why not? What about MH programs or other programs like violence prevention/sexual offender programs?
9) In your opinion, what gaps (if any) are there in the current system for the treatment of offenders?
10) Any Additional Comments