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Addressing the Issue of Problem Gambling in the Criminal Justice System: A Series of Case Studies

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Abstract

The prevalence rates of problem gambling in the adult correctional population are 5 to 10 times higher than those found in the general population. Yet little has been published about dealing with problem gamblers in correctional settings. We conducted a literature review and interviewed 16 key informants who provide services to clients experiencing problem gambling and/or who have worked in the criminal justice system. Our objective was to gain greater understanding of programming for problem gambling for clients who are involved in the criminal justice system, with a particular focus on Ontario. The published literature on this topic is remarkably sparse. In fact, only two peer-reviewed published studies were identified that formally evaluated a treatment program for problem gambling for clients in these settings. However, we uncovered a small number of programs (10) that had been developed for, and delivered to, this population, including a gambling treatment court in Buffalo, Gamblers Anonymous, outpatient treatment during probation or parole, brief psychoeducational programs, brief therapy, a full intense treatment program, and inpatient treatment after release. We present a series of short case studies of these programs. Although some programs have been delivered within correctional institutions, others have been offered either after release or prior to sentencing. A major issue is the lack of awareness of problem gambling in the criminal justice system among judges, lawyers, wardens, corrections workers, and parole officers. The results are discussed in terms of issues and opportunities for programming for problem gamblers in the criminal justice system.

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

Résumé

Chez la population carcérale adulte, les taux de prévalence du jeu compulsif sont de cinq à dix fois plus élevés que dans l'ensemble de la population. Pourtant, peu de choses ont été publiées sur les joueurs pathologiques en milieu correctionnel. Nous avons effectué une revue de la littérature et avons interviewé 16 informateurs clés qui fournissent des services aux clients ayant un problème de jeu ou qui ont travaillé dans le système de justice pénale. Notre objectif consistait à mieux comprendre les programmes pour traiter le jeu compulsif destinés aux clients qui ont eu des démêlés avec la justice, avec un intérêt particulier pour l'Ontario. Étonnamment, il existe très peu de publications sur ce sujet. En effet, nous n'avons trouvé que deux comptes rendus d'étude publiés et validés par un comité de lecture qui ont évalué en bonne et due forme un programme de traitement pour le jeu pathologique destiné aux clients de ce milieu. Toutefois, nous avons découvert un petit nombre de programmes (10) qui ont été élaborés à l'intention de cette population, et qui lui ont été offerts, notamment un programme judiciaire de traitement du jeu pathologique à Buffalo, le groupe d'aide Joueurs Anonymes, un traitement ambulatoire durant la probation ou la libération conditionnelle, des programmes psychopédagogiques de courte durée, une thérapie brève, un programme complet de traitement intensif et un traitement en établissement après la libération. Nous présentons une série de courtes études de cas de ces programmes. Bien que certains de ces programmes aient été offerts dans des établissements correctionnels, d'autres ont été proposés après la libération ou avant la condamnation. Le principal problème réside dans le fait que les juges, les avocats, les directeurs, les intervenants correctionnels et les agents de libération conditionnelle connaissent mal le jeu pathologique dans le cadre du système de justice pénale. Les résultats sont analysés en fonction des difficultés et des avantages des programmes destinés aux joueurs pathologiques qui ont eu des démêlés avec la justice.

Introduction

In a review of the literature on gambling problems among people in correctional settings, Williams, Royston, and Hagen (2005) found that the prevalence for both males and females ranged from 17% to 60%, with an average of around 33% across samples. Similar prevalence numbers have been found in more recent studies (May-Chahal, Wilson, Humphreys, & Anderson, 2012; Turner, Preston, McAvoy, & Gillam, 2013; Turner, Preston, Saunders, & McAvoy, 2009). Among participants recruited from several provincial and federal correctional institutions in Ontario, Turner et al. (2009, 2013) report that slightly less than a quarter of those surveyed had either a moderate or severe gambling problem and, in particular, 9% had a severe gambling problem (Turner et al., 2013). The rate of moderate and severe problem gambling (PG) in these studies is about 10 times that of the general population (Williams, Volberg, & Stevens, 2012).

Turner et al. (2009) also interviewed their participants and found that problem gamblers often reported being caught in a cycle of gambling, debt, and crime, followed in turn by more gambling. For example, one participant reported that "gambling led to debt, my debt led to crime… and around it goes" (p. 163). Turner et al. (2009) reported that 65% of participants with pathological gambling described gambling as a criminogenic factor in at least some of their criminal activity. If unable to resolve their gambling problems, it is likely that they will continue to be caught in this cycle.

Although research on gambling in correctional populations in Canada and elsewhere suggests a considerable need for gambling treatment for this population, no system-wide services for PG have been provided in Ontario or in any other jurisdiction. Correctional Service of Canada (CSC) does offer a number of educational and training programs, including programs to deal with substance abuse (CSC, 2014). However, services for PG are not currently offered to offenders on a system-wide basis in Canada. This situation is not unique to Canada. Perrone, Jansons, and Morrison (2013) note that within the correctional environment, PG treatment services remain largely undocumented and unevaluated. Perrone et al. (2013) also note a lack of awareness in the criminal justice system of PG as an issue. An examination of the literature found only a small number of publications on the topic.

We used a combination of literature review and interviews with experts in the field to explore programs for PG and to understand the state of programming for people with gambling problems who are in correctional settings. In particular, we interviewed experts[1] who had knowledge of the correctional population, with an emphasis on Ontario, to give us a good understanding of the issues involved in setting up a PG program for a correctional population. Our study included experts who had worked with either provincial or federal correctional institutions in Ontario, experts from the treatment system in Ontario, and key experts from outside the province. This paper is essentially a series of case studies that illustrate programs that have been offered at one of the various stages of the correctional process, including pre-incarceration, incarceration, post-release transition, and post-release integration (Visher & Travis, 2003). The programs are described to show how they fit into the continuity of care for problem gamblers and to show where rehabilitation science can help to reduce recidivism (see Visher & Travis, 2003). Given the heterogeneity of various prison settings, we expected that the structure of the programs would vary accordingly. We believe that by cataloging these case studies, we can begin to accumulate a body of literature on this topic and encourage further development of programs for PG in the criminal justice system. People interviewed included PG counsellors, parole officers (POs), programming staff, people involved in the management of correctional programming, a judge, and a long-time member of Gambler's Anonymous. The research was guided by the following questions:

1. What programs have been run for people in correctional settings?

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

2. How are these programs structured?

3. Have these programs been scientifically evaluated?

Method

Participants for Qualitative Interviews

Sixteen people were interviewed between March 2012 and March 2013. All had expertise and experience in dealing with problem gamblers in a correctional setting, in the treatment of PG, or in developing or managing programs for clients in the correctional setting. The sampling strategy was purposive because this 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 (Sandelowski, 1995). The initial sample was recruited from contacts we had established during our earlier studies of gambling problems in the criminal justice system (e.g., Turner, et al. 2013). We also contacted people who had published studies or had given conference presentations in this area and asked them if they would agree to participate. This approach was supplemented with a snowball technique in which participants were asked if they knew others who would have useful information. Of the people approached for an interview, none declined. The result is a series of case studies that illustrates potential interventions at various stages of the correctional process.

Literature Review of PG Programs

This was a scoping literature review. We attempted to examine all studies of programs that we could find in the published literature, grey literature reports, and conference presentations. A literature search was conducted using the search terms listed in Table 1. This search yielded two papers that described interventions. One paper described the evaluation of a brief treatment program (Nixon, Leigh, & Nowatszki, 2006), and a second

Table 1
Search Terms Used to Examine the Published Literature

Search terms	Total found	Examined for inclusion	Selected for inclusion
Prison* and gambl* and treatment	35	3	0
Prison* and gambl* and prevention	7	1	1
Offenders and gambl* and treatment	27	0	0
Offenders and gambl* and prevention	15	1	0
Prison* and gambl* and intervention	4	1	1
Forensic and program* and gambl*	7	0	0
Forensic and client* and gambl*	2	0	0

Note. An asterisk is used as a wild card to capture any completion of a word (e.g., gambl* = gambler, gamble, gambling, gambled).

paper described a program for the general prison population that taught them about the gambling lifestyle (Walters, 2005). A search for citations of those papers failed to yield any additional published papers. A Google search for grey literature also yielded a PowerPoint report on a program offered in Oregon (Marotta, 2007) and a number of government reports (e.g., McKenna, Brown, Rossen, & Gooder, 2013; Perrone et al., 2013) that included information on programming for people in custody with gambling problems.

Procedure

Semi-structured interviews were used with the experts to learn from their experience, to determine the advantages and limitations of various approaches, and to obtain their views on dealing effectively with PG in the criminal justice system. Most interviews occurred in person. However, depending on the location of the expert, some interviews were carried out over the phone or by email. The interview included some common core questions in which participants were asked to describe the program and to discuss its background, including its theoretical orientation, treatment method, and any evaluation of the program. Other questions differed, depending on the person being interviewed, and were tailored to the individual program under discussion. Shorter versions of this questionnaire were used for some experts in which the questions were more targeted to a specific, smaller set of issues (e.g., gambling court, GA, outpatient treatment services, and inpatient services).

The study was approved by the Research Ethics Board of the Centre for Addiction and Mental Health (CAMH). Anonymity was not practical, as a number of the experts included in this study are published authors (e.g., Judge Farrell, Gordon Leigh, Arnie Wexler, Chris Myers, Colleen Tessier, Brenda Teasell). We obtained their consent to use their names in the paper. For the rest of the participants, we use participant numbers (Participant 6, 7, etc.). Both a summary of the interviews and a draft of the technical report for this study were sent to the participants so that they had an opportunity to comment or correct their contributions to the report.

Data Analysis

Data analysis began with transcription of the interviews. The lead researcher (NT) 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. The information was then organized according to general themes by NT. Given that the experts spoke directly to the issues, the data analysis was straightforward.

Results

By interviewing 16 experts and performing a literature search, we found detailed information on 10 programs that had been offered to problem gamblers at various stages in the correctional process. In the following section, we list each of these case studies according to the four sequential stages of the correctional process. This list is not to be

taken as exhaustive; rather, it reveals important information for anyone interested in researching or developing services for problem gamblers who experience incarceration. Each program described is unique, but shares some common traits with other programs. Table 2 displays some of the key features and differences between the programs.

From the literature review and interviews, we organized the information into four major categories based on the stage in the correctional process: (1) diversion to problem-solving courts; (2) Gamblers Anonymous (GA), a mutual aid fellowship; (3) brief psychoeducational intervention and treatment during incarceration; and (4) post-release programs during parole. Categories 3 and 4 also were further subdivided into brief psychoeducational information sessions (3A and 4A) and treatment (3B and 4B).

Diversion to Problem-Solving Courts

One option for people who become involved in the criminal justice system is diversion from correctional institutions into a special problem-solving court where clients are mandated to treatment instead of prison (Lahn, 2005; Rose, 2003). For those with gambling problems, a gambling treatment court (GTC) could be modelled after the more general practice of problem-solving courts, where clients with psychiatric or substance use problems are redirected away from prison into a therapeutic situation in which the emphasis is on rehabilitation rather than punishment (Cooper, 2003; Farrell, 2011; Nolan, 2002; Peters, Kremling, Bekman, & Caudy, 2012; Slinger & Roesch, 2010).

The most common problem-solving courts are drug treatment courts (DTCs). The first DTC appeared in Florida in 1989 (Wiseman, 2005). According to Gutierrez and Bourgon (2009), there are now 1,700 DTCs in various countries around the world, including the United States, Canada, Australia, and several European countries. A number of studies have reported that DTCs decrease recidivism (Gutierrez & Bourgon, 2009; Latimer, Morton-Bourgon, & Chretien, 2006) and save funds by mitigating the costs of incarceration (Chandler, Fletcher, & Volkow, 2009).

Currently, the idea of a problem-solving court has been extended to PG in two places. One is the Amherst GTC located in Buffalo, New York, and the other is in Nevada, where state law permits diversion for problem gamblers (Nevada Council on Problem Gambling, 2010). The program located in Buffalo, New York, is overseen by Judge Mark Farrell. To find out more about the Amherst GTC, we contacted Judge Farrell and attended a conference presentation he gave in Toronto in 2011 (Farrell, 2011). In a therapeutic court, defendants are required to plead guilty but are not sentenced to prison (Rose, 2003); rather, they work their way through their problems, attending court and therapy sessions as needed. Defendants are motivated to make progress (Farrell, 2011) by means of regular monitoring, accountability, and a system of psychosocial support. This process lasts at least 1 year. If they complete the program, all charges are dropped. If they miss one of their weekly therapy sessions, a mild penalty is applied such as “increased frequency

Table 2
Overview of the Programs Discussed in This Report

Program	Type	Stage	Sex	Setting	Sessions	Hours	Method	Orientation	Focus	Evaluation
Gambling court	Diversion	1	M & F	Court	As needed		Problem-solving court	Biopsychosocial/ disease model	PG	Farrell (2011)
GA	Mutual aid	2, 3, & 4	M & F	Any	As needed		Mutual aid	Twelve-step model	PG	
ADAPT	Information inside	2	M & F	Provincial prison	4	6	Brief psychoeducational	Cognitive/behavioural	PG & SUD	
Lifestyles	Treatment inside	2	M	US state prison	20	30	Psychoeducational	Cognitive/behavioural	PG & non-PG	Walters (2005)
Lethbridge	Treatment inside	2	M & F	Provincial prison	6	9	Brief treatment	Cognitive/behavioural	PG	Nixon et al. (2006)
OPTIONS	Treatment inside	2	M	Federal minimum	16	40	Intense group treatment	Cognitive/behavioural	PG	
Oregon	Treatment inside	2	F	US state prison	6	9	Brief treatment	Cognitive/behavioural	PG	Marotta (2007)
KAIROS	Information post-release	3	M	Parole/ probation	1 of 5	0.75	Brief psychoeducational	Cognitive/behavioural	SUD& PG	
CAMH	Treatment post-release	3 & 4	M & F	Any	As needed		Outpatient counselling	Cognitive/behavioural	PG	
Windsor	Treatment post-release	3 & 4	M & F	Parole	21 days	168	Inpatient counselling	Cognitive/behavioural	PG	

Note. "Stage" refers to the four stages of the criminal justice system re-entry as described by Visher and Travis (2003), where 1 = pre-prison, 2 = in prison, 3 = post-release transition, and 4 = post-release integration. M = male; F = female; PG = problem gambling; GA = Gamblers Anonymous; SUD = substance abuse; CAMH = Centre for Addiction and Mental Health.

of court appearances" (Farrell, 2011, slide 58). They face increased severity for each subsequent act of non-compliance. If clients violate too many of the terms of the contract with the GTC, they could be sent to a correctional institution (Rose, 2003).

With GTC, the judge also functions as a social worker, and the court is a proactive agent of change (Farrell, 2011). The Amherst GTC uses a disease-based model of PG with a focus on treatment. The judge manages the process as team leader. The prosecution, defence lawyer, therapists, and others are part of this team rather than in adversarial roles (Farrell, 2011). This teamwork potentially creates conflict of interest for therapists and defence lawyers with respect to confidentiality because the client's behaviour is reported to the judge. However, the goal is the best interest of the client as well as the best interests of society.

There are a number of difficulties and challenges in setting up a GTC. In addition to speaking with Judge Farrell, we also spoke with Brenda Teasell (BT) a social worker formerly with the Problem Gambling Institute of Ontario in Toronto, and Colleen Tessier (CT), Senior Program Consultant for Education & Community Resources at CAMH in Toronto, about their experiences in exploring the possibility of setting up a GTC in Ontario.

First, both Judge Farrell and CT note that there is some difficulty in identifying candidates for GTC. In drug courts, cases often involve drug use or drug sales. However, gambling is mostly legal and so many arrests occur as a secondary consequence of gambling because of issues such as impaired driving after gambling, fraud, or theft. According to CT, many people in the criminal justice system doubt that there would be enough clients who would benefit from a GTC in Ontario. In the United States, casinos provide free alcohol to patrons, often leading to impaired driving charges, but such practices are not legal in Canada. Therefore, driving under the influence after leaving a casino is less often the reason for an arrest. In Canada, people with gambling problems often enter the criminal justice system because they are charged with theft (79.2%), possession of property obtained by crime (79.2%), break and entry (58.3%), robbery (50%.0), fraud (33.3%), or other financial crimes (Turner & McAvoy, 2011).

Second, another barrier to a GTC noted by BT stem from the severity of the crime. For example a robbery, or a fraud involving a large sum of money (e.g., $20,000), may preclude a diversion to a problem-solving court.

Third, as noted by BT, CT and Judge Farrell, there is no definitive test for violation of the GTC conditions, such as urinalysis, making it difficult to monitor compliance or to measure relapse (Farrell, 2011). Marlowe, Festinger, Foltz, Lee, and Patapis (2005) point out that compliance typically hinges on the perceived certainty of detection, making this issue particularly problematic for GTCs. As a way to monitor progress, Farrell uses self-reports and information from family and therapists. Of the 129 people admitted to the GTC in Buffalo over the life of the program, 38 are still in it. Of the 91 people who have been through the program, 57 (62.6%) have graduated

and 34 (37.3%) have returned to criminal court. Of the 57 who graduated, 41 (71.9%) are in recovery and 16 (28.1%) have relapsed. These numbers indicate that the program has successfully diverted about 45.1% (41 / 91) of its clients away from the cycle of gambling and crime. Nonetheless, CT and BT indicated that efforts to explore the possibility of a GTC in Ontario have been met with skepticism about the issue of compliance.

Fourth, acceptance of a GTC by parties concerned (including society at large) has not always been forthcoming. Judge Farrell noted that many in the judicial system simply do not view PG as an addiction. In addition, the political atmosphere in Canada in recent years (2005 to 2015) followed a policy of getting tough on crime rather than on rehabilitation (Sullivan, 2014). Judge Farrell noted that mandatory sentencing guidelines in the United States restrict a judge's ability to use the discretion needed for diversion. Even defence councils may be resistant to a GTC because its structure necessitates a very different relationship with clients, far removed from traditional roles.

Fifth, in many jurisdictions, especially in the United States, there are no systemic treatment avenues for people with gambling problems and no relationship between the criminal justice system and treatment facilities. Treatment services are available in Ontario but, according to CT and BT, the links between the criminal justice system and the treatment system are weak. In particular, there is little awareness of the issue of problem gambling in the criminal justice system.

Sixth, CT also noted that many in the Canadian legal system report a lack of resources such as staff and time to set up a program. Everyone she talked to described being too busy to help set up such a program.

Mutual Aid Fellowships (GA)

A second option is mutual aid fellowship, where people who face addiction problems voluntarily help each other in their goal of abstinence (Alcoholics Anonymous World Services, Inc., 1976). The first and most notable mutual aid group is Alcoholics Anonymous (AA), which was established in 1935 (Ferentzy & Turner, 2013, p. 164). AA was founded and run by alcoholics with the goal of helping each other to achieve and maintain sobriety (Alcoholics Anonymous World Services, Inc., 1976; Ferentzy & Turner, 2013, p. 107). GA was founded in the 1950s (Ferentzy, Skinner, & Antze, 2009). It is a mutual aid fellowship modelled after AA that uses a similar 12-step approach (Gamblers Anonymous International Service Office, 1984). GA now holds meetings in most North American communities and to a lesser degree has established itself worldwide. Similar to those in AA, GA groups are peer-support groups made up of individuals who try to assist each other to cease gambling and remain abstinent in the long term ("maintaining recovery," Wexler & Wexler, 2014, p. 103). GA views PG as a compulsion and an illness and promotes total abstinence from gambling as the only form of recovery. GA is somewhat different from AA in that GA devotes much of its time to "pressure relief" (Wexler & Wexler, 2014, p. 110) to help deal with the

crippling financial difficulties that its members face. During a pressure relief session, more experienced members give advice to newer members on challenges involving financial and legal considerations (Ferentzy, Skinner, & Antze, 2006; GA, 2000, Wexler & Wexler, 2014) such as handing over financial control to someone else (e.g., spouse), contacting creditors, making a budget, and creating a repayment plan (GA, 2000). GA differs from formal treatment in that it involves peer support rather than professional intervention, yet the goals are similar: to help members stop gambling and to deal with character traits, such as self-centredness, that purportedly cause the excessive gambling (Custer & Milt, 1985).

Correctional facilities in Canada encourage mutual aid fellowships such as AA and Narcotics Anonymous (NA) to run within the facilities as social groups. Similar groups for gamblers could operate in Canadian correctional facilities; however, we were unable to find any information about GA groups that were being run in Ontario prisons at the time of this study. To learn more about the prospects of GA for people involved with the criminal justice system, we interviewed Arnie Wexler (AW), who was a compulsive gambler and has been in recovery through GA for almost 50 years. AW is currently one of the foremost experts on compulsive gambling in the United States, is a Certified Compulsive Gambling Counsellor, and was the Executive Director of the Council on Compulsive Gambling of New Jersey for 8 years. Since joining GA, AW has helped numerous other gamblers with their recovery. According to AW, "lots of people are in jail because they suffer a gambling addiction." AW reports that he has testified at court trials for over "50 problem gamblers over the years" including two recent cases. AW told us that most lawyers do not know how to deal with gambling addiction. He added that most jails in the United States have AA and NA meetings but few have GA meetings. He said that it is "hard to get them going in correctional institutions." AW told us that he ran a GA group in a prison from 1972 to 1974 every Friday night in New York State with 20-25 gamblers attending every week. Later when he was executive director of the council on compulsive gambling of New Jersey, AW started three GA groups in prisons. His success in developing programs in correctional facilities suggests that there is interest in GA groups among this population, but typically someone from outside the system needs to take the initiative to arrange and conduct the groups and to ensure that the groups remain active.

Part of the problem with getting GA groups running is a general lack of awareness of PG within the criminal justice system. In short, staff might not encourage the creation of such groups. In addition, potential participants are often in denial about their problem. AW noted that most people do not understand the reality of PG and think that all you need to do is "tell gamblers just stop and that will work." He said "people look at other addictions and say those people are sick." But they look at "gamblers and say they are bad people and crooks." Echoing the words of Judge Farrell, he noted that this is true for the general public, lawyers, judges, and prison administrations.

Three of our respondents (Chris Myers [CM] and Participants 9 and 12) noted that within the correctional setting, gambling was more stigmatized than were other

addictions. In particular, people who admitted to having a gambling problem opened themselves up to potential ridicule or exploitation by other inmates. This notion of PG being more stigmatized should be further studied to verify whether it is a serious concern. AW also noted that stigma might help to explain the scarcity of GA groups in prisons. He noted that he had "never heard of a GA meeting started in a prison without the help of contacts from outside to get the ball rolling and start a GA meeting for them." However, once a group is up and running, the clients have no difficulty opening up at the meeting. AW also noted that when a prison guard was present at a meeting, the participants would not readily share their stories. But without any guard present, the participants had no problem talking about their experiences of gambling and crime. However, he also suggested that sustaining a group could require the ongoing commitment of a GA member from the outside.

Brief Psychoeducational Interventions and Treatment During Incarceration

A third option for people who have gambling problems and are facing a prison stay is treatment during incarceration. Treatment is a broad concept that can encompass a variety of programs and approaches and can range from brief psychoeducational sessions to long-term, in-depth individual counselling.

The vast majority of PG treatment research and evaluation studies have focused on community-based PG services, and little attention has been directed towards evaluating PG treatment for correctional populations (Perrone et al., 2013). Treatment services for PG are now available in many jurisdictions; most are modelled after substance abuse treatment and often follow biopsychosocial, cognitive-behavioural, or 12-step approaches (Berg & Briggs, 2002; O'Conner, Ashenden, Raven, & Allsop, 2000; Toneatto & Dragonetti, 2008; Toneatto & Millar, 2004). However, for clients living in prison, the availability of PG services is inadequate. If a program facilitator or psychologist, often from outside the institution, starts a program in prison, these programs are typically modelled after those used with non-correctional populations (Perrone et al., 2013). A number of gambling-specific programs for people in the criminal justice system in Australia and New Zealand have been offered in specific locales. Few have been formally evaluated or the evaluations have not been made publically available (Emshoff, Zorland, Mooss, & Perkins, 2008; Perrone et al., 2013). A prevention program in Minnesota (see Emshoff et al., 2008) was well received. For example, 84% of the clients reported being "very satisfied" or "satisfied" with the gambling component of the program, 89% reported being able to identify the signs of PG, and 92% reported that they knew where to get help. However, the program was not evaluated with respect to harm reduction.

In Auckland, New Zealand, Brown, Bellringer, and McMillan (2002) designed and developed a brief (60-minute) group-based, interactive, psychoeducational intervention for participants who were incarcerated and experienced gambling problems, with follow-up one-on-one PG counselling on request. The goal of the program 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 over their gambling behaviour, 29% reporting being more likely and 13% being less likely to seek treatment. Long-term outcomes were not reported.

At the more intense end of the spectrum, a program in Utica, New York (Powell, 2001), offered group sessions in a New York State correctional institution. The program consisted of a 10-week module for clients who were identified with gambling problems. Again, no information was reported on outcomes.

In summary, a small number of programs have been implemented to help people with criminal justice involvement and problems with gambling. For the most part, these programs have not been rigorously evaluated in terms of reduced harms associated with gambling (including reduction in criminal involvement) or cessation of gambling.

Interventions for this population varied in intensity from brief psychoeducational sessions to intense treatment, similar to community-based treatment. In the next two sections, we provide case studies to illustrate the types of interventions that have been provided for PG during incarceration, separated into brief psychoeducational sessions (3A) and treatment programs (3B).

Brief psychoeducational sessions inside prison. The simplest intervention for PG in correctional institutions is the brief psychoeducational session. The boundary between programs that are brief psychoeducational sessions and those that are full treatment programs is not clear-cut, but psychoeducational sessions tend to be short programs that do not offer sufficient time with a counsellor to be called therapy. These programs are often intended for people who are in the pre-contemplation stage of change (cf. Prochaska, DiClemente, & Norcross, 1992). In addition, psychoeducational sessions are not necessarily focused on gambling per se, but often touch on other conditions such as substance abuse.

During our previous research (e.g., Turner et al. 2013), we identified a 4-week psychoeducational session program offered by the ADAPT treatment agency to people staying at two provincial prisons in Ontario (one for females and one for males). We interviewed two of the counsellors who have worked for this program, Participants 7 and 16. The program is entirely voluntary and presented in the form of a four-session psychoeducational awareness program. Weekly sessions include (1) information on understanding addiction and myths and stigmas regarding "addicts"; (2) similarities between people facing PG and substance abuse, the negative consequences of these behaviours, and motivations for change; (3) family impact, relationships, communication, and recovery needs; and (4) relapse prevention, including urges and triggers, coping skills, and maintaining change. Originally, the program was specifically for people facing gambling problems (or for people who wanted to learn about PG), but more recently it has become a joint PG and substance abuse program. The four sessions are modular or independent of each other, and each session is about 1.5 hours.

Treatment while incarcerated. In our research, we uncovered four treatment programs that have been conducted in a correctional facility: (1) the Gambling Awareness and Prevention Project in Alberta (Nixon et al., 2006), (2) the GEAR program at the Coffee Creek correctional facility in Oregon, (3) a program teaching inmates how to break out of the gambling lifestyle (Walters, 2005), and (4) a program run by CM at the Frontenac correctional facility in Ontario called the OPTIONS program. Case studies for each are presented below.

The most rigorously evaluated program that we uncovered was the six-session Gambling Awareness and Prevention Project offered at a provincial prison in Lethbridge, Alberta, Canada (Nixon et al., 2006). This was a psychoeducational, group-based gambling program for prison inmates that focused on awareness of gambling and PG, reducing cognitive distortions, and changing attitudes towards a more realistic understanding of gambling. In addition to obtaining information from the paper by Nixon et al. (2006), we also interviewed Gordon Leigh about the program. The project was evaluated with a pre-test/post-test design and included measures of gambling problems, cognitive errors, and attitudes towards gambling. The program was designed with both prevention and gambling awareness in mind, and thus anyone who wanted to participate was accepted (no exclusion criteria). The program consisted of six interactive sessions and used a Socratic method of instruction in which the group leader asked questions to elicit answers from participants based on their experience. The clients used a workbook in which they recorded the information they learned during the session. The workbook also contained information about gambling that the clients might not know. Seventy-one inmates (64.8% male) completed the baseline questionnaires. The evaluation sample consisted of 49 participants who completed the follow-up questionnaires, for a completion rate of 69% (Nixon et al., 2006). Nixon et al. (2006) reported 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. The investigators did not find any significant differences in math skill scores or a decrease in gambling problems. The results indicated that the program was effective in changing attitudes towards gambling.

A second program we found was based in a state prison in the United States. An Oregon-based program for women in prison included six 90-minute, small-group psychoeducational classes, as well as a self-change guide. The results of this evaluation showed a significant improvement in knowledge and attitudes about gambling, including a greater awareness that treatment is available. Marotta (2007) also had positive qualitative feedback from the participants. For example, one participant said, "I am so grateful this program has come to Coffee Creek – I need it desperately" (p. 14). At 6-month follow-up, 208 participants were re-contacted (70% attrition).[2]The exact sample size was not reported in the PowerPoint presentation. Of these participants, 64% of the women reported they had set goals to reduce or eliminate gambling, and 97% endorsed the program as helpful. At intake, the majority (70%) of the participants scored in the pathological range of the South Oaks Gambling Screen, but after 6 months, only 10% of the participants did so. This effect was also sustained after a

year, with only slightly more than 10% of the participants in the pathological range (Marotta, 2007). However, the high attrition rate weakens the strength of these findings.

The third program reviewed also took place in an American state prison. It was designed to help inmates break out of a gambling lifestyle, as described by Walters (2005). The program was an advanced session for inmates who had completed part of the three-tiered Lifestyle Change Program at a medium security prison in the United States. This 20-week psychoeducational group was designed to offer an alternative to GA's 12-step program. The goal of the lifestyle intervention was to "modify conditions, redefine choices, and alter cognitions that have supported problem gambling" (Walters, 2005, p. 22). The Advanced Gambling Lifestyle group accentuates choice by encouraging participants to take responsibility for their actions and accentuates confidence by furnishing participants with training in basic social, coping, and cognitive skills. In addition, the curriculum includes "specially designed videotapes (eg, The Gambling Experience), news magazine segments (e.g., 48 Hours, 20/20), and full-length movies (e.g., The Gambler, Rounders) spread out over 20 weeks, for a total of 30 contact hours" (Walters, 2005, p. 23). Any inmate who had completed the first tier of the Lifestyle Issues program was eligible for participation in the Advanced Gambling Lifestyle group. Participation was voluntary and a gambling problem was not required for enrolment. The evaluation design included a control group consisting of people who had volunteered for the group but had been transferred before the first group session. Analysis indicated that the group resulted in a decrease in disciplinary reports of the offenders relative to the control group.

We located a fourth program for PG conducted in Kingston by CM, which is run in a minimum security federal prison in Canada. Additional information was provided by several colleagues in the correctional services who were familiar with his program (Participants 9, 10, 12, and 13). The program generally begins with 6-12 participants per group and runs for 16 sessions of about 2 hours each (twice a week). CM noted that the first day is spent developing a confidentiality contract with the participants because of the stigma of gambling among fellow inmates. Subsequent sessions include a mix of cognitive-, motivational-, and information-oriented sessions. Other sessions cover leisure activity, relaxation, debt management, and managing of emotions. CM said that the main source of material was the program offered in Lethbridge, Alberta (see Nixon et al., 2006). CM reported that he also spoke to the facilitators at ADAPT for additional advice on running his group. Initially, he ran the program as eight sessions, but has increased it to 16 sessions. To date, CM has offered the program to clients at two minimum and one medium security institution in Kingston. According to CM, one factor that is critical to the success of a program inside correctional institutions is "developing good relationships with everyone you encounter when you walk into an institution" especially security staff. CM also noted that the CSC staff and management have been helpful in establishing the program.

Post-Release Programs During Parole

The fourth group of programs are those that are available to people who are on conditional release, probation, or parole (Perrone et al., 2013). McKenna et al. (2013) discuss the importance of continuity of care and suggest educating parole and

probation officers about PG so that they refer their clients to treatment services. According to Ministry of Corrections documents (Minister of Justice, 2013, 2014), a person can be granted early release if she or he agrees to abide by a correctional plan addressing rehabilitative needs, and then meets with a parole officer (PO) to review specific expectations for carrying out the correctional plan. A PO can order a client to attend a community addiction and mental health service for assessment or treatment and the client would have to consent to allow the PO to communicate with those involved in the client's gambling-related interventions. Failure to meet any of the requirements could result in revocation of the conditional release.

To learn more about parole, we interviewed Participants 10 and 13, who had worked as POs and had experience working with PG clients on parole. Participant 10 also has experience running and managing programs for people in prison and spoke about helping clients prepare for parole hearings and subsequent release. According to Participants 10 and 13, most clients do not readily mention their gambling status when preparing for parole. Participant 10 typically meets offenders when they first arrive at the institution, interviews them to determine the programs for which they are suitable, ensures that they have access to the programs needed for completion of their correctional plan, and prepares offenders for their parole hearings and their accompanying paperwork prior to the hearings. Gambling problems are not currently part of the regular intake, and so this issue is rarely documented in the correctional record (Turner et al., 2013). Most people in the criminal justice system simply do not think about PG as a major issue, and that includes the POs, other criminal justice workers, and even clients. The lack of screening means the issue is just not typically on their radar. The reluctance of clients to mention gambling-related problems may be due to (1) a lack of awareness of their problem, (2) the stigma and potential danger of having their gambling problem known by other inmates (e.g., their weakness might be exploited), or (3) the clients not wanting to have additional conditions placed on their parole. Participants 10 and 13 also described how the lack of available programs for PG in prison, coupled with a limited number of escorted or unescorted temporary absences that would allow clients to seek treatment in the community, puts the clients in a double-bind situation. Admitting to a gambling problem, in the absence of any programming to deal with it, could make it more difficult to get parole. The interview participants also mentioned that they try not to overuse or "burn" any particular resource, and so they limit the number of clients that they refer to any particular resource.

As with the services offered while people are incarcerated, programs for people on parole range from brief psychoeducational-oriented sessions (4A) to full treatment programs (4B). Case studies of each type are discussed in the following two sections.

Brief psychoeducational programs during parole. We interviewed Participants 8 and 11 about their work with KAIROS, a community-based substance use disorder (SUD) program. Previously an independent agency and part of the larger Youth Diversion Program, KAIROS is a Kingston, Ontario-based community outreach rehabilitation program for young offenders and for provincial probation clients.

KAIROS offers assistance to those with alcohol or other drug use concerns, to those with gambling-related problems, and to the families of clients. Participant 11 has provided SUD and PG supportive services to provincial clients inside and outside of prison for over 20 years. The program is designed for clients who are identified by their probation or PO to have substance use and/or gambling problems related to their offence(s). The general approach is cognitive-behavioural and educational. The program is "low key" in that it does not require the participants to say anything, or to write anything, and there is no homework. The participants can contribute to the group if they wish, but are not required to do so. The target population is "pre-contemplators," who may have been ordered by a judge to have drug/alcohol treatment in cases in which the offence involved substance use. The groups may range from 6 to 10 people. The program runs once a week, 90 minutes per session, for five 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 clients with their travel and work arrangements and to further encourage program attendance. Only one of the five sessions is specifically focused on gambling. This session provides facts to the clients about the real risks and rewards of gambling involvement and information on how to identify PG. It also examines some of the myths and distorted beliefs about gambling, including notions of "luck," chance, and probability, and includes discussion of responsible gambling and harm reduction. Participant 8 also stressed that the presentation tries to remain neutral about the decision to gamble. Clients are encouraged to contact Participant 8 "for a more in-depth review of their gambling" if they have any concerns. POs have insisted that clients not be allowed to miss any of the five sessions. 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.

Treatment while on parole (or probation). The final type of program we discuss is formal treatment while on probation or parole. What is said below can also apply to people prior to sentencing (e.g., while the person is out on bail) or to those serving non-custodial sentences such as probation. We focus on the case studies of two programs in this section: (1) regular treatment services for PG based in Toronto, Ontario, that can be mandated as a parole or probation condition; and (2) a residential program in Windsor, Ontario, offered to people meeting the criteria for PG. Neither of these programs was specifically designed for people on parole or probation, but often people from correctional settings are referred to such programs.

Most of the experts we contacted had worked within the criminal justice system. However, most PG treatment occurs outside of the criminal justice system. Most often, treatment services are run as part of the health care system. The counselling is typically done by social workers or specialist addiction counsellors. To fill out our exploration of the treatment system, we interviewed a PG counsellor (Participant 15) who works for an addiction treatment agency in Toronto. The counsellor, who preferred to remain anonymous, told us she based her responses on her professional experience working for several years, but she cautioned us that this "does not mean

this it is reflective of the outside society/community." She told us that she had many clients with criminal histories as a consequence of gambling-related problems, including one client who had threatened to blow up a casino, another who had stolen money from work because of gambling debts, and another who had committed fraud by writing cheques for money he did not have in order to gamble with the proceeds. She estimated that less than 30% of her clients had a criminal history. She told us that with clients on probation, POs 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."

The program typically includes weekly groups, including a preparation group, an 8-week cognitive-behavioural therapy group, and up to 6 months of aftercare. The program provides some flexibility in the form of individual sessions and additional groups if needed. In addition, the therapist refers the client to other appropriate resources such as employment counselling, psychiatric care, housing services, debt management, and anything else that might help improve their lives. The treatment focuses on the needs of the client and may not fit with the expectations of the POs who may prefer a longer or more intensive program. Nonetheless, progress updates that describe the interactions with the client are sent to the POs. Participant 15 also noted that clients on probation "are treated like other clients in the program attending groups and individual sessions. We take every person's needs into consideration."

Another option for people on parole is the inpatient program for PG located in southwestern Ontario. This program has been providing gambling-specific treatment since 1994 (Hotel-Dieu Grace Healthcare, 2013). Participants 10 and 13 report that POs like the Windsor program because it is residential and has a definite start and finish. The residential treatment services are available to residents across Ontario. According to their website:

The residential program is a structured 21-day closed cycle. Program components include individual and group therapy, understanding anger, change and goal setting, stress reduction, defense mechanisms, meditation, recreation/exercise, identifying and understanding feelings, communication styles, relapse prevention, art therapy and spirituality. (Hotel-Dieu Grace Healthcare, 2013)

We contacted Participant 16 from the program and asked if clients from correctional settings presented any special problems. Participant 16 responded, "I have asked staff to make comments on your questions. There was very little that suggested that there were any special issues with this population." Participant 16 went on to say that as a rule there are no special problems. However, "those with a more pronounced Personality Disorder can be disruptive due to quickness to raise voice, get defensive or avoid self-reflection." In addition, it was noted that the "facility is non-medically staffed" so that arrangements have to be for clients who are on some medications such as methadone. It was noted that clients who are referred from

correctional settings, in terms of how well prepared they are for treatment, are “not any more or less than other clients referred from our referral agencies.”

Summary of Case Studies

We interviewed 16 people about programming for PG and uncovered detailed information on 10 programs through a literature search and interviews with experts in the field. Table 2 displays some of the key differences between the case studies that we examined. The Options program was comprehensive and focused specifically on PG from a cognitive behavioural point of view. The program in Lethbridge also focused specifically on gambling problems. In contrast, the ADAPT and KAIROS programs were more generally about addiction, rather than just gambling per se, and designed to raise awareness and provide information rather than treatment. The structure varied from program to program.

Nonetheless, there are some commonalities. Most of the case studies examined take a biopsychosocial perspective on the disorder and use some version of cognitive-behavioural therapy delivered in a group setting. GA programs have their own 12-step disease-oriented philosophy that was originally developed to guide alcoholics to sobriety through mutual support (see Ferentzy & Turner, 2013). The approach is based on their 60 years of experience as a mutual aid society. The GA disease model has also influenced mainstream treatment with its focus on group discussion and its inclusion of social and family support to help recovery (Ferentzy et al., 2010). The GA disease model has influenced the development of GTC, which also uses a disease model of PG. However, GTC has incorporated 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.

The opportunities for intervention described in this paper align approximately with the stages of incarceration described by Visher and Travis (2003). Part 1 aligns with their “Preprison stage,” Parts 2 and 3 align with their “In prison” stage, Part 4A aligns with their “Postrelease transition stage,” and Parts 4B and 2 could align with both their “Postrelease transition” and “Postrelease integration” stages (Visher & Travis, 2003, p. 92).

Discussion

In this study, we set out to determine the state of knowledge on programming for problem gamblers in correctional facilities. We researched information about programs that have been run for this population, how these programs were structured, and whether they had been scientifically evaluated. Our review uncovered a number of programs within the criminal justice system that have been implemented to help individuals with gambling problems. As noted in the Introduction, previous studies have shown that many people in correctional settings have a severe gambling problem (e.g., May-Chahal et al., 2012; Perrone et al., 2013; Turner et al., 2009,

2013; Williams et al., 2005). Although several case studies involved programs that offered services to this population, currently none of the programs examined are widely available to people who are incarcerated. Thus, there are gaps in service within corrections and with respect to continuity of care. In all cases, these programs were offered by people outside of the correctional institutions, typically from treatment agencies. These services are an important element of service provisions and could be important components of the continuity of care (see also Visher & Travis, 2003) that would provide the best chance of rehabilitation. As noted by Visher and Travis (2003), it is not known at which stage of the criminal justice system that an intervention would have the most impact. We hope that by documenting the various cases, we will encourage more research into this topic from which conclusions can be drawn about the efficacy of interventions at these various stages.

GTCs could be rolled out in a similar manner to DTCs or could be affiliated with DTCs. A GTC could be an effective approach for someone who is having their first encounter with the criminal justice system and who has committed non-violent crimes related to gambling. One issue that precludes such an option is that clients with severe gambling problems have often committed financial crimes such as fraud or theft that may be considered too serious for a problem-solving court. As noted, currently only two problem-solving courts that we know of deal with PG: in Buffalo, New York (Farrell, 2011; Rose, 2003) and one in Nevada (Nevada Council on Problem Gambling, 2010). CAMH has also been exploring this idea since 2011 (Teasell & Turner, 2012; Turner, 2011), as there is some interest among those in the DTCs in Ontario in the possibility of expanding the service to include a GTC. Unfortunately, there are considerable challenges, including the lack of a biological screening mechanism for relapse (e.g., urinalysis for drug/alcohol use), skepticism about a sufficient number of people with gambling problems in contact with the justice system who might benefit from such a program, and lack of time and staff resources to develop a GTC. However, there are already DTCs in Canada, and so perhaps these issues can be overcome by educating those in the criminal justice system about PG, including the number of potential clients and method of compliance monitoring (e.g., tracking bank accounts and expenditures, reports from therapists or collaterals).

Mutual aid groups such as GA can play an important role for clients with criminal justice involvement both in the correctional setting and during post-release. 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. GA may not be an optimal solution for all clients because it is run by non-professionals, it incorporates beliefs such as the necessity of "hitting bottom" that can be counterproductive, and it has a religious component that can be a barrier for some people (Ferentzy & Turner, 2013). However, GA is often a useful adjunct to therapy (Lesieur & Blume, 1991; Petry, 2002), providing a supportive community of people with similar goals. Arguably, GA's major strength lies in its collective belief that PG can be overcome (Ferentzy et al. 2006; Ferentzy, Skinner, & Antze, 2009). Of importance is the fact that GA groups are free, which can be particularly helpful in the current fiscal

climate within the public and health care system. This option is being underused in correctional settings in Ontario. It is possible that the reason for the low uptake of GA within the prison environment is the stigma associated with PG or a desire to avoid additional probation conditions. Typically, the organization of GA groups requires the efforts of dedicated individuals to start the group and keep it running. Perhaps both federal and provincial correctional authorities could play a role in providing some assistance to clients who wish to be in or even to start a GA group within an institution.

Brief, integrated psychoeducational sessions that cover both substance abuse and gambling-related problems could be offered pre- (e.g., ADAPT) or post-release (e.g., KAIROS). This might be a good first step in raising awareness among clients about the issues related to gambling and substance abuse, but may not be sufficient to help a person escape from the cycle of gambling, debt, and crime. Brief psychoeducational programs for clients during probation are perhaps the easiest to implement, but getting people to admit to their PO that they are experiencing gambling problems may be a challenge because the client may view this admission as an additional barrier to early release and might not like the idea of being required to attend programming as a condition of release. Intensive programs such as that offered by CM are a more ideal solution for people with severe gambling problems. There are good reasons to begin treatment while people are incarcerated. For example, clients in prison have the time to attend groups to increase the structure in their day and doing so may relieve the boredom of being in prison. In addition, clients may be motivated to attend to qualify for early parole. According to Turner et al. (2013), nearly half of the problem gamblers who are incarcerated have stopped gambling while in prison, in part because of the lack of available forms of gambling (e.g., no electronic gambling machines). Relapse prevention before their release may be of great help to these clients. However, it takes a truly dedicated counsellor to initiate and run such a program.

A number of our interview participants expressed the view that an official program offered by CSC would be ideal. CSC already offers educational and training programs; programs for general crime prevention, violence prevention, and family violence prevention; substance abuse programs; sex offender programs; and community-based correctional programs (CSC, 2014). Thus, it may be feasible for CSC to offer a gambling information program either separately or integrated with existing programs. We will explore this topic in a later paper.

According to Perrone et al. (2013), there is a lack of awareness of PG within the criminal justice system and a lack of screening for PG within the correctional field. This sentiment was also noted by AW, Judge Farrell, and a number of other interview participants. In fact, according to CT, some doubt exists that there would be enough clients for a GTC, even though numerous published studies have shown high rates of PG in this population (May-Chahal et al., 2012; Turner et al., 2009, 2013; Turner, Stinchfield, McCready, McAvoy, & Ferentzy, 2016; Williams et al., 2005). In addition, these studies suggest that gambling problems may put a person at a higher risk for recidivism because the gambler is often trapped in a cycle of gambling, debt,

and crime (Turner et al., 2009). The lack of awareness limits the options available—such as diversion from incarceration, availability of information, or in-depth programs during incarceration and services to people on parole—for those in contact with the criminal justice system who also experience gambling problems. Add to this the complication that some people encountering the criminal justice system may be reluctant to admit to staff that they have a gambling problem to avoid having mandatory programs imposed on them, or because of the stigma associated with PG, or simply because they are in denial about having a gambling problem.

Our research also shows that little effort has been concentrated on the evaluation of existing gambling treatment services to establish whether these services are effective. Perrone et al. (2013) argue that "most problem gambling treatment programs, service models and methods of delivery are either undocumented or poorly documented" (p 27). As a first step toward dealing with these gaps in knowledge, we summarized the literature and conducted interviews with experts to understand what is known and being done and what more could be done to assist people experiencing gambling problems who become involved with the criminal justice system.

Limitations

The method used in this study is a combination of literature review and qualitative interviews with a small sample of key experts primarily from Ontario; thus, our experiential evidence and conclusions may best reflect the provincial context of Ontario. The focus of our literature review was directly on gambling treatment programs, and so we did not examine substance abuse or general mental health programs that might address some aspects of gambling problems. 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. Still, the researchers are skilled in scrutinizing their own biases and letting interview participants tell their own story. In addition, during the analysis, three of the researchers reviewed and summarized the qualitative data. We also ensured accuracy by sending the summaries back to the interview participants for their review.

Another limitation is that we did not include any respondents in a political role or in upper level management in the criminal justice system who would be able discuss with us the prospects of implementation of any of these options. However, we hope that this report will initiate such a dialogue.

Conclusions

In this paper, we presented a number of case studies that illustrate the current context of PG treatment for people involved with the criminal justice system as it currently exists in Ontario and in other jurisdictions. Several case studies have been scrutinized. Despite the high rates of PG in the population (e.g., May-Chahal et al., 2012; Perrone et al., 2013; Turner et al., 2009, 2012; Williams et al., 2005), the

published literature on this topic is scant and services for this population are few. The current situation does not, in general, meet the needs of correctional clients with gambling problems. PG is not treated as a priority. There seems to be no formal screening for PG when people enter custody, and no system-wide service is currently available. One recommendation from this study would be to screen for PG at intake in order to demonstrate the need, identify potential clients for programs, and provide a means of evaluating the impact of such programs. By consulting with experts, we were able to demonstrate significant gaps in the current system. It is unlikely that the situation in Ontario is unique, as it appears to be the case in many jurisdictions. In fact, problem gamblers in the criminal justice system in Ontario may be better off than in other jurisdictions because of the hard work of some of the people interviewed in this study. Options that could be available include problem-solving courts, GA, psychoeducational sessions, or full-treatment sessions delivered to people in prison and to those on probation or parole. Ideally, all such options would be offered along a continuum of care.

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