



office of crime statistics and research

# GAMBLING INTERVENTION PROGRAM TRIAL: EVALUATION REPORT

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# Acronyms

ABI	Acquired Brain Injury
AMC	Adelaide Magistrates Court
CAA	Courts Administration Authority
CBT	Cognitive Behavioural Therapy
DCSI	Department for Communities and Social Inclusion
GHS	Gambling Help Services
GIP	Gambling Intervention Program
HREC	South Australian Department for Health and Ageing Human Research Ethics Committee
HRE1	Heart rate during exposure baseline
HRE2	Heart rate during exposure post treatment
HRR1	Heart rate resting baseline
HRR2	Heart rate resting post treatment
ITP	Inpatient Treatment Programme
K10	Kessler 10
OARS	Offenders Aid Rehabilitation Services Community Transitions
OCSAR	Office of Crime Statistics and Research
OPG	Office of Problem Gambling
PGSI	Problem Gambling Severity Index
SGTS	Statewide Gambling Therapy Services
TIC	Treatment Intervention Court

# Executive Summary

This report outlines the findings of the Gambling Intervention Program (GIP) Trial Evaluation conducted by the Office of Crime Statistics and Research (OCSAR). The GIP Trial is a voluntary program developed to complement the suite of treatment intervention programs in operation in the Adelaide Magistrates Court. The aims of the GIP Trial are to:

- reduce gambling urges;
- improve psychosocial outcomes; and
- achieve a non-custodial sentence on completion of the program.

Referrals to the GIP are received from the general criminal court list. Eligibility to participate in the GIP requires that defendants plead guilty to the charges they are facing and are suitable for release on bail. Once a defendant has been assessed and accepted on the program, their assessment information is sent to the gambling treatment and case management providers (Statewide Gambling Therapy Service and Offender Aid and Rehabilitation Services respectively). The defendant is required to initiate contact with service providers to commence treatment.

The GIP includes a bi-monthly court review process where the Magistrate is provided with an update in relation to the treatment and case management of GIP defendants. Regular progress reports are provided to the CAA by the gambling treatment and case management providers. This information is collated and provided to the Magistrate. Defendants also receive a copy of this information and participate in a conversation with the Magistrate about how they are managing. At the conclusion of the six-month program, defendants return to the Treatment Intervention Court (TIC) for sentencing by the GIP Magistrate.

## Evaluation methodology

The evaluation used both qualitative and quantitative forms of data collection and analysis, including:

- stakeholder interviews with key individuals involved in the implementation and/or delivery of the program;
- observations of various components of the program (court reviews, sentencing hearings, Steering Committee meetings);
- analyses of administrative data provided by the Office for Problem Gambling (OPG), the Courts Administration Authority (CAA), Statewide Gambling Therapy Service (SGTS) and OARS Community Transitions (OARS); and
- document analysis (court reports and assessment forms).

## Key findings

### Profile of defendants accepted to the program

- Between 1 July 2015 and 30 April 2017, 27 defendants were referred to the GIP Trial by defence lawyers and Magistrates.
- Of the 27 defendants referred to the program, 23 were accepted to the program.
- Of the 23 defendants accepted to the program, 11 (48%) were female and 12 (52%) were male, with a mean age of 45 years.
- The most common offence type was Fraud With Respect To Government Benefits (14 of the 23 participants accepted to the program), followed by Larceny (8 of the 23 participants).
- Three of the 23 participants accepted to the GIP were charged with more than one offence type.

## SGTS participant profile and outcomes

- The CAA referred 23 participants to SGTS for therapeutic treatment between 1 July 2015 and 30 April 2017.
- Of the 23 participants referred to SGTS during the evaluation period, 22 completed a screening assessment and were recommended for therapeutic treatment.
- Problem Gambling Severity Index (PGSI) Scores collected by SGTS were available for 20 of the 22 participants who completed a screening assessment. The scores ranged from eight to 27 (mean of 18).
- Of the 22 participants recommended for treatment, as at 30 April 2017:
  - eleven (48%) had completed therapeutic treatment;
  - one withdrew from treatment before completion and opted to be sentenced without completing the program; and
  - ten (44%) were still in treatment.
- The number of sessions attended by the 11 treatment completers ranged from five to 18 (mean of 9).
- For the 11 treatment completers, the mean length of time spent receiving therapeutic treatment was seven months (range of 1 to 15 months).
- The most common length of time completers spent receiving treatment was two months (3 of the 11 treatment completers).
- Of the 22 participants treated by SGTS, eight were referred to OARS for case management support.
- All of the 11 treatment completers achieved a Victorian Gambling Screen Harm to Self Sub-Scale (VGS-HS) score below 21 by their fourth session (range of 0 to 18, median of 1).
- Of the 11 treatment completers, nine participated in a three month follow-up VGS-HS assessment. All of the nine participants achieved a further reduction in their VGS-HS score, with three of the nine recording a score of zero.
- Heart rate (HR) data were available for 10 of the 11 treatment completers. All of the 10 participants recorded a reduction in their HR during exposure to gambling from their first to most recent session. On average, the participants HR during exposure reduced by 11 bpm (range of -1 to -20).

## OARS participant profile and outcomes

- The CAA referred 23 participants to OARS for case management support between 1 July 2015 and 30 April 2017.
- Of the 21 participants who completed a first assessment, 17 participants recorded a Kessler 10 (K10) score measuring psychological distress. The median score was 25.
- Of the 21 participants who completed a first assessment, 19 identified legal issues, followed by mental health (15), physical health (9), financial (6), alcohol and other drugs (5), isolation (5), grief and loss (5), employment (5), and family issues (2).
- Of the 21 participants case managed by OARS over the evaluation period, 19 were referred to gambling counselling services delivered by OARS.
- Reductions in the number of participants with specific issues were recorded for all but two of the 10 issues identified at the first assessment.
- Between the first assessment and most recent assessment, the participants' stage of change generally shifted from *preparation* (12 of 19) to *action* (13 of 19).
- Seven participants' case files were recorded as closed during the data collection period. Of these, six were recorded as closed at completion of all their Service Plan activities with the remaining participant's case file recorded as closed before their Service Plan activities were complete. This participant was recorded as ceasing contact with OARS without notice.

## **GIP completer outcomes**

- Ten participants' matters were finalised between 1 July 2015 and 30 April 2017, including nine who successfully completed the program, and one who was terminated from the program prior to completion.
- Court reports for the nine participants who completed the program recorded high levels of engagement and improvements across a range of psychosocial areas.
- Eight of the nine completers achieved a score of zero at their most recent Gambling Urges Scale (GUS) assessment (data was not available for one completer).
- Gambling Related Cognitions Scale (GRCS) scores were available for seven of the nine completers, with all but one recording a reduction from their first to their most recent GRCS assessment.
- Work and Social Adjustment Scale (WSAW) scores were available for eight of the nine completers. All eight completers recorded reductions between the first and most recent WSAW assessment.

## **Sentencing outcomes**

- In line with the aims of the program, eight of the nine GIP completers received a non-custodial sentence (suspended sentence). The remaining participant received a sentence of imprisonment of three months in addition to a two year suspended sentence bond (unsupervised) upon their release from prison.
- The length of the penalties handed down by the Magistrate ranged from six months to three years.
- The most common penalty duration was a two year suspended sentence bond (unsupervised) received by three of the nine program completers.

## **Stakeholder interviews**

- Nine interviews were conducted with 15 persons responsible for the management or operation of the GIP.
- Stakeholders reported that the GIP had been operating as intended, and that there was unanimous support for it to continue.
- While a number of issues were initially identified with regard to referral pathways, participant assessment and low referral numbers, no major concerns were reported regarding its operation or impact.
- Although no participants agreed to take part in the evaluation, surveys from individuals involved in OARS case management services also indicates positive support from participants for the program.

## **Program strengths**

The main strengths of the GIP identified by respondents were:

- The high level of collaboration and communication between agencies;
- The gambling treatment component, particularly in relation to the use of heart rate monitoring to show changes in gambling urges;
- The case management component to address participants' psychosocial needs during and after the program; and
- The potential for the program to raise awareness about problem gambling amongst the legal profession and the broader community.

## Areas for improvement

Respondents identified three main areas for improvement:

- Participant screening assessment fatigue;
- Referral pathways between agencies; and
- Awareness of the GIP amongst defence lawyers and the community.

## Conclusions

The development and implementation of the GIP has demonstrated a collaborative effort by criminal justice agencies and gambling help services to address the multiple and varied needs of defendants charged with gambling-related offences.

While some process issues were identified, the evaluation found that the GIP had successfully met its objectives of reducing gambling urges and achieving non-custodial sentences for participants. In addition, there was unanimous support for the program from stakeholders.

## Recommendations

It is recommended that:

- the Gambling Intervention Program (GIP) be continued in the Adelaide Magistrates Court;
- Steering Committee meetings be maintained to ensure ongoing communication between stakeholders. Consideration should also be given to including agencies responsible for facilitating Restorative Justice Conferences should such meetings occur;
- a Program Manual be developed to support existing and new GIP staff;
- consideration be given to developing a targeted marketing and communications strategy to educate legal professionals and judicial officers about the GIP and the outcomes it has achieved for defendants charged with gambling related offences; and
- consideration be given to inviting future program completers to provide feedback about their experiences of the GIP, particularly in relation to the risk of assessment fatigue and other areas for improvement identified by stakeholders.

# Introduction

In 2012, a working party comprising key stakeholders from Gambling Help Services (GHS) and various criminal justice agencies was established out of a mutual recognition of the need for a rehabilitative approach within the criminal justice system for problem gamblers.

The Gambling Intervention Program (GIP) Trial commenced on 1 July 2015 and is a collaborative venture between the Office for Problem Gambling (OPG), the Courts Administration Authority (CAA) and GHS. The trial was funded by the Gamblers Rehabilitation Fund, which is administered by the Department for Communities and Social Inclusion (DCSI) through the OPG.

The program is based in the Adelaide Magistrates Court and is open to persons charged with offences related to problem gambling. Based on a holistic approach, the main purpose of the program is to treat participants for gambling urges and assist them through the criminal justice system. The trial included a structured six-month program incorporating therapeutic treatment (Graded Exposure Therapy and Cognitive Behavioural Therapy), case management and regular court reviews, culminating in sentencing by a dedicated Magistrate in a specialist court.

This report presents the findings of an evaluation of the Gambling Intervention Program (GIP) Trial conducted by the Office of Crime Statistics and Research (OCSAR) from December 2016.

# Description of the Program

The GIP Trial complements the suite of treatment intervention programs in operation in the Adelaide Magistrates Court. It is designed to provide offenders appearing before the court on minor or summary offences with access to gambling treatment as part of the court process. The program is available to adult defendants with a gambling problem that is clearly linked to their offending behaviour. It has been specifically designed to meet the needs of offenders who are suitable for release on bail and would benefit from gambling therapy.

Overall, the aims of the GIP are to:

- reduce gambling urges;
- improve psychosocial outcomes; and
- achieve a non-custodial sentence on completion of the program.

The GIP contains a number of key elements including:

- intake, assessment and multi-agency liaison by Courts Administration Authority (CAA) staff;
- gambling therapy provided by Statewide Gambling Therapy Service (SGTS);
- case management, counselling, and court support and restorative justice provided by Offender Aid Rehabilitation Services Community Transitions (OARS); and
- bi-monthly court reviews and sentencing in a specialist court.

## Intake and assessment

Referrals to the GIP are received from the general criminal court list. This can occur via a Magistrate or defence counsel on behalf of a defendant. Eligibility to participate in the GIP is based on a clinical assessment by a CAA case manager and a demonstrable nexus between the problem gambling and the offending behaviour the defendant is charged with.

The assessment captures information on the following:

- demographics and cultural affiliation;
- alcohol and other drug use;
- mental health;
- nexus between gambling behaviour and offending behaviour;
- medical history;
- psychosocial assessment (relationships, support networks, education, employment, finances); and
- legal history.

This information is then incorporated into a recommendation and treatment plan for consideration by the dedicated Magistrate overseeing the GIP.

The program is voluntary and defendants must give their informed consent to participate. The GIP also requires that defendants plead guilty to the charges they are facing and be suitable for release on bail. Upon consent, the defendant is required to appear at an acceptance hearing in the Treatment Intervention Court (TIC). At this hearing the Magistrate considers the recommendation of the CAA case manager and either accepts the defendant on to the program or declines the request and returns the defendant's matter to the general criminal list.

Once a defendant has been accepted on the program, their assessment information is sent to the gambling treatment provider and the defendant is required to initiate contact to commence treatment.

## **Gambling treatment**

SGTS are responsible for providing treatment for problem gambling under the GIP. SGTS conduct an initial assessment of the client to determine their suitability to participate in Cognitive Behavioural Therapy (CBT), and determine their level of gambling addiction and treatment needs. Therapy generally consists of between eight to 12 weekly treatment sessions depending on the client's needs. This includes graded exposure therapy combined with CBT. The purpose of this approach is to reduce participants' gambling urges during exposure to gambling cues and to challenge participants' beliefs about gambling.

Treatment outcomes are assessed using both psychological testing and self-report measures, and also objective measures of pulse and arousal levels at various stages of the treatment process. Depending on the needs of the client, SGTS may refer participants to OARS during the treatment phase. For those not connected to OARS while undergoing treatment, they are required to be referred at the completion of their therapy component for consideration for long term case management.

## **Case management support**

OARS Community Transitions are responsible for conducting an initial assessment with defendants to inform the provision of case management and court support during the program. In conjunction with the assessment information provided by the CAA and SGTS, and further screening where required, OARS develop a client-centred case plan. This identifies the client's psychosocial needs and what services and support are needed to assist the defendant through the program, including: relationship and/or financial counselling, referral to other services (e.g. a psychologist), court support, and advocacy with other services.

Where appropriate, OARS may also provide a restorative justice approach, incorporating the Centre for Restorative Justice and the Victim Support Service (VSS) in facilitating a restorative justice meeting. This involves a formally structured meeting between the victim and the offender to discuss the offence and its impact on the victim. During this meeting, the offender may be issued sanctions to undertake such as making restitution or reparation to the victim, or undertaking community service. A victim's participation in a restorative justice conference is voluntary and they can withdraw at any stage in the lead up to or during the meeting.

No restorative justice conferences were conducted during the evaluation period.

## **Court review and sentencing**

The GIP includes a bi-monthly court review process where the Magistrate is provided with an update in relation to the treatment and case management of GIP defendants. SGTS and OARS provide regular progress reports to the CAA who collate this information for the Magistrate. Defendants also receive a copy of this information and participate in a conversation with the Magistrate about how they are managing. At the conclusion of the six-month program, defendants return to the TIC for sentencing by the GIP Magistrate.

# Evaluation Scope and Methodology

A process and outcomes evaluation of the GIP was undertaken by the Office of Crime Statistics and Research (OCSAR) from December 2016. The evaluation sought to examine project implementation and operational procedures at the trial site in the Adelaide Magistrates Court (AMC) following its commencement on 1 July 2015.

The evaluation examined:

- the suitability of persons being referred to the GIP;
- the appropriateness of the eligibility criteria;
- the effectiveness of the service model in addressing the needs of the participants, including the identification of program gaps;
- the program strengths;
- how behaviour change and program effectiveness were measured and reported back to the CAA;
- how the compliance and progress of clients were used to inform magistrates' decisions;
- whether participants reduced their gambling urge;
- whether participants show improved psychosocial outcomes;
- client satisfaction; and
- whether participation in the program led to non-custodial sentences upon completion.

Measuring the impact of the GIP Trial on gambling-related offending was outside the scope of this evaluation.

## Evaluation methodology

This section provides a summary of the evaluation methodology, which used both qualitative and quantitative forms of data collection and analysis.

### Ethics

OCSAR conducted the GIP Trial Evaluation according to National Health and Medical Research Council (NHMRC) guidelines. The Evaluation Framework developed by OCSAR was approved by the Office for Problem Gambling (OPG) and ethics approval was obtained from the South Australian Health Human Research Ethics Committee (HREC).

Ethics approval from HREC was subject to a number of conditions regarding contact with participants, data linking and types of reporting (e.g., case studies). These conditions are discussed in the relevant sections below.

### Stakeholder interviews

Feedback was collected from key individuals involved in the development and delivery of the program, including CAA case managers, CAA management, judicial officers, Steering Committee members, SGTS staff, OARS staff and OPG staff. A total of nine face to face interviews were conducted with 15 stakeholders between January 2017 and March 2017.

The interviews were semi-structured and the questions varied according to the stakeholder's role in relation to the GIP. An additional key stakeholder provided a written response to the interview questions. The interview questions were designed to address the evaluation objectives. The length of interviews ranged from 25 minutes to an hour depending on the respondent's level of involvement in the program. Interviews were digitally recorded and transcribed. A qualitative analysis of similarities and differences in stakeholders' perceptions was conducted to interpret these data.

## **Participant interviews**

A total of nine defendants were invited to participate in a voluntary interview via a letter (Appendix 1). The letter included an information sheet about the evaluation and an invitation to contact the evaluators should the participant be interested in attending an interview. The letter was addressed by the CAA TIC Senior Case Manager, to preserve the anonymity of the participants. This method of contact was requested by HREC to ensure that the participants did not feel coerced to engage with the evaluation. The defendants who were sent letters had either completed the program or had been active on the program for four months or more. One of the letters sent to a participant was returned as this individual was no longer at the address on file.

Overall, none of the nine defendants responded to the invitation to provide feedback. Following advice from CAA regarding the vulnerability of the participants, it was agreed that follow-up letters would not be sent. As such, direct participant feedback about the GIP Trial is not available for this report. However, some information from satisfaction surveys conducted by OARS has been included, as well as a brief summary of comments by one participant at a sentencing hearing.

## **Observation of various components of the program**

The evaluators attended the GIP Steering Committee meetings to observe their operation and also undertook observations of court reviews, including acceptance and sentencing hearings.

## **Analysis of administrative data**

De-identified administrative data for the period 1 July 2015 to 30 April 2017 was provided to OCSAR by individuals and agencies involved in the development and implementation of the GIP.

The CAA provided a spreadsheet including:

- demographic characteristics;
- referral numbers;
- acceptance rates;
- completion rates;
- offence information;
- court review information; and
- sentencing outcomes for program completers.

SGTS provided:

- referral numbers;
- demographic characteristics;
- heart rate monitoring;
- measures of problem gambling; and
- treatment outcomes.

OARS provided information on:

- referral numbers;
- demographic characteristics;
- assessment information;
- other issues identified at the first assessment carried out by OARS; and
- feedback from satisfaction surveys conducted by OARS.

## **Data linking**

Due to the expected small number of GIP participants, HREC expressed concern that participants may be easily re-identified from the combined CAA, SGTS and OARS administrative data. As a result, OCSAR did not have ethics approval to link the datasets from each agency, and was subsequently unable to track individual participants through the program. Data from each source has therefore been analysed and reported on separately.

### **Case studies**

Due to concern regarding the possible re-identification of participants, the use of case studies in the evaluation was not approved by the HREC.

### **Document analysis**

The evaluators met with OPG staff to discuss the evaluation and received access to documentation related to the implementation and operation of the program. This included minutes of Steering Committee meetings, Memorandums of Administrative Agreement between key service delivery agencies and other records kept in relation to the program. OCSAR also met with CAA staff to discuss referral pathways and received examples of final report recommendations provided to the GIP Magistrate at the sentencing hearing. Through correspondence, OARS provided information in relation to referral and assessment documentation, the types of case management support provided to GIP participants, and the psychosocial outcomes of case management support.

# Findings

## 1. GIP participant throughput, profile and outcomes

This section provides a summary of the throughput and profile of defendants referred to the GIP between 1 July 2015 and 30 April 2017, based on de-identified administrative data provided by CAA, SGTS and OARS. It should be noted that each data set was analysed separately. Due to the small number of GIP participants, and subsequent concerns about possible re-identification, the evaluators did not have ethics approval to link data between CAA, SGTS and OARS.

### 1.1 Initial referral to GIP and assessment by CAA

#### Number of defendants referred to the GIP

During the evaluation period, 27 defendants were referred to the GIP.

#### Source of referrals to GIP

Defendants were referred to the program by defence lawyers and Magistrates. A breakdown of referral sources was not recorded during the evaluation period.

#### Number of defendants who completed an assessment interview

Of the 27 defendants referred to the GIP over the study period, 24 (89%) completed an assessment interview. Of the remaining three defendants who did not complete an assessment:

- one individual did not attend the assessment interview;
- one individual's assessment interview was terminated due to non-compliance; and
- one individual had been referred and was awaiting assessment.

The two defendants who did not attend or complete an assessment had no further involvement with the program.

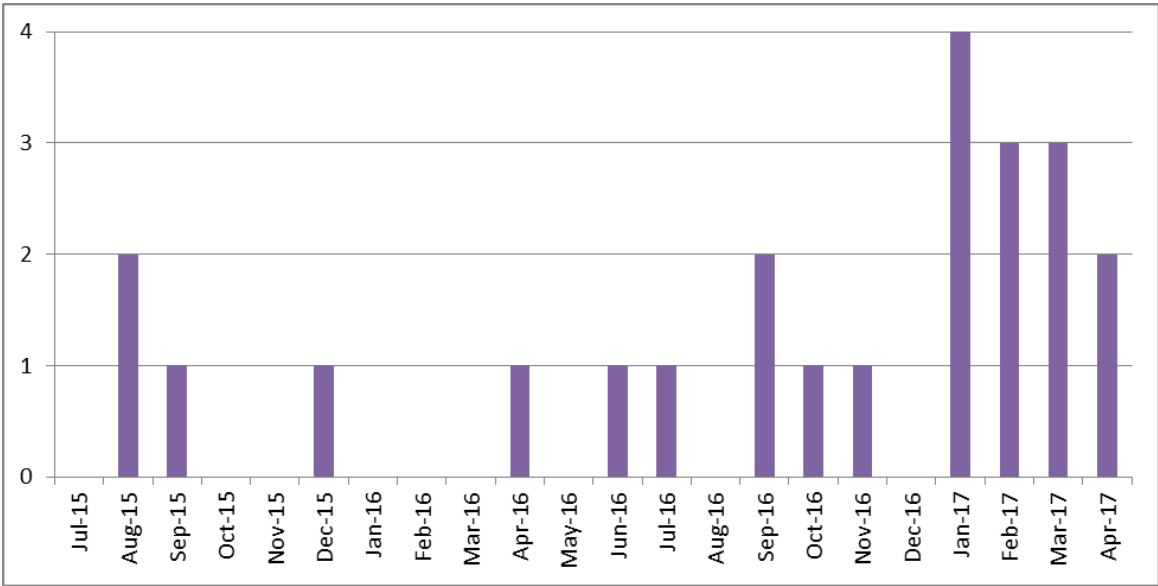
#### Number of defendants accepted to the GIP

Figure 1 shows the number of defendants accepted to the GIP per month between 1 July 2015 and 30 April 2017. Of the 24 defendants who completed an assessment interview, 23 (96%) were accepted to the program. The remaining participant was not accepted due to drug dependence which required treatment before acceptance.

As shown, the number of defendants accepted on to the GIP remained low in the first 18 months of the program, with 11 acceptances up to the end of December 2016. However, the number of acceptances has recently increased, with 10 in the first four months of 2017.

The mean length of time between the assessment interview date and the date of acceptance to the GIP was three weeks (range of 1 to 10 weeks).

**Figure 1: Number of defendants accepted to the GIP during the evaluation period**



**1.2 Profile of defendants accepted to the program**

**Gender and age**

Of the 23 defendants accepted to the program, 11 (48%) were female and 12 (52%) were male, with a mean age of 45 years (ranging between 26 and 63).

**Types of gambling-related offences**

The defendants accepted to the GIP were charged with one or more of the following offences:

- Fraud With Respect To Government Benefits (14 participants);
- Larceny (8);
- Non Aggravated Serious Criminal Trespass - Shops (1);
- False Pretences (1);
- Breach of Bail (1); and
- Offences Against Good Order (1).

In addition, one participant was the subject of a warrant/summons regarding the enforcement of a breached bond.

The most common offence type was Fraud With Respect To Government Benefits – Other (14 of the 23 participants accepted to the program), followed by Larceny (8 of the 23 participants).

Three of the 23 participants accepted to the GIP were charged with more than one offence type.

**1.3 SGTS participant profile and outcomes**

This section summarises the throughput and profile of participants who received therapeutic treatment delivered by SGTS between 1 July 2015 and 30 April 2017.

**Number of participants referred to SGTS**

The CAA referred 23 participants to SGTS for therapeutic treatment between 1 July 2015 and 30 April 2017.

**Gender, age and ethnicity**

Consistent with the CAA data, of the 23 participants referred to SGTS, 11 (48%) were female and 12 (52%) were male, with a mean age of 45 years.

Ethnicity data was recorded for 22 participants:

- Australian (n=15);
- African (n=3);
- Thai (n=2);
- Italian (n=1); and
- South Pacific (n=1).

### **Number of participants who completed a screening assessment**

All but one of the 23 participants referred to SGTS completed a screening assessment for therapeutic treatment during the study period.

#### *Problem Gambling Severity Index*

During the initial screening assessment, PGSI scores were collected from participants to identify problem gambling. The PGSI is a self-assessment tool that measures indicators of problem gambling in the 12 months prior to assessment (Appendix 2). PGSI scores range from 0 = never to 4 = almost always. A score of eight or more indicates a severe level of problem gambling.

PGSI scores were available for 20 of the 22 participants who completed a screening assessment. The scores ranged from eight to 27 (mean of 18).

### **Number of participants recommended for therapeutic treatment**

All 22 participants who completed a SGTS screening assessment were recommended for therapeutic treatment.

### **Status of participants recommended for therapeutic treatment**

Of the 22 participants recommended for treatment, as at 30 April 2017:

- eleven (48%) had completed therapeutic treatment;
- one (%) withdrew from treatment before completion and opted to be sentenced without completing the program; and
- ten (44%) were still in treatment.

### **Number of sessions attended by treatment completers**

The number of sessions attended by the 11 treatment completers ranged from five to 18, with a mean of nine. This includes the initial assessment session used to collect information to inform recommendations for therapeutic treatment.

### **Length of time spent receiving treatment**

For the 11 treatment completers, the mean length of time spent receiving therapeutic treatment was seven months (range of 1 to 15 months). The most common length of time completers spent receiving treatment was two months (3 of the 11 treatment completers).

### **SGTS referrals to OARS**

Eight participants were referred to OARS by SGTS during the trial. Generally, SGTS provided treatment participants with OARS' contact details and offered to make a referral for case management support on participants' behalf. Feedback from SGTS indicates some treatment participants had already been in contact with OARS before commencing therapeutic treatment.

### **SGTS GIP participant outcome measures**

SGTS used the following tools to measure the impact of the therapeutic approach on problem gambling:

- Victorian Gambling Screen Harm to Self Sub-Scale (VGS-HS); and
- heart rate (HR) monitoring to measure changes in HR responsivity to gambling cues.

### *Victorian Gambling Screen Harm to Self Sub-Scale (VGS-HS)*

The VGS-HS assessment tool is a 15-item measure of problem gambling (Appendix 3). The scores range from 0 = no harm to self to 60 = high harm to self. A score of 21 or more indicates a pathological gambling disorder. VGS-HS scores were collected at participants' first and fourth session, as well as at three months and six months after commencing treatment.

Table 1 outlines the VGS-HS scores for the 11 SGTS treatment completers. First session VGS-HS scores ranged from four to 50 (median of 36), with nine recording a score of 21 or higher. By the fourth session, all of the SGTS treatment completers achieved a VGS-HS score below 21 (range of 0 to 18, median of 1). Of the nine treatment completers who completed a three month follow-up VGS-HS assessment, all achieved a further reduction in their score, with three recording a VGS-HS score of zero. One treatment completer participated in a six month follow up VGS-HS assessment. This participant had achieved a VGS-HS score of zero at their three month follow up and maintained this score at the six month follow up. Overall, the VGS-HS scores of treatment completers generally decreased over time.

**Table 1: VGS-HS scores for SGTS participants**

Participant*	First Score (1st session)	Second Score (4th session)	3 month follow-up score	6 month follow-up score
1	50	18	9	-
2	39	1	1	-
3	39	6	2	-
4	38	0	0	-
5	36	9	8	-
6	36	7	4	-
7	34	1	-	-
8	25	1	1	-
9	22	5	0	0
10	8	0	-	-
11	4	0	0	-
Median	36	1	1	

\* Participant number randomly allocated for Table 1 only.

## Changes in treatment completers' heart rate (HR) responsivity to gambling cues

SGTS treatment included the recording of baseline and follow up measures of participants' heart rate (HR) at resting<sup>1</sup> and during exposure to gambling cues<sup>2</sup>.

HR data were available for 10 of the 11 treatment completers. As shown in Table 2, all 10 showed a reduction in their HR during exposure to gambling cues from their first session to the most recent session. There were four weeks between each session. The average decrease in these participants' HR during exposure to gambling cues was 11 bpm (range of -1 to -20).

**Table 2: Heart Rate Measures for SGTS participants during exposure to gambling cues**

Participant*	First Score During Exposure	Second Score During Exposure	Third Score During Exposure
1	101	91	-
2	101	91	-
3	97	96	-
4	93	83	-
5	90	70	-
6	85	78	-
7	81	79	68
8	79	65	-
9	77	68	-
10	76	66	-
11	-	-	-
Median	85	78	-

\* Participant number randomly allocated for Table 2 only.

## 1.4 OARS participant profile and outcomes

This section summarise the profile and outcomes of participants who received case management support from OARS between 1 July 2015 and 30 April 2017.

### Number of participants referred to OARS

In the original program model, it was intended that participants would be referred by CAA to SGTS, and then referred by SGTS to OARS at the appropriate time. However, it appears that some participants contacted OARS and commenced case management at the same time they were receiving treatment from SGTS. Although the evaluators were not able to track individual participants' pathways through the program, advice from service providers indicates that participants experienced a range of pathways: from CAA to SGTS only, from CAA to SGTS and then to OARS, or from CAA to SGTS and OARS at the same time.

Overall, 23 participants were referred to OARS during the data collection period, including eight after receiving services from SGTS.

<sup>1</sup> Resting heart rate is the average number of times a participant's heart beats per minute when they are at rest.

<sup>2</sup> Heart rate during exposure is the average number of times a participant's heart beat per minute during exposure to gambling cues.

## **Gender, age and country of birth**

Gender and age was recorded for 22 of the 23 participants referred to OARS. Twelve participants (55%) were female and 10 (45%) were male, with a mean age of 45 years. Country of birth was recorded for 21 participants: Australia (14) and Other (7).

## **First assessment**

During the data collection period, 21 of the 23 participants referred to OARS completed a first assessment. Information collected at this assessment included PGSI scores, Kessler 10 (K10) scores, the main type of gambling, and issues other than gambling.

### *Problem Gambling Severity Index*

PGSI scores were recorded for 18 of the 21 participants who completed a first assessment. The median PGSI score was 14.5, the most common score was zero (3 of the 18 participants), and the majority (15 of the 18 individuals) recorded a score of eight or more.

### *Kessler 10 scores*

The Kessler 10 (K10) is a measure of psychological distress. The minimum score is 10, indicating no psychological distress, and the maximum score is 50, indicating severe psychological distress. K10 scores were recorded for 17 participants. Of these the median score was 25.

### *Main type of gambling*

The majority of the participants identified gaming machines as their main type of gambling (16 participants). Two indicated horse/greyhound racing and one each recorded lottery products, sports betting and other (no further breakdown available).

### *Other issues identified at first assessment*

Nineteen of the 21 participants who completed a first assessment identified the following issues other than gambling:

- legal (19 participants);
- mental health (15);
- physical health (9);
- financial (6);
- alcohol and other drugs (5);
- isolation (5)
- grief and loss (5);
- employment (5); and
- family issues (2).

### *Stage of change*

Of the 21 participants who completed a first assessment, 19 participants recorded information relating to five of the steps involved in changing their gambling behaviour. These stages include:

1. Pre-contemplative
2. Contemplative
3. Preparation
4. Action
5. Maintenance

Of the 19 participants with stage of change information, 12 were recorded as being in the *preparation* stage at their first assessment, six in the *action* stage and one in the *pre-contemplative* stage.

### **Type of case management support provided to participants**

The following areas were targeted in individualised case plans:

- Mental Health (18 participants);
- Family and Relationships (9);
- Health (9);
- Financial (8);
- Employment (4);
- Alcohol and other drugs (3);
- Grief and loss (3);
- Accommodation (3);
- Cultural isolation (3); and
- Social and recreational needs (3).

Of the 21 participants case managed by OARS over the evaluation period, 19 were referred to gambling counselling services delivered by OARS.

### **Number of sessions completed**

Of the 21 participants who completed a first assessment, the average number of case management sessions completed during the program was five (ranging from 0 to 12 sessions).

### **Progress from first to most recent assessment**

The following section reports on the progress made by 21 participants between their first and most recent assessment up to 30 April 2017. It should be noted that the most recent assessment may have occurred at different stages of the program for different participants.

#### *Stage of change*

As shown in Table 3, between the first assessment and most recent assessment, the participants' stage of change generally shifted from *preparation* (12 of 19) to *action* (13 of 19). In addition, four participants were recorded in the maintenance stage at the most recent assessment. None of the 19 participants regressed in their stage of change during the evaluation period.

**Table 3: Participants' stage of change from first to most recent assessment, 1 July 2015 to 30 April 2017**

Stage of change	First assessment	Most recent assessment
Pre-contemplative	1	0
Contemplative	0	1
Preparation	12	1
Action	6	13
Maintenance	0	4
Total	19	19

#### *Issues*

Table 4 summarises the range of issues reported by 21 participants at the first and most recent OARS assessments.

As shown, reductions in the number of participants with specific issues were recorded for all but two of the 10 issues identified at the first assessment. The number of participants with legal issues reduced from 19 at first assessment to 10 at the most recent, and the number who

identified alcohol and other drugs reduced from five to one. Smaller reductions were recorded for physical health (9 to 6), mental health (15 to 13) and financial (6 to 4). The number of participants experiencing employment issues, grief and loss or isolation reduced from five to four. Conversely, the number of participants with family issues increased from two to four, and one participant reported domestic violence issues at the most recent assessment.

**Table 4: Participants' stage of change from first to most recent assessment, 1 July 2015 to 30 April 2017**

Issue	First assessment	Most recent assessment
Legal	19	10
Mental health	15	13
Physical health	9	6
Financial	6	4
Employment	5	4
Grief and loss	5	4
Isolation	5	4
Alcohol and other drugs	5	1
Family	2	4
Domestic Violence	0	1
Total assessed	21	21

#### *Accommodation status*

Although accommodation was targeted in three individualised case plans, it was identified as an area of need in two participants' first and most recent assessments. One participant was supported by OARS to move to more affordable accommodation during the program due to financial pressures. One participant required emergency housing during the program and was assisted by OARS to access hotel accommodation. This participant subsequently secured a private rental accommodation with the support of OARS.

#### *Functional capacity*

During the first and most recent assessment, functional capacity scores were collected from participants to identify whether problem gambling impaired:

- ability to work;
- home management (cleaning, shopping, cooking, looking after home or children, paying bills);
- social leisure activities (such as parties, bars, clubs, outings, visits, dating or home entertainment);
- private leisure activities (such as reading, gardening, collecting, sewing, walking);
- and
- ability to form and maintain relationships with others.

Functional capacity scores range from 0 = not at all, to 8 = severely impaired. Functional capacity scores were available for 19 of the 21 participants who completed a first and subsequent assessment. Table 5 shows the median functional capacity scores in relation to home management, social leisure activities and private leisure activities generally reduced from the first

to most recent assessment. Conversely, the median functional capacity scores in relation to participants' ability to work and ability to maintain relationships slightly increased from four to five from the first to the most recent assessment.

**Table 5: Participants' functional capacity at first and most recent assessment, 1 July 2015 to 30 April 2017**

Capacity	First median score	Most recent median score
Ability to work	4	5
Home management	2	2
Social leisure activities	6	2
Private leisure activities	4	2
Ability to form and maintain relationships	4	5

### **OARS finalised participants**

Of the 21 participants who completed a first assessment with OARS, seven participants' case files were recorded as closed during the data collection period. Of these, six were recorded as closed at completion of all their Service Plan activities with the remaining participant's case file recorded as closed before their Service Plan activities were complete. This participant was recorded as ceasing contact with OARS without notice.

#### *Length of time spent receiving case management support*

For the seven participants with closed case files, the mean length of time<sup>3</sup> spent receiving case management support from OARS during the data collection period was two months (ranging between 0 and 7 months). The most common length of time that participants with closed files spent receiving case management support was less than one month (4 of the 7 participants).

#### *Final assessments*

Final assessments were conducted for GIP participants who completed their engagement with OARS. Final assessments were not conducted for participants who continued to engage with OARS after they completed GIP, who disengaged from OARS case management prior to a final appointment or who were terminated from the program.

As at the end of the evaluation period, three final assessments<sup>4</sup> had been conducted for GIP participants receiving services through OARS and a further four were yet to be completed.

Of the three participants who completed a final assessment, two had a first and second K10 score recorded. Table 6 shows that one participant recorded no change to their K10 score between assessments. The other participant's K10 score doubled from the first to the final assessment. Generally, feedback from stakeholders indicated that, for some participants, the process of talking about issues (some of which relate to experiences of trauma) in one-on-one sessions with OARS counsellors, SGTS therapists or external psychologists may have affected their feelings of anxiety or depression, and subsequently, their K10 scores. For example, in Table 9, the significant increase in one of the three individual's K10 scores may reflect that participant feeling more anxious as a result of talking about painful or difficult issues with a counsellor or therapist. A

<sup>3</sup> From date of registration to date most recent assessment completed.

<sup>4</sup> One participant's first registration data was recorded as taking place in March 2015.

follow up K10 assessment post-engagement in the GIP would assist in identifying any long term trends in participants' anxiety levels as a result of the program.

**Table 6: K10 Scores for OARS participants**

Participant*	First K10 Score	Second K10 Score
1	36	-
2	19	19
3	15	32
Median	19	25.5

\*Participant number randomly allocated for Table 6 only.

At the first and final assessment, participants were asked to score their level of confidence in relation to being in control of their gambling. The scores range from 1 = not at all confident to 10 = extremely confident. Table 7 shows that all three participants who completed a final assessment felt that their confidence in being in control of their gambling had increased since their first assessment.

**Table 7: Confidence in Control of Gambling Scores for OARS participants**

Participant*	First Confidence in Control of Gambling Score	Second Confidence in Control of Gambling Score
1	7	9
2	7	9
3	6	8
Median	7	9

\*Participant number randomly allocated for Table 7 only.

Participants were also asked how satisfied they were with how they were managing their finances at their first and final assessment. Table 8 shows the satisfaction ratings of the three participants who completed both a first and final assessment. Two participants recorded no changes to their satisfaction level, whereas one participant's satisfaction increased from their first to the final assessment.

**Table 8: Satisfaction with Finances for OARS participants**

Participant*	First Satisfaction with Finances Rating	Second Satisfaction with Finances Rating
1	Very Satisfied	Very Satisfied
2	Fairly Dissatisfied	Fairly Satisfied
3	Fairly Satisfied	Fairly Satisfied

\*Participant number randomly allocated for Table 8 only.

## **1.5 Court observations**

This section provides a summary of the process and outcomes of the nine GIP hearings observed by OCSAR between 15 December 2016 and 30 March 2017, including:

- two acceptance hearings,
- four court reviews, and
- three sentencing hearings.

The evaluators documented their observations regarding:

- feedback reported to the CAA on participant behaviour change and program effectiveness;
- interactions between the Magistrate and the participant; and
- the impact of participant compliance and progress on the GIP Magistrate's decision in relation to sentencing.

### **Feedback reported to the GIP Magistrate on participant behaviour change and program effectiveness**

The evaluators observed the GIP Magistrate referring to reports on participant behaviour change and program effectiveness provided by Treatment Intervention Court staff, SGTS staff and OARS staff before court reviews and sentencing hearings. Examples of indicators of participant behaviour change and program effectiveness included:

- compliance with directions to undergo detoxification and/or therapeutic treatment;
- the participant's engagement with therapeutic treatment and case management support services and the staff who deliver these services;
- the participant's attendance to appointments; and
- changes in the participant's substance use, their mental and physical health, any financial issues or challenges, as well as employment issues.

The evaluators also observed the GIP Magistrate refer to recommendations made by staff in relation to:

- additional treatment, such as referral to an external psychologist and/or ongoing case management support provided by OARS;
- the need for the defendant to attend further court reviews; and
- sentencing outcomes.

### **Interactions between the Magistrate and the participant**

This section presents a summary of the interactions between the GIP Magistrate and defendants observed by the evaluators.

#### *Court reviews*

Generally, the GIP Magistrate addressed defendants directly, seeking comment from the defence counsel and police or public prosecutors when needed.

#### *Sentencing hearings*

At sentencing hearings, before formal proceedings began, the GIP Magistrate would generally leave the bench and invite the participant to exit the stand to participate in a semi-formal GIP graduation ceremony. The evaluators observed the GIP Magistrate reflecting on the defendant's achievements, personal circumstances and issues they had faced when they were first referred in to the program. The GIP Magistrate then handed the participant a certificate to mark their graduation from the program. The evaluators observed the GIP Magistrate lead the court in applause for the participant. At this point, the GIP Magistrate returned to the bench and asked the participant to return to the defendant's box before formal proceedings commenced.

## **1.6 GIP Completer outcomes**

Ten GIP participants had their matters finalised by 30 April 2017. Of these, one participant was finalised at a court review prior to completion due their low level of engagement in the program.

The CAA provided OCSAR with the de-identified court reports of nine participants who successfully completed the program and whose matters were finalised during the evaluation period. The court reports present a summary of feedback from service providers (OARS, SGTS and external psychologists) collated by CAA case workers and provided to the Magistrate. The CAA also provided the Gambling Urge Scale (GUS), Gambling Related Cognitions Scale (GRCS), and Work and Social Adjustment Scale (WSAS) scores in relation to eight participants. One participant's GUS, GRCS and WSAS scores had not been provided to the CAA at the time of writing.

### **Participant engagement**

Feedback from service providers in relation to the engagement of the majority of participants was generally positive.

### **Psychosocial outcomes**

The majority of the nine program completers were perceived by service providers to have shown improved psychosocial outcomes as a result of the program.

#### *Reduction in feelings of anxiety*

One participant had showed some improvement to their levels of anxiety as a result of the therapeutic support they had received during their participation in the GIP.

#### *Improvement to mental health*

As a result of their participation in the program, four of the nine completers' access to mental health support had improved. Of these four participants, three had been diagnosed with depression during the program and had shown some improvement as a result of ongoing therapeutic treatment provided by SGTS and OARS to help them manage their symptoms.

#### *Increase in physical health support*

Five court reports mentioned that OARS and SGTS played an integral role in referring these individuals to health care providers, such as a general practitioner, for assessment and treatment.

#### *Strengthening of social support*

Seven court reports indicated that the participant's connection with social supports, such as family, friends and social clubs, had strengthened as a result of their participation in the program.

#### *Increase in stress/distress tolerance*

During the evaluation period, SGTS had the option to refer a participant to an external psychologist to improve their stress and distress tolerance before commencing therapeutic treatment as part of the program. One of the nine court reports mentioned that the participant's stress and distress tolerance had improved as a result of the counselling they received from an external psychologist.

A summary of the outcomes discussed in the nine final court reports is presented in Table 9.

**Table 9: Psychosocial outcomes of program completers, 1 July 2015 to 30 April 2017**

Participant <sup>^</sup>	Reduction in feelings of anxiety	Improvement to mental health support	Increase in physical health support	Social support strengthened	Increase in stress / distress tolerance
1	1	1	1	1	-
2	-	-	-	1	-
3	-	-	-	-	-
4	-	1	-	1	-
5	-	-	1	1	-
6	-	-	-	1	-
7	-	1	1	1	1
8	-	1	1	1	-
9	-	-	1	-	-
Total	1	4	5	7	1

<sup>^</sup>Participant number randomly allocated for Table 9 only.

### **Impact of therapeutic treatment on gambling urges**

The court reports indicate that the majority of participants who completed the program during the evaluation period achieved a reduction in gambling urges as a result of the therapeutic treatment.

#### *Changes in participants' Gambling Urge Scale [GUS] from beginning to end of treatment*

The Gambling Urge Scale (GUS) is a questionnaire measuring the extent of gambling urge based on the participant's self-reported thoughts and feelings at the time of completing the questionnaire. The scale consists of six items rated on a Likert (0–7) scale including statements such as, 'I crave a gamble right now', and, 'All I want to do is gamble' (total scores ranging from 0 to 42).

As shown in Table 10, GUS scores were available for eight of the nine program completers. All eight recorded a decrease between their first assessment and most recent assessment, with seven recording a most recent score of 0.

**Table 10: GUS scores for GIP completers**

Participant*	First GUS Score	Most recent GUS Score
1	32	0
2	26	0
3	21	0
4	12	0
5	6	0
6	5	2
7	12	0
8	10	0
9	N/A	N/A
Median	12	0

\*Participant number randomly allocated for Table 10 only.

#### *Changes in participants' Gambling Related Cognitions Scale from beginning to end of treatment*

During the evaluation period, SGTS collected Gambling Related Cognitions Scale [GRCS] scores from participants at the beginning and end of treatment. The GRCS is a 23-item self-report questionnaire which uses a 7-point Likert scale to measure participants' erroneous beliefs about gambling, such as the role of behaviour or rituals in increasing the likelihood of winning. There are five subscales within the GRCS:

- Illusion of control (4 items)
- Predictive control (6 items)
- Interpretative bias (4 items)
- Gambling-related expectancies (4 items)
- Perceived inability to stop gambling (5 items)

The total score of these five subscales is the GRCS score. A reduction in GRCS score indicates a lessening in a participant's erroneous beliefs about gambling. It should be noted that the length of time between participants' first and second GRCS score has not been included to protect the identity of individuals. GRCS scores were available for seven of the nine completers, with all but one recording a reduction from their first to their most recent GRCS assessment. One participant recorded a slight increase in their GRCS score at the end of treatment (from 75 to 80). The median GRCS score reduced from 77 at the first assessment to 23 at the most recent.

**Table 11: GRCS scores for GIP completers**

Participant*	First GRCS Score	Most recent GRCS Score
1	108	23
2	104	72
3	100	23
4	75	80
5	71	33
6	57	23
7	77	23
8	N/A	N/A
9	N/A	N/A
Median	77	23

\*Participant number randomly allocated for Table 11 only.

### **Impact of therapeutic treatment on participants' functional capacity**

#### *Changes in participants' Work and Social Adjustment Scale from beginning to end of treatment*

During the evaluation period, SGTS collected Work and Social Adjustment Scale (WSAW) scores from GIP participants. A WSAW score of 20 or above indicates moderately severe psychopathology, whereas scores between 10 and 20 indicate significant functional impairment. WSAW scores were available for eight of the nine completers. All eight completers recorded reductions between the first and most recent WSAW assessment, with seven most recent scores less than 10.

**Table 12: WSAW scores for GIP completers**

Participant*	First WSAW Score	Most recent WSAW Score
1	32	0
2	32	0
3	26	0
4	21	14
5	19	2
6	14	0
7	12	0
8	7	0
9	N/A	N/A
Median	20	0

\*Participant number randomly allocated for Table 12 only.

### *The impact of participant compliance and progress on the Magistrate's decision in relation to sentencing*

The evaluators observed the GIP Magistrate commenting on the defendant's compliance and progress before handing down the sentence. Generally, before handing down the defendant's sentence, the GIP Magistrate acknowledged receipt of one or more of the following documents:

- an offender history report;
- sentencing recommendation reports prepared by TIC staff;
- a submission by the police or public prosecutor in relation to sentencing;
- a submission by the defence counsel in relation to sentencing; and
- feedback from defence counsel and/or the prosecutor in relation to whether the defendant had made partial or full reparation to the victim.

The GIP Magistrate generally commented on the impact of the following factors in relation to sentencing:

- the sentencing principles of deterrence and rehabilitation;
- the severity of the offence;
- changes in the defendant's attitudes and behaviour in relation to problem gambling;
- submissions made by the defence counsel and the public/police prosecutor in relation to sentencing;
- effort undertaken by the participant to actively engagement with the therapeutic treatment program;
- efforts made by the participant to make reparation to the victim, such as the participant's employer; and
- the willingness of the defendant to engage in a Restorative Justice Conference.

## **1.7 Sentencing outcomes**

Nine participants successfully completed the program and had their matters finalised at a sentence hearing.

Table 13 shows the types and duration of sentences handed down to the nine GIP completers. Eight of the nine completers received a non-custodial sentence, including seven who received a suspended sentence bond (1 supervised and 6 unsupervised) and one who received a good behaviour bond.

The remaining participant received a custodial sentence of three months in prison with a Suspended Sentence Bond (unsupervised) period of 2 years upon release.

The length of the penalties handed down by the GIP Magistrate ranged from six months to three years. The most common penalty duration was a two year unsupervised suspended sentence bond (3 of the 9 program completers).

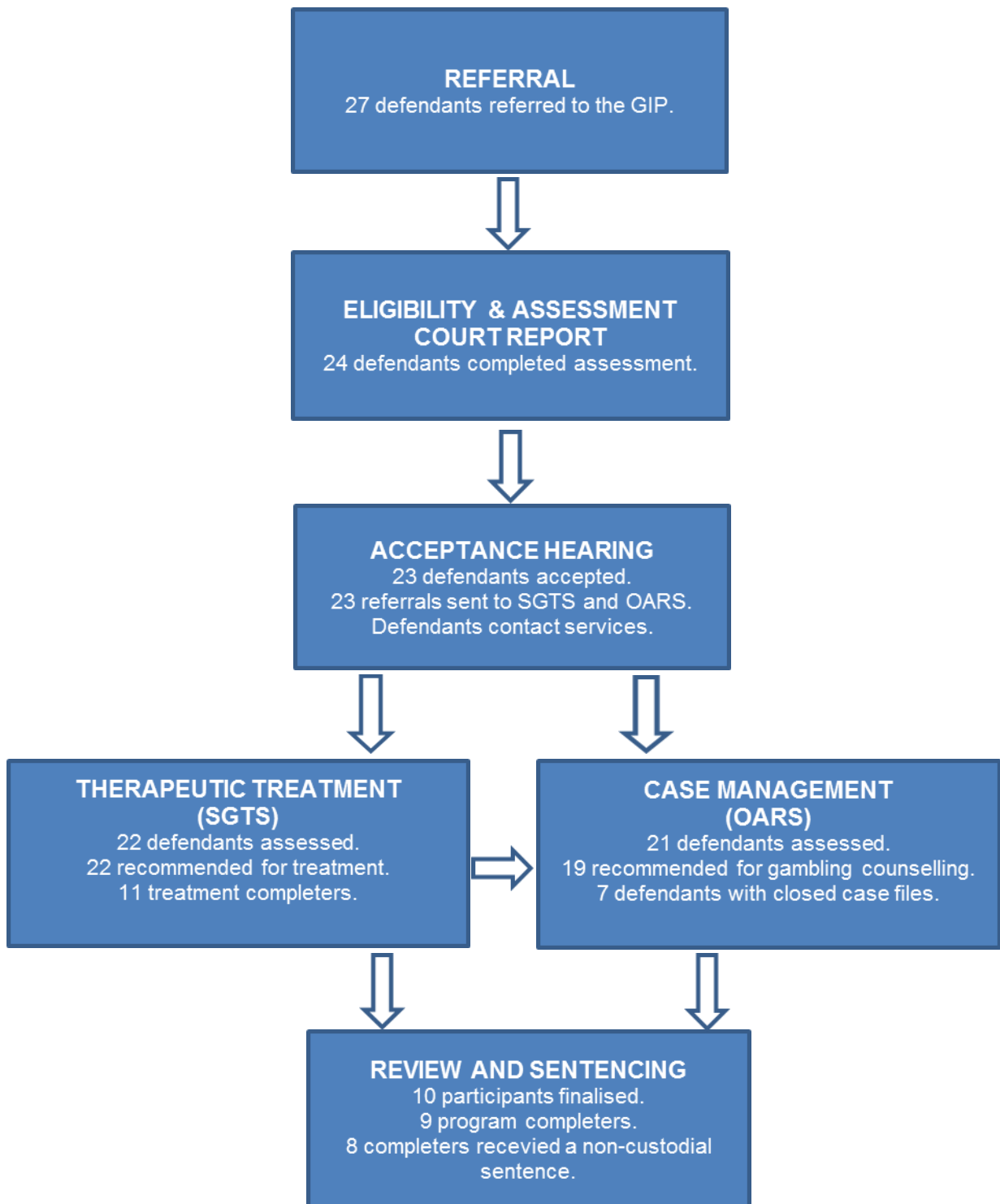
**Table 13: Type, frequency and duration of sentence**

Sentence type	No. of participants	Median duration (months)	Range (months)
Prison Sentence	1	3	-
Suspended Sentence Bond - Supervised	1	24	-
Suspended Sentence Bond - Unsupervised	7	18	12 to 36
Good Behaviour Bond - Unsupervised	1	6	-

## 1.8 Participant Throughput Summary

The throughput of GIP participants from referral to finalisation is summarised in Figure 2.

**Figure 2: GIP Trial Participant Throughput**



## 2. Stakeholder feedback

The findings in this section are based on interviews with stakeholders involved in the development and implementation of the GIP Trial. In line with the aims of the evaluation, respondents were asked a range of questions regarding the implementation and operation of the GIP, as well as their views on the impact and outcomes of the program. The interviews primarily focussed on:

- the appropriateness of the eligibility criteria and the suitability of persons being referred to the GIP Trial;
- the level of collaboration between services involved in the delivery of the program;
- the effectiveness of the service model in addressing the needs of the participants;
- the impact of the program on sentencing;
- the strengths of the GIP; and
- areas for improvement.

### 2.1 Appropriateness of the eligibility criteria and suitability of referrals

The majority of respondents felt that defendants referred for assessment for the program met the program's eligibility criteria, particularly in relation to the nexus between gambling and offending.

*I think there's often a clear nexus with gambling because they've taken money from their employer, or they've underreported at Centrelink, or they've manipulated a situation so that they have money available to them to go and gamble.*

All of the respondents noted the need for defendants to be in a state of readiness to be suitable for the program. Some stakeholders expressed concern about a small number of problem gamblers with severe mental health issues or cognitive impairment, such as Acquired Brain Injury (ABI), being referred for an assessment interview. These stakeholders felt that severe mental health issues or ABI reduced a defendant's capacity to participate in and benefit from the Cognitive Behavioural Therapy (CBT). However, there was general support amongst this group of respondents for referring these defendants in any case because they were likely to be referred on to other service providers to support them through the court process.

*You'd rather that they have an opportunity and get some benefit... referring is better than nothing.*

The majority of the respondents supported the CAA delaying assessment interviews for defendants with other complex needs, such as psychological trauma, to enable these individuals to work with external clinical psychologists to build their stress tolerance before commencing therapeutic treatment under the GIP.

*When they go into the graded exposure therapy, if they don't have the psychological resilience to deal with that stress, it could be too much for them to cope with and then they may resort back to gambling or they may resort to other things to cope with that level of stress.*

Most of the respondents observed that the screening assessment undertaken by the CAA often revealed a range of comorbid issues in addition to problem gambling and offending that needed addressing. Most of the stakeholders felt that it was common for these issues to be complex and inter-related. The types of comorbid issues identified by respondents included substance abuse, financial issues, accommodation needs, dysfunctional relationships with family, social isolation, physical health issues, and mental health issues. Generally, respondents agreed that it can be difficult to determine the relationship of these issues to problem gambling in the short term, making it difficult to successfully address one need at a time, or prioritise one need over another.

*...it would be rare that someone would present purely with a gambling problem and nothing else.*

*...a lot of times it's a comorbid problem; it's not only gambling but it's also either drug use or mental health issues and then it's hard to distinguish one from the other and what causes one or the other.*

Three respondents observed that, early in the implementation of the program, there were several discussions between Steering Committee members and the Commonwealth Department of Public Prosecutions (CDPP) about the suitability of defendants charged with Commonwealth offences, such as Centrelink fraud. Feedback from these stakeholders indicates that the Steering Committee and the CDPP agreed early in the program that such Commonwealth matters could be dealt with by the TIC.

## **2.2 Collaboration between services**

Respondents were generally positive about collaboration between agencies during the implementation stage of the program. Four stakeholders reported some confusion about the referral process early in the program. In particular, concerns were raised that some participants had been contacted by OARS without SGTS making a referral for case management support.

*I think there have been some tensions with the different stakeholders between what they might expect of each other and what happened.*

*Originally, when this was all being designed, the Steering Committee developed a flow chart. The one we initially agreed on had the treatment service up front for a full assessment... and then if there were any psychosocial issues, SGTS would refer on to other providers in the system.... So that was the plan and that's how I thought it was going to work but it hasn't actually worked like that...*

However, it was reported that any confusion had been discussed and resolved by these agencies coming together at informal meetings to clarify the referral process between service providers. This collaboration resulted in a change to the referral process, where rather than the CAA sending referrals to SGTS only, participant information collected at the assessment interview would be sent to both SGTS and OARS. While this change has been positively received overall, one respondent expressed concern about the impact on some clients:

*So then it was rejigged so that CAA would refer to both SGTS and OARS at the same time and the client would be then required to go to both at once. So the situation as it stands is that the person goes to both... for some clients it's worked to go to both and for others it's too much. One client today said she is seeing someone every day of the week.*

Overall, respondents were positive about information sharing between agencies. Most of the respondents indicated information sharing between agencies had improved significantly since the start of the program.

*I think that people are flexible and forthcoming with information.*

The majority of stakeholders commented on the Client Pathway Model (Appendix 4) as a point of reference in relation to referrals between agencies during the course of the trial.

*We developed a flowchart which was a Client Pathway Model and that was done with the OPG, Statewide and the Courts and it was signed off by everybody.*

One stakeholder felt that further documentation was needed, such as a GIP Program Manual, to support new and existing workers involved in the delivery of services within the program.

## 2.3 Change of gambling treatment service provider

The OPG funded the SGTS until December 2016 to provide gambling treatment. From November 2016, as a result of an open tender process, PsychMed was appointed by OPG to provide gambling treatment services.

A number of respondents expressed concern about the possible impact of this change on the therapeutic treatment provided to participants, particularly in relation to the objective measure of gambling urges, which in turn may affect the Magistrate's assessment of the participant's progress.

One respondent felt that it may be beneficial to have more than one therapeutic treatment provider available to participants, particularly if the program continued and demand for the GIP increased.

*...in the future, we will hopefully be able to refer to two places.*

No further information is available regarding the impact of the change in provider, as SGTS agreed to continue receiving referrals for GIP and, at the time of writing, there have been no referrals to PsychMed.

## 2.4 The effectiveness of the service model

All of the respondents felt that the program had met its aims and objectives, and that the GIP was effective in addressing the therapeutic and social support needs of participants.

*There is a defined outcome and a defined goal that we're aiming for and the way the GIP's set up it establishes the resolve very well for people which leaves them to be so motivated and actually do something and it gets them through the tough phases.*

The majority of the stakeholders commended the quality of the services provided by SGTS and OARS during the trial. Most of the respondents felt the case management support component was integral to the success of the program in addressing the needs of participants with comorbid issues, particularly during the court process and after defendants' matters were finalised. There was general agreement that the CAA and OARS case management staff played a vital role in helping participants understanding the court process and the support services available to them.

*I don't think that [participants] see the wood for the trees... when you're going through court, it's a very scary process...so [case management] breaks that down for them. That's what case management does.*

Three respondents commented on CAA and OARS case managers working together to support defendants, particularly in relation to interpreting what the GIP Magistrate said to the defendant during proceedings.

*Case workers know where the Magistrate's at in his thinking and we can help guide and steer the defendant in the right direction.*

The majority of respondents felt that the therapeutic treatment services provided by SGTS were sound and suited to the objectives of the program because of the focus on collecting physiological evidence to demonstrate the effectiveness of the intervention. There was general agreement that the heart rate monitoring and CBT services provided by SGTS had been successful in reducing participants' gambling urges.

*By all accounts I think the treatment SGTS provided met the brief.*

*The defendants, all but one, have spoken highly of the Statewide Gambling Service's involvement and the therapeutic benefit of that. So from that point of view they've been extremely helpful and extremely successful.*

However, two respondents felt that the therapeutic treatment component of the program was disruptive to the therapeutic support some participants were already engaged with before they were referred to the program.

*...some of the clients who may have already been engaged with a psychologist have a preference to stay with their psychologist ...*

Most of the respondents felt that the therapeutic treatment provided by SGTS helped participants gain insight into their gambling addiction as well as the impact of the treatment on their urge to gamble. Generally, respondents agreed that the heart rate monitoring method was an appropriate way to measure gambling urges. It was noted that participants who completed the treatment were generally presented with a hardcopy of the data so that they had a tangible record of the progress they had made as a result of the treatment.

*...it was very powerful, clinically, with the patient...*

*[Participants] can go, "look, there's no adrenaline anymore and I'm thinking clearer", and it's concrete. For me, that seems to be why it's working well with the people that are coming through.*

## **2.5 Court processes**

Respondents were asked about the court review process, including the frequency of reviews, information provided in court reports, and the role of the Magistrate.

It was noted that GIP participants attend a court review every two months, compared to the weekly contact for other programs such as Drug Court. However, the majority of respondents felt that the level of contact was appropriate for GIP.

The court reports provided to the Magistrate were considered to be relevant and useful.

The majority of respondents commented positively on the level of communication between the GIP Magistrate and participants. Five of the stakeholders observed that the Magistrate used positive reinforcement to praise participants when they engaged in the program. Equally, there was general agreement that the GIP Magistrate also held participants accountable for their behaviour and actions if they did not comply with court orders in relation to their treatment and case management plans.

*I think the Magistrate plays a strong role in the review... where things are going well there's reinforcement, or where things are not quite what they should be there's a full and frank conversation about it and clients are engaged in a very neutral way to tease apart that issue and to set them off on the right track. I think that's the power of good Magistrates in courts - Magistrates that show a level of interest in the individual will always get better outcomes and better performances from clients and that's a very cooperative process in that courtroom... it's not talking at them, it's talking with them.*

*I think it's important that the defendants come to court regularly so that they realise that they're going to have to face an authoritative figure and explain any abhorrent behaviour...*

One respondent felt having participants attend regular court reviews was an effective way to communicate the seriousness of the charges and the consequences the defendant would be faced with if they did not engage in treatment.

Overall, it was felt that the court reports and regular attendance at court reviews gave GIP participants a strong incentive to continue with their treatment and participate in the program.

## **2.6 The impact of the program on sentencing**

There was general agreement amongst respondents that successful completion of the program had a positive impact on sentencing. Generally, stakeholders felt that defendants were more likely to receive a non-custodial sentence if they completed the program than they otherwise would have received if they remained on the general court list. The majority of stakeholders commented on the effectiveness of the heart rate monitoring method in reducing participants' urge to gamble and the role the outcome of these measures played in demonstrating to the GIP Magistrate that the defendant had changed their gambling behaviour as a result of the program.

*We wanted the best evidence possible to give the Magistrate the highest level of confidence that when he gave a really lenient sentence that he wasn't basing it on hearsay.*

All respondents felt that the GIP Magistrate considered a range of factors at sentencing, such as the severity of the offence, sentencing principles and case law.

*The starting point has to be the seriousness of the offence and the defendant's criminal history...*

*I think Magistrates make their decisions based on the law and based on the facts before them and they certainly use those reports for their factual information...*

All of the stakeholders commented on the GIP Magistrate's consideration of a participant's compliance with staff responsible for delivering the case management support and therapeutic treatment services, as well as the participant's attitude towards their rehabilitation.

*...attendance and engagement, looking for meaningful work, overcoming challenges and obstacles that might initially have been a barrier to full engagement.*

The majority of respondents felt that if a client had demonstrated their commitment to the program by attending all of their appointments and following the direction of the service providers involved in their rehabilitation, it was likely they would receive a reduced, non-custodial sentence.

*Anybody who successfully completes a program has demonstrated that they are capable of rehabilitation which is an extremely important factor in the sentencing process and so they will get a suspended sentence on successful completion.*

## **2.7 Strengths of the GIP**

Respondents were asked to identify the strengths of the GIP. All respondents strongly supported the program, felt there was a need for it to be a regular feature of the South Australian criminal justice system, and were in favour of it continuing.

There was a general feeling amongst stakeholders that without the high level of collaboration and communication between agencies involved in development and implementation of the GIP Trial, the program would not have met its aims and objectives.

*...I've not had anybody on the Gambling Intervention Program have a bad word about any of the staff or counsellors that they've been referred to.*

*I think there's a lot of goodwill for the pilot and I think Office of Problem Gambling have been really great to work with.*

The majority of respondents also commented on the collection of evidence, such as heart rate monitoring to show changes in gambling urges, as a primary strength of the program. These respondents generally felt that explaining these measures and results to participants helped them gain insight into their physiological and psychological responses to their gambling urges, and encouraged participants to be accountable for their engagement in the treatment process.

*I think the strengths of the GIP are getting somebody to recognise that they have a problem...*

*...it is a good model because it does provide some tangible testing.*

*I think that we are organised and set up to do an intervention that is evidence-based... it's a very formulaic intervention with a bit of flexibility in consideration of people's different comorbid issues.*

Equally, most of the respondents also identified the case management component as a key strength because it addressed the psychosocial needs of participants both during and after their engagement in therapeutic treatment.

*Case management connects people with other things like employment and accommodation, sorting out their pension entitlements, mental health issues and advocating for them with other services if they're not getting the attention that they need.*

Another strength identified by stakeholders relates to the potential for the GIP to play a central role in raising awareness about problem gambling amongst the legal profession and the broader community.

*Having the courts now looking at problem gambling as a reason for diversion is going to change the way that the community views gambling and that's probably ultimately the biggest plus.*

Overall, respondents were strongly supportive of the GIP model and unanimous that this collaborative approach to rehabilitating defendants with problem gambling should be maintained.

## **2.8 Areas for improvement**

Respondents were asked what they thought were the main areas for improvement. Although there was broad support for the program, three main process issues were identified as areas in need of improvement should the GIP continue. The three main issues related to:

- participant screening assessment fatigue;
- referral pathways between agencies; and
- awareness of the GIP amongst defence lawyers and the community.

### **Participant screening assessment fatigue**

There were mixed views regarding the appropriateness of a screening assessment being conducted by each agency involved in the implementation of the GIP. Some respondents felt that having to complete multiple assessments was an onerous task for participants.

*Well, one organisation needs to do the assessing...double dipping and doing all of that again, I don't think we need to put the clients through that and that wasn't the intention...*

*... we shouldn't be going over the same stuff over and over again.*

Respondents were divided equally in their support for one of the agencies taking over the bulk of the assessment process to reduce assessment fatigue, or for each agency continuing to conduct their own assessments with a participant to measure and address their needs.

### **Referral pathways between agencies**

Overall, respondents were generally positive about the level of information sharing between agencies.

*I think that people are flexible and forthcoming with information...*

The Client Pathway Model (Appendix 4) was considered to be a useful resource by the majority of stakeholders interviewed. The majority of respondents reported that they referred back to this document during the implementation of the trial to ensure they were following the appropriate referral and information sharing processes.

*We developed a flowchart which was a Client Pathway Model ... and it was signed off by everybody and that clearly states where we fitted in.*

However, as indicated, four respondents observed that, early in the implementation stage of the trial, there seemed to be some confusion about the referral and assessment process between service providers.

However, feedback from stakeholders indicates that these concerns were addressed early in the trial by the agencies concerned.

### **Awareness of the GIP amongst defence lawyers and the community**

Some concern was expressed regarding the low number of referrals to the GIP in the first six months of the program. Reasons suggested by stakeholders for this slow uptake included a lack of knowledge of the GIP amongst defence lawyers and the legal profession more broadly.

*You need the confidence of the legal profession in particular because in a way they are the gate keepers.*

The majority of respondents also felt the stigma associated with gambling addiction created a barrier for defendants to seeking help and support.

*...the reality I think is that gambling is highly stigmatised... it's easier to get people to admit to a heroin problem than a gambling problem...*

The majority of respondents felt there was an urgent need to improve communication about the program to the legal profession, judicial officers and the broader community and that this would have a positive impact on increasing referrals should the program continue.

*I think the program as a whole from my perspective has been more than just successful. Implementation of it was... it was slow, to start with and that was slow referrals to come through. You have to reach a lot of people in the... legal fraternity – solicitors, the Law Society, Legal Aid, there's an awful lot of people that contribute to people going through the courts.*

Generally, respondents felt awareness of the GIP could be increased by communicating the results of the program to the legal profession, judicial officers, and the broader community.

*...you need to have a few go through with a few successes for the word of mouth to be passed around.*

*...with anything new, people take a while to get on board with it. I think we've seen a recent rush of referrals and I think that's more because we're starting more to talk with lawyers and I do think that court programs change all the time so there's occasionally confusion generally about what we're offering, just simply by virtue of the fact that we're responding to different types of needs and offending all the time and programs are implemented and altered and increased or cutback... so I think that sometimes can produce a lack of clarity about what's being offered for offenders...*

## **2.9 Participant feedback**

As indicated, none of the GIP completers agreed to participate in an evaluation interview. However, information on the case management experience of participants was collected by an OARS Team Leader who had not been involved in the delivery of the GIP during the data collection period. The Team Leader contacted 20 participants, with nine providing responses.

### *Meeting the participant's needs*

Participants were asked by the OARS Team Leader whether their case worker had supported the participant in addressing their needs. The comments made by participants were generally very positive.

*[The case worker] tried to help me, he's very good. He tried to help me out with getting a fridge. He advocated with Origin Energy about my hot water system.*

*Good to talk with someone.*

*[The case worker] tries to support me, encourages me, makes me feel I have support. I almost committed suicide, feeling a lot better now.*

### *Providing court support to the participant*

Participants were asked by the OARS Team Leader how they found the court experience in relation to the support provided by their OARS case worker. Generally, participants felt that their OARS case worker was supportive and helpful during the court process.

*Good, [the] worker always explained everything.*

*It was nice to have him [the case worker] there. He ran through some different scenarios which was nice.*

### *Collaboration between SGTS and OARS in delivering services to participants*

Participants were also asked to share their perspectives on how effectively SGTS and OARS worked together in providing support to the participant. Respondents generally felt the relationship between SGTS and OARS was positive and the agencies worked well together.

*Pretty good, obviously the two services do different things but both services were helpful and communicated with each other.*

### *Areas for improvement identified by participants*

Participants were asked whether they felt there were any areas for improvement in relation to the case management support component of the GIP. In general, participants were satisfied with the way case management services had been delivered by OARS and did not identify any areas for improvement. One respondent had not met with their case worker yet so did not feel they could comment on areas for improvement at the time their feedback was collected.

*No concerns off the top of my head.*

*I'm happy with what the worker has done for me, very supportive.*

*Still new, haven't seen my worker regularly yet.*

***Participants' overall experience of the program***

Participants were asked what their overall experience was of the GIP. In general, participants provided very positive feedback about their experiences of the program and felt the GIP should continue.

*GIP program will be a lifesaver.*

*The program helped a lot and I would definitely recommend it to others.*

*Both SGTS and OARS workers have helped me think positively.*

In addition, the evaluators observed one participant responding during a sentencing hearing. The participant had been granted permission by the GIP Magistrate to address the court directly to convey their gratitude to the GIP service providers. The participant commented that their gambling urges had been significantly reduced as a result of the services provided by SGTS. The participant also commented that they felt supported throughout the court process by OARS and CAA staff. Overall, the participant felt that the GIP was effective in reducing gambling urges and that having ongoing access to case management support had a positive impact on their life.

# Summary

This report provides the results of a process and outcome evaluation of the Gambling Intervention Program (GIP) Trial.

The evaluation was conducted from December 2016 to May 2017, on behalf of the Office for Problem Gambling. The evaluation involved obtaining comprehensive feedback from persons directly involved in the management and operation of the GIP, including the GIP Magistrate, staff of the Courts Administration Authority and service providers from Statewide Gambling Therapy Services and Offenders Aid and Rehabilitation Services. Administrative data from the CAA and the service providers were also analysed to determine the throughput, profile and outcomes for GIP participants.

## Throughput

Referrals to the GIP were low in the first 18 months of the trial, but have recently increased. As at 30 April 2017, there have been 27 referrals, 23 persons accepted, 13 active and 10 finalised participants, including nine successful completers.

## Stakeholder responses

Stakeholders reported that the GIP had been operating as intended, and that there was unanimous support for it to continue. While a number of issues were initially identified with regard to referral pathways, participant assessment and low referral numbers, no major concerns were reported regarding its operation or impact. Although no participants agreed to take part in the evaluation, surveys from individuals involved in OARS case management services also indicates positive support from participants for the program.

## Outcomes

**Participant Insight into Gambling:** VGS-HS scores of treatment completers show that the program was successful in improving these participants' insight into their gambling. A third of treatment completers achieved a VGS-HS score of zero at their most recent treatment session, with the remaining treatment completers also achieving reductions in their VGS-HS scores between sessions. Feedback from stakeholders indicates that participants benefited from having access to summaries of their heart rate monitoring data as it helped them to understand their gambling cues and their physiological responses to these cues.

**Impact of therapeutic treatment approach:** The therapeutic treatment approach delivered by SGTS was successful in reducing gambling urges in treatment completers. All treatment completers showed a reduction in their heart rate during exposure to gambling cues from their first session to the most recent session.

**Impact of case management on psychosocial outcomes:** Overall, the case management support delivered by OARS was successful in improving the psychosocial outcomes of participants. Between the first assessment and most recent assessment, the participants' stage of change generally shifted from *preparation* (12 of 19) to *action* (13 of 19). In addition, reductions in the number of participants with specific issues were recorded for all but two of the 10 issues identified at the first assessment.

**GIP completer outcomes:** Court reports for the nine participants who successfully completed the program during the evaluation period show high levels of engagement and improvements across a range of psychosocial areas. Overall, the program was generally successful in reducing gambling urges and improving functional capacity.

**Impact of GIP on sentencing outcomes:** In line with the aims of the program, eight of the nine GIP completers during the evaluation period received a non-custodial sentence.

## Conclusion

The development and implementation of the GIP has demonstrated a collaborative effort by criminal justice agencies and gambling help services to address the multiple and varied needs of defendants charged with gambling-related offences.

While some process issues were identified, the evaluation found that the GIP had successfully met its objectives of reducing gambling urges and achieving non-custodial sentences for participants. In addition, there was unanimous support for the program from stakeholders.

It is therefore recommended that:

- the Gambling Intervention Program (GIP) be continued in the Adelaide Magistrates Court;
- Steering Committee meetings be maintained to ensure ongoing communication between stakeholders. Consideration should also be given to including agencies responsible for facilitating Restorative Justice Conferences should such meetings occur;
- a Program Manual be developed to support existing and new GIP staff;
- consideration be given to developing a targeted marketing and communications strategy to educate legal professionals and judicial officers about the GIP and the outcomes it has achieved for defendants charged with gambling related offences; and
- consideration be given to inviting future program completers to provide feedback about their experiences of the GIP, particularly in relation to the risk of assessment fatigue and other areas for improvement identified by stakeholders.

# Appendices

## Appendix 1: Letter of introduction to GIP participants



**Government of South Australia**  
Attorney-General's Department

**Office of Crime Statistics and Research**

45 Pirie Street  
Adelaide SA 5000

GPO Box 464  
Adelaide SA 5001  
DX 336

Tel 08 8463 4364

13 February 2017

Dear GIP trial participant,

This letter is to invite you to take part in the evaluation of the Gambling Intervention Program Trial. As someone who has taken part in the program we are interested in your feedback. This will help us to work out if the program has helped you and if it can be improved in any way. The Office of Crime Statistics and Research has been asked to do this evaluation. We are completely separate from the Courts Administration Authority, Statewide Gambling Services and Offender Aid Rehabilitation Services. Anything you tell us will not be repeated to anyone else in a way that will identify you. Your feedback will be combined with other participants' feedback to protect your privacy.

If you would like to give some feedback on your experience of the program please call 8207 1954 to arrange an interview time. An information sheet, which tells you more about the evaluation, is attached. Please read it and feel free to ask any questions.

We look forward to hearing from you.

Yours sincerely

Emma Ziersch  
Senior Research and Evaluation Officer  
Office of Crime Statistics and Research



## Information Sheet

### Evaluation of the Gambling Intervention Program Trial

Principal Researcher: Emma Ziersch

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#### The project

The Office of Crime Statistics and Research is evaluating the Gambling Intervention Program (GIP) Trial to see how it is working. As someone who has been involved in the program, you are an important part of the evaluation process.

This information sheet explains what taking part in the evaluation will mean. Please read it carefully and ask any questions before you start. If you do agree to participate this will not have any influence on the potential outcome of your court matter.

#### Taking part in the GIP evaluation

As part of the evaluation we will be observing the court review process. The CAA case worker will tell you when this occurs.

You can be involved in the evaluation of the GIP trial by participating in an interview at a time that is convenient for you. Participation in an interview is voluntary. You are free to change your mind and withdraw at any stage. If you decide not to consent to an interview, this **will not affect your participation** in the GIP. If you are willing to participate please contact us on 8207 1954 to arrange an interview time that suits you.

#### What will an interview involve?

The interview is usually done face to face and takes around 45 minutes. The researcher will ask to record your interview, but if you prefer not to have it recorded, the researcher will take notes.

We would like to ask you important questions about your experiences of the GIP Trial. These include questions about the assessment and referral process, the treatment sessions, case management and what you thought of the program overall. We will also ask you about what impact the program has had on your gambling and other areas of your life.

You can ask to stop the interview at any time and you don't have to answer any questions that you don't want to answer. If you feel upset at any time in the interview, please let the researcher know.

You can also contact your GIP treatment counsellor or case worker to talk to them if you feel upset after the interview. Alternatively you may wish to phone the Gambling helpline on 1800 858 858 or Lifeline on 13 11 14.

Your answers will help us to see whether the GIP actually changed people's lives, what works well and anything that could be improved about the Program.

#### Confidentiality

All information you provide is confidential, but sometimes researchers are required to share information by law. They have a legal requirement to share information if they think that a child is at risk of harm or if they think that someone participating in their research may hurt themselves or another person. Please ask if you would like more information about this aspect of the project.

#### Results of the project

The findings of the evaluation will be put into a report for the Office of Problem Gambling and the GIP Steering Committee only. Your name will not be used in the report and the findings will be combined to limit the potential for any information to identify who you are.

If you would like to be sent a summary of the results of the evaluation when it is finished, please contact us on the number below.

#### Further Information or Any Problems

This project has been approved by the SA Health Human Research Ethics Committee. It is being carried out according to the guidelines set down by the National Health and Medical Research Council of Australia. If you require further information or have any problems concerning this evaluation, you can contact us by phone on 8207 1954.

If you have any complaints about the way the evaluation is being done or questions about your rights as a participant in this research, please contact Lauren Perry, Executive Officer of the SA Department of Health Human Research Ethics Committee on 08 8226 6431.

## Appendix 2: Problem Gambling Severity Index (PGSI) Assessment Tool

### CPGI-PGSI

Please answer each of the following questions about your gambling and **how often** events have occurred over the **last 12 months**.

In the last 12 months, how often:

	<i>Never</i>	<i>Sometimes</i>	<i>Most of the time</i>	<i>Almost always</i>
<i>Point scoring codes</i>	0	1	2	3
1. Have you bet more than you could really afford to lose?				
2. Have you needed to gamble with larger amounts of money to get the same feeling of excitement?				
3. When you gambled, did you go back another day to try to win back the money you lost?				
4. Have you borrowed money or sold anything to get money to gamble?				
5. Have you felt that you might have a problem with gambling?				
6. Has gambling caused you any health problems, including stress or anxiety?				
7. Have people criticised your betting or told you that you have a gambling problem, regardless of whether you thought it was true?				
8. Has your gambling caused any financial problems for you or your household?				
9. Have you felt guilty about the way you gamble or what happens when you gamble?				

*Scale total = sum of (1) to (9). Min = 0, max = 27.*

### Appendix 3: Victorian Gambling Screen Harm to Self Sub-Scale (VGS-HS) Assessment Tool

**VGS**

Please answer each of the following questions about **how often** events have occurred over the **last month (4 weeks)**. If you have not gambled in the last month then some of the questions may not apply to you, and the response to those questions will be 'Never'.

**In the last month, how often:**

*Never*      *Rarely*      *Sometimes*      *Often*      *Always*

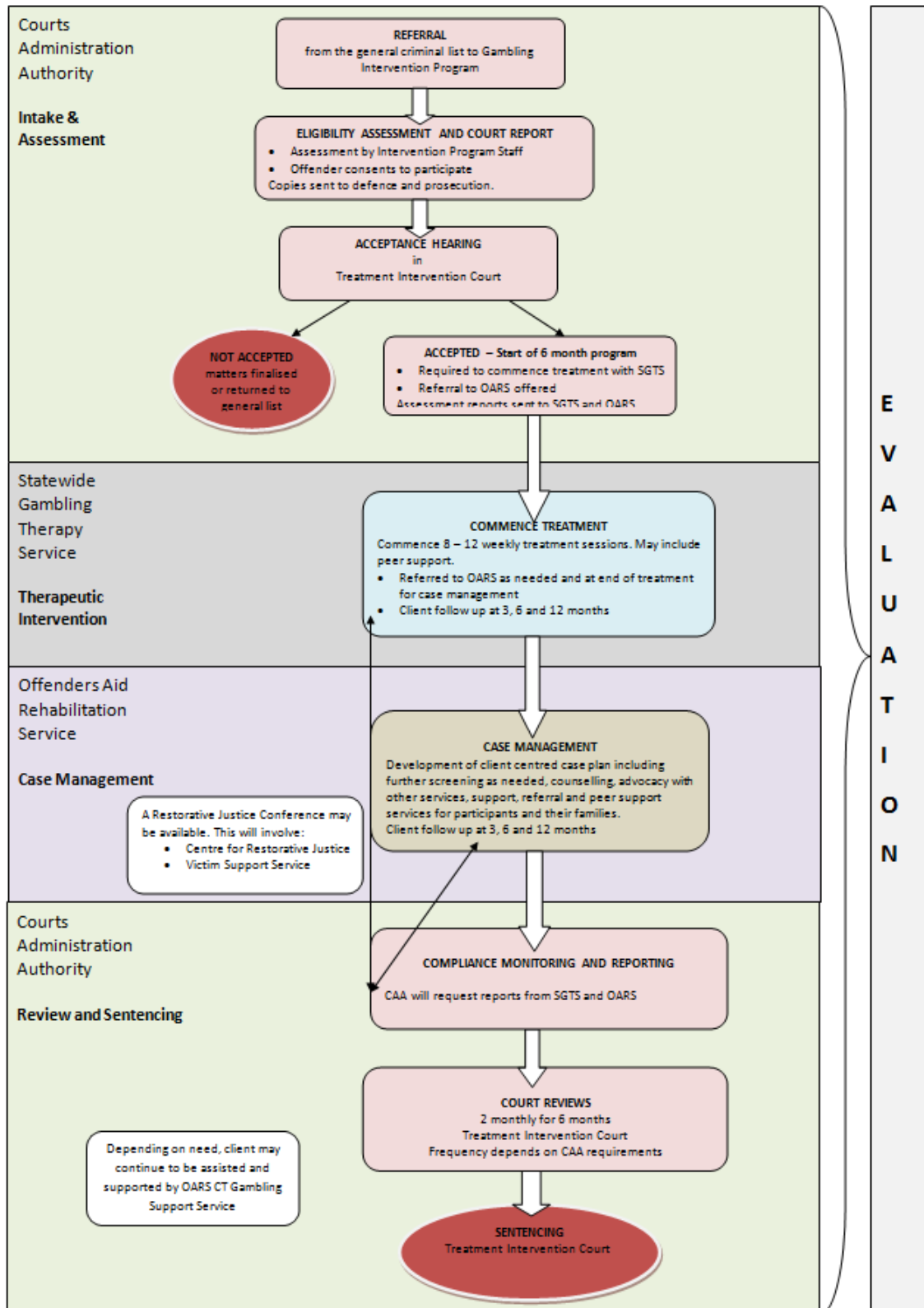
*Scale scoring codes*

	0	1	2	3	4
1. If you gambled in the last month, did you feel as if you were on a slippery slope and unable to get back up again?					
2. Has your need to gamble been too strong to control?					
3. Has gambling been more important than anything else you might normally do?					
4. Have you felt that after losing you must return as soon as possible to win back any losses?					
5. Has the thought of gambling been constantly in your mind?					
6. Have you lied to yourself about your gambling?					
7. Have you gambled in order to escape from worry or trouble?					
8. Have you felt bad or guilty about your gambling?					
9. Have you thought you shouldn't gamble or should gamble less?					
10. Has anyone close to you complained about your gambling?					
11. Have you lied to others to conceal the extent of your involvement in gambling?					
12. Have you hidden betting slips, Lotto tickets, gambling money or other signs of gambling from your spouse, partner, children or other important people in your life?					
13. Did you spend more money on gambling than you could afford?					
14. Did your gambling make it harder to make money last from one payday to the next?					
15. Did you borrow money to gamble with?					

## Appendix 4: Client Pathway Model

### Gambling Intervention Program (GIP) Client Pathway Model

Endorsed by Steering Group on 14<sup>th</sup> May



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