

FINAL REPORT

Rethinking Problem Gambling in the South Australian Criminal Justice System

A critical review of the literature on problem gambling
and therapeutic justice

Office for Problem Gambling

Prepared by Oteng Karikari

Table of Content

Abbreviations	3
Executive Summary.....	4
PART 1 Introduction	6
1.1 Background	6
1.2 Scope	7
1.3 Outline	7
PART 2 Gambling and Problem Gambling	9
2.1 Introduction	9
2.2 Definition of Gambling and Problem Gambling	9
2.3 An Overview of Gambling and Problem Gambling in Australia	11
2.4 Risk Factors and Comorbidity of Problem Gambling	14
2.5 Gambling and Crime	18
2.5 Problem Gambling: Disease or Vice	21
PART 3 Therapeutic Justice	25
3.1 Introduction	25
3.2 Therapeutic Justice: What Is It?	25
3.3 Therapeutic Justice: The South Australian Experience	29
3.4 Intervention Points	34
3.5 Screening Tools	36
PART 4 Next Steps	38
4.1 Introduction	38
4.2 Recommendations	38
Bibliography	42

ABBREVIATIONS

ACIS – Assessment and Crisis Intervention Service
AGTC – Amherst Gambling Treatment Court
AIC – Australian Institute of Criminology
AMA – American Gaming Association
APA – American Psychiatric Association
AUDIT – Alcohol Use Disorders Identification Tool
BBGS – Brief Bio-Social Gambling Screen
CALD – Culturally and Linguistically Diverse
CCCJ – Centre for Criminology and Criminal Justice
CJS – Criminal Justice System
CJSWP – Criminal Justice System Working Party
CPGI – Canadian Problem Gambling Index
DSM – Diagnostic Statistical Manual for Mental Disorders
EIGHT – Early Intervention Gambling Health Test
FCCG – Florida Council on Compulsive Gambling
FVC – Family Violence Court
GA – Gamblers Anonymous
MAGS – Massachusetts Gambling Screen
MCDP – Magistrate Court Diversionary Program
NCS-R – National Comorbidity Survey Replication
NODS – National Opinion Research Centre DSM Screen for Gambling Problems
NSW – New South Wales
OCSAR – Office of Crime Statistics and Research
OPG – Office for Problem Gambling
PC – Productivity Commission
PGSI – Problem Gambling Severity Index
PJSCGR – Parliamentary Joint Select Committee on Gambling Reform
SA – South Australia
SACES – South Australian Centre for Economic Studies
SLUGS – Sydney Laval University Gambling Screen
SOGS – South Oaks Gambling Screen
TIP – Treatment Intervention Program
VGS - Victorian Gambling Screen

EXECUTIVE SUMMARY

The rapid expansion of gambling in Australia, which has led to an ‘increasing number of gamblers experiencing severe problems related to their gambling, and the criminal, legal and treatment issues that arise when problem gamblers commit illegal acts suggest an urgent need’ for a rethink of how the criminal justice system should respond (FCCG, 2005 p9). Problem gambling is commonly perceived as a personal weakness, as a poor choice but not a compulsion in Australia. The purpose of this report is to review the literature on the question of whether problem gambling is a medical condition, particularly the rationale for its reclassification as a mental disorder under the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V). This report also provides a comprehensive review of the literature, including specific unpublished studies, reports and conference papers. It assesses the application of therapeutic justice, and explores the ways in which problem gambling can be accommodated under the therapeutic framework within the South Australian criminal justice system.

It concludes that while it may be unwise to categorise all instances of problem gambling as medical conditions, there is evidence to support the assertion that at least some cases of problem gambling are due to an underlying pathology or addictive disorder. The challenges for the justice system are to identify these cases and to enact reforms consistent with seeing problem gambling through the therapeutic lens. Again, the diagnosis of an offender as a problem gambler does not - and should not - absolve them of responsibility for any crime they might have committed but should be relevant in sentencing. Furthermore, ‘policy makers and government leaders, community leaders, and law enforcement and criminal justice professionals must become educated about problem gambling and active in the effort to establish a more effective criminal justice response to gambling related crimes’ (FCCG, 2005 p9).

This report proposes ‘an approach that incorporates the expansion of research and prevention education efforts, the inclusion of gambling assessment, intervention and treatment in law enforcement and criminal justice system protocols, and an approach to public policy development and decision-making’ on problem gambling that is informed by the latest thinking on the topic and international best practices (FCCG, 2005 p9). It emphasises the need for the extension of the eligibility criteria for

Treatment Intervention Program (TIP) to include problem gambling to reduce recidivism.

1.0 INTRODUCTION

1.1 Background

Gambling is now regulated and legalised in South Australia. However, this legal status has not resolved all the issues which arise in the overlap of gambling and the criminal justice system. In general and for most people, gambling is perceived as a legitimate and acceptable form of social entertainment. It is a source of enjoyment for people and revenue for the government. However, recent years have seen the unprecedented proliferation of gambling venues and gambling promotion, with a concomitant expansion of participation. The myriad of negative consequences for some gamblers and for society that has followed this explosion have engaged the attention of researchers and policy makers. Problem gambling is the most prominent fallout of increased gambling.

Problem gambling has been shown to be linked with participation in criminal activities. Previous research has established that a large proportion of pathological gamblers commit crimes, which may lead to involvement in the criminal justice system (Emshoff et. al, 2008). Further, problem gambling behaviour among clients of the criminal justice system is difficult to detect for a number of reasons.

These clients are usually reluctant to volunteer information about their gambling problem possibly because of the stigma attached to it or possibly because gambling is seen too readily as under the client's control and leading to criminality just as do many other behaviours. In any case, there is no incentive for clients to admit to a gambling problem. Under current settings, even if a client does declare that they have a problem with gambling, such an admission does not have a role in the system and will not help mitigate any sentence that will be faced.

In this context problem gambling poses a serious challenge to the criminal justice system (CJS): how it can effectively deal with people coming into contact with it who might be problem gamblers. This issue is currently before a Criminal Justice System Working Party (CJSWP) which is made up of representatives from the Office of Problem Gambling (OPG), correctional services, the gambling help service sector and other key stakeholders. The CJSWP commissioned this report to review existing literature concerning how best the criminal justice system in South Australia may

respond to problem gambling. Opportunities and gaps in the knowledge base where further research might be needed to inform policy and decision making on the issue in South Australia were also to be identified.

This report is prepared by Oteng Karikari, a student of Carnegie Mellon University, Australia, as part of his internship at the Office for Problem Gambling under the Department of Communities and Social Inclusion, South Australia and under the supervision of Dr Paul Chapman.

1.2 Scope

The scope of this inquiry extends to our understanding of problem gambling. If gambling is conceived of as an entertainment, then too much gambling is merely an indulgence. But if problem gambling is better thought of as an addiction, then justice requires that it be treated differently. This paper follows the latest international thinking about how problem gambling should be conceived. It reviews the current debate about the categorisation of problem gambling, examines problem gambling within the context of therapeutic jurisprudence and justice, and addresses the issue of how problem gambling should be dealt with in the criminal justice system of South Australia.

1.3 Outline

In Part II which follows, this report gives an overview of gambling and of problem gambling in South Australia in particular. It also distinguishes between gambling and problem gambling, offering definitions of both and highlighting the peculiar characteristics of problem gambling. It also examines the comorbidity of problem gambling including its association with crime and other addictive conditions, and the latest developments in the medical/ mental disorder models for conceptualising problem gambling. Part III looks at the concept of therapeutic jurisprudence and its application to the delivery of justice in South Australia, with particular emphasis on the origins and role of problem-solving courts. It also provides an assessment of appropriate screening tools, and highlights the challenges that hinder the timely identification of problem gamblers at the various stages of the criminal justice process.

Part IV makes recommendations, including federal legislative reforms and other strategies for effectively dealing with problem gambling in the South Australian criminal justice system.

2.0 GAMBLING AND PROBLEM GAMBLING

2.1 Introduction

This section focuses on general discussions around the major issues related to gambling and problem gambling. It begins by discussing the definitions of and distinction between gambling *per se* and problem gambling and proceeds with an overview of gambling and problem gambling in Australia. The link between gambling and crime, the risk factors for and comorbidity of problem gambling are then discussed. Finally, this section delves into the debate about the conceptualisation of problem gambling and the latest developments in that regard. In particular, it looks at the current research underlying the reclassification of problem gambling as a mental disorder under the fifth edition of the DSM (DSM-V).

2.2 Definition of Gambling and Problem Gambling

The consideration of problem gambling within the criminal justice must begin by distinguishing it clearly from gambling *per se*. Once this is done, problem gamblers coming into contact with the CJS can be identified and it is then possible for them to be dealt with differently from others who do not gamble or are not problem gamblers.

Gambling is the act of risking money or something of value on the outcome of an event. It is undertaken by betting, playing of gaming machines or casino games and taking part in lotteries. To many people, gambling is a form of entertainment. Some individuals, however, develop a pattern of gambling characterized by lack of control, chasing of losses, lies, and illegal acts (Petry & Armentano, 1999) and this condition is referred to as problem gambling.

Problem gambling is conceptualised differently in different jurisdictions including as a medical disorder/mental health problem, as an economic activity problem, as lying on a continuum of gambling behaviour, being expressed in terms of harm to the individual and to others, and as a social construct. These different conceptualisations inform the definition of problem gambling and the nomenclature used to refer to it. The term used when problem gambling is thought of as an economic activity problem is excessive gambling and it denotes a situation where the gambler spends far above their means on gambling. According to Blaszczynski, Walker, Sagris and

Dickerson's (1997), it refers to "... a level of gambling expenditure that is considered to be higher than can be reasonably afforded ..." (cited in Brown, 2010, p 18).

The terms used by those who see it as a medical disorder or mental health problem include 'addictive', 'compulsive' and 'pathological' gambling. Problem gambling, when it is perceived as lying on a continuum of behaviour, is said to range from an extreme of non-gambling, through social gambling with no obvious adverse impacts, to problem gambling which leads to adverse consequences for the gambler and others and, finally, to the other extreme of pathological gambling with far-reaching adverse consequences. It is also sometimes defined relative to the harms it causes to the individual gambler and others affected by their gambling behaviour. Dickerson, McMillen, Hallebone, Volberg and Woolley (1997) define it as "the situation when a person's gambling activity gives rise to harm to the individual player, and/or to his or her family, and may extend into the community" (cited by Dickerson, 2003 p 6).

Over the years, various definitions of problem gambling have emerged in Australia but the most widely accepted is given by Neal, Delfabbro and O'Neil, (2005): "Problem gambling is characterised by difficulties in limiting money and/or time spent on gambling which leads to adverse consequences for the gambler, others, or for the community" (p 3). In the US, the term 'problem gambling' is usually used to denote "a level of gambling, which is at an earlier stage, or which leads to fewer problems than the later stage or more severe problems experienced or caused by those gamblers who are clinically diagnosed as pathological gamblers". However, for the purpose of this report, unless otherwise stated, it is used as an all-encompassing term for "amblers who are experiencing problems but who do not meet the diagnostic criteria and those who are clinically diagnosed as pathological gamblers" Neal, Delfabbro and O'Neil, (2005).

There are no visible signs or physical changes that will indicate a gambling problem. However, some of the indicators of problem gambling behaviour may include:

- going for long, unexplained periods of time,
- not doing things previously enjoyed any more,
- increasing gambling time and places,

- placing sudden and dramatically increased bets,
- cancelling special occasions for gambling,
- intensifying interest in gambling (constant tension & excitement),
- boasting about winning;
- evading inquiries about losing,
- exaggerating the display of money and other possessions,
- gambling when there is a crisis,
- dropping off in other activities,
- frequently absenting from home and work,
- using the phone excessively,
- withdrawing from family,
- exhibiting personality changes (increased irritability/hostility),
- diverting family funds.

In summary, this section has shown that problem gambling may be conceived in a number of ways. However, we can say that a problem gambler is typically someone with a pattern of excessive gambling and that results from impaired control over their gambling behaviour. So the focus is on significant negative consequences deriving from this impaired control and persistence in excessive gambling despite these negative consequences. The question of how widespread and prominently or otherwise gambling, and problem gambling feature within the Australian context is answered in the next section.

2.3 An Overview of Gambling and Problem Gambling in Australia

The community's attitude towards gambling influences the size and characteristics of the industry, which in turn can have impacts on the incidence of problem gambling.

This section elucidates those matters, forming a clear picture of the extent and nature of problem gambling in South Australia, and making it possible to move towards successfully managing problem gamblers within the criminal justice system.

Gambling is a popular and growing leisure activity for Australians. Almost 90 per cent of Australians gamble at least once a year. It is growing in comparable nations too. Estimates based upon survey data indicate that between 80% and 94% of British adults, between 24% and 68% of American adults, and between 76% and 79% of Canadian adults have gambled at some time in their life (Griffiths & Delfabbro, 2002, Delfabbro & LeCouteur, 2003). Australians spent \$19.04 billion on gambling in 2009-2010 (Productivity Commission, 2010 cited by Delfabbro, 2011).

Online gaming, particularly online sports betting, is becoming increasingly popular. The rapid growth in sports betting activity in recent years and the widespread advertising of sports betting products and services have led to what some describe as the 'gamblification' of sports (cited by McMullan, 2011).

According to a report by the Parliamentary Joint Select Committee on Gambling Reform (PJSCGR, 2011):

- sports betting is one of the fastest growing areas of the gambling market, estimated to be worth \$250 million annually in Australia;
- around \$205 million was spent by gamblers on sports betting in 2007–08.
- sports betting expenditure has increased significantly over the past two decades reaching \$171 million in 2006-07;
- that for the 12 months to September 2011, Australians spent \$2.6 billion betting on races with sports betting expenditure increasing from \$0.4 billion to \$0.8 billion over the same period;
- Australians will spend \$611 million on online sports betting in 2011, representing a 230 per cent increase from 2006 and that online wagering is expected to be worth \$10.6 billion or 38 per cent of the gambling industry by 2016-17.

Gambling taxation provides a significant and growing proportion of revenue collected by state and territory governments. Revenues from gambling taxes provide approximately 12% of state generated tax. In per capita terms Victoria (over \$350 per

adult) and South Australia (\$300 per adult) collect the most gambling revenue (compared with the Australian average of \$260 per adult) (Productivity Commission, 2010).

There are wide disparities in taxation rates (i.e. in government revenue as share of expenditure) for gambling across jurisdictions as well as between different forms of gambling. The highest taxation rates are in South Australia, Western Australia and Victoria, where revenue from gambling is over 30 per cent of expenditure. By form of gambling, taxation rates vary from 65 per cent on lottery products, 25 per cent on gaming machines, 18 per cent on racing and 12 per cent on casino table games. South Australia ranks second of all States and Territories in terms of total taxation revenue derived from gambling taxes at 13.5 per cent. Between 1994-95 and 2003-04 gambling taxation revenue in South Australia increased in real terms at the rate of 8.9 per cent per annum, from \$223 million to \$479 million, representing a 115 per cent increase (SACES, 2006, Productivity Commission, 2010).

The remarkable expansion of legalized gambling has brought with it a mixture of social and economic costs and benefits (Williams, Rehm, & Stevens, 2011). In Australia, as the Productivity Commission (1999) - quoted by Crofts (2003) - points out, "some aspects of the perceived negative social impacts of gambling appear to be provoking widespread social concern". A primary concern is problem gambling.

Currently, adult prevalence rates of problem gambling are estimated to be 0.7 per cent and 1.7 per cent of the Australian adult population for problem and moderate risk gambling respectively (Productivity Commission, 2010). This means that 115,000 and 280,000 Australians are problem gamblers and moderate risk gamblers respectively. The Australian prevalence rate is, however, relatively lower than the average past year prevalence rate which, depending on the year and jurisdiction, ranges between 0.5% and 7.6% of adult population (Williams, Volberg, & Stevens, 2012). A prevalence in 2005 found 1.6% of South Australians aged 18 years or over to be moderate and high risk gamblers. This represented approximately 18,000 adults, 5,000 of whom were high risk gamblers. Overall, adult South Australians who gambled at some time over the previous year decreased from 76% in 2001 to 70% in 2005 (Taylor et al., 2006).

This section has shown that gambling is a favoured entertainment for Australians and also an important source of tax revenue to governments, especially State governments. It has shown that gambling can become a problem and when it does it is associated with many behavioural problems. We are left to ask why 2.4% and 2.8% of adult Australians and South Australians respectively are identified as problem gamblers? This is interrogated further in the next section.

2.4 Risk Factors for and Comorbidity of Problem Gambling

Problem gambling is often known to be co-morbid with a range of other issues and social problems. To the extent that gambling can lead to these comorbid behaviours, it can be strongly associated with crime. Hence, it can bring people in contact with the criminal justice system. For the system to respond well, the links between gambling and other destructive behaviours need to be explored and understood.

Winters & Kushner (2003) gives 3 possible comorbid causal relationships between problem gambling and other disorders:

- pathological gambling directly causing a comorbid disorder,
- a comorbid disorder directly causing pathological gambling, and
- another factor serving as a common cause of both pathological gambling and the comorbid disorder.

As with other comorbidities, 'there are most likely multiple factors which contribute to the link between gambling and problem behaviours, with specific combinations of these factors varying across individuals' (Mazmanian et al, 2009).

Many authors have reported that:

- people with psychiatric issues are more likely to have a gambling problem;
- lifetime depression rates among problem gamblers is between 70 - 76 %;
- 87% of compulsive gamblers have been found to suffer from a personality disorder. Specifically, mood disorders: (60%), anxiety disorders (40%), antisocial personality disorder (33%);

- between 30% and 43% of gamblers meet the criteria for Attention Deficit Disorder; (ADD);
- nearly 75% of problem gamblers have an alcohol use disorder;
- roughly 40% to 63% of problem gamblers have a drug abuse disorder;
- 43% of problem gamblers engage in other compulsive behaviours such as shopping (23%), sexual behaviour (17%), and intermittent explosive disorder (13%);
- 12% to 18% of Gamblers Anonymous members 12 -18 % have attempted suicide;
- nearly 50% have made plans to kill themselves, and up to 80% reported wanting to die.

(McCormick et al, (1984), Shaffer, Hall, & Vanderbilt, (1999), Black, D.W., & Moyer, T. (1999), Emshoff, J. & Perkins, A. (2008), Zimmerman, Chelminski, & Young, (2006).

The literature reports that approximately 75 per cent of problem gamblers meet psychiatric criteria for a major depressive disorder, with 40 per cent expressing clinically significant suicidal ideation. An important observation is that, in addition to those seeking gambling-specific treatment, high rates of depression are found within community samples of problem gamblers (Thomas and Jackson, 2009). Among problem gamblers seeking treatment, 49% indicated that a comorbid condition increased the severity of their gambling problem. Among psychiatric disorders, the most commonly studied relationships involve the associations between problem gambling and substance use disorders and psychotic, anxiety, and mood disorders (Westphal & Johnson, 2003).

An analysis of a sample of 9,282 English-speaking adults collected from the gambling data in the National Comorbidity Survey Replication (NSC-R), showed that almost all participants who had pathological gambling during the course of their lifetime also had another lifetime psychiatric disorder (96.3 percent), and 64.3 percent suffered from three or more disorders. Substance-use disorders were significantly elevated

among participants with pathological gambling (Kessler, Hwang, LaBrie, Petukhova, et al., 2008) cited by PJSCGR, 2012. The DSM-V Work Group, as discussed in section 2.6, has drawn heavily on this study to support its recommendations relative to problem gambling.

General population surveys and studies of clinical samples have shown a high rate of comorbidity between mental health disorders and pathological gambling. Problem gamblers who seek help for gambling also show significantly higher incidences of depression, bipolar disorders, anxiety disorders, and substance use disorders than control populations (Mazmanian et al, 2009), drawing on the work of (Hodgkins, Pedin, & Cassidy, 2005; (Dell’Osso, Allen, & Hollander, 2005) . Prevalence rates of substance use disorders have been estimated to be 25% to 63% among problem gamblers and 9.35% among the general population (Crockford & el-Guebaly, 1998, Grant et. al, 2004), with consistent prevalence rates being approximately 50% (Westphal & Johnson, 2003).

Zimmerman, Chelminski, and Young (2006) measured psychiatric disorders among a sample of 1,709 people seeking treatment and found that 2.3% of them qualified for a lifetime diagnosis of problem gambling. They also reported that problem gamblers experienced significantly more comorbidity during their lifetime than others in the sample, with an average of 4.7 disorders.

Thomas and Jackson (2008), in a community survey, found that:

- 35.7% of problem gamblers have a “severe mental disorder” as defined by scores on the Kessler K10;
- The rate of “likely hazardous alcohol use” as measured by the WHO AUDIT in the problem gambler groups was 50 per cent;
- The rate of being categorised as being at risk of depression in the problem gambler group was 71.4 per cent;
- The rate of being categorised as a daily smoker in the problem gambler group was 57.1 per cent.

Petry, Stinson and Grant (2005) draw on the findings of a 2001 national survey involving a sample of 43,093 adult household residents in the US and report that, among problem gamblers identified:

- 73.2% had an alcohol use disorder,
- 38.1% had a drug use disorder,
- 60.4% had nicotine dependence,
- 49.6% had a mood disorder,
- 41.3% had an anxiety disorder, and
- 60.8% had a personality disorder.

They also conclude that problem gambling is “highly co-morbid with substance use, mood, anxiety, and personality disorders” and that “treatment for one condition should involve assessment and possible concomitant treatment for co-morbid conditions” (pp 574).

An observational study by Battersby et al. (2010) found that of the 158 people sampled, who exhibited moderate to severe levels of problem gambling and other comorbid conditions, 53% and 56% suffered severe or extremely severe depression and anxiety respectively, and 29% had a harmful or dependent pattern of alcohol use.

This section has shown that problem gambling concurs with other issues and conditions. These co-morbidities are manifestations of problem gambling and/or predispose people to developing problem gambling. Since these issues or conditions can themselves lead to criminal behaviour, their comorbid association with problem gambling adds to any criminality associated with gambling *per se*. So identifying problem gamblers and dealing with them appropriately are pertinent matters for the criminal justice system. To examine this issue further, the following section discusses the direct link between gambling and crime. It aims to determine the extent to which gambling influences people to commit crime.

2.5 Gambling and Crime

For the criminal justice system to deal effectively with crime and to reduce recidivism, it needs to explore all the possible pathways through which people come in contact with it. This includes the ways in which gambling and problem gambling lead people to commit crimes. If people whose gambling behaviour is the primary cause of their crimes are identified, they can be given the right services and the right sentences, with the greater probability of their not re-offending.

Problem gambling can be perceived as occurring through a series of stages. The initial experience often involves early wins or gambling successes but, in accordance with the law of probability, this soon gives way to increasingly heavy losses, followed by a period of desperation and despair in which the problem gambler attempts to obtain money to continue gambling. At this stage, the temptation to commit crimes to obtain more money to recoup losses might become more evident (Delfabbro, 2011). Again, the financial difficulties and high levels of debt suffered by problem gamblers may cause some of them to engage in illegal activities to finance their gambling or gambling-related debt (Marshall & Marshall, 2003).

Sakurai and Smith (2003) have drawn on a number of studies to draw some interesting conclusions about the relationship between gambling and crime. The summary of the relevant portions of their work, 'Gambling as a motivation for the commission of financial crime' is given below. Many studies have examined:

- people using gambling counselling services, attending self-help groups such as Gamblers Anonymous, or undergoing inpatient hospital treatment;
- prison inmates who report gambling problems in connection with their offending behaviour; and
- samples of the general population.

A study by Jackson et al. (1997) on illegal activity among 1,452 pathological gamblers who were undergoing counselling found that 30 per cent of the subjects admitted that they had been involved in gambling-related illegal acts. In another study, Blaszczyński & McConaghy (1994) conducted semi-structured interviews with

306 problem gamblers in NSW who were attending Gamblers Anonymous or had been admitted to hospital for inpatient treatment. Nearly 60 per cent admitted having committed a gambling-related offence (most commonly theft, embezzlement or misappropriation), and almost one-quarter reported that they had been convicted.

In their study of male prison inmates in New Zealand, Abbott et al. (2000) found that the inmates surveyed had participated in gambling activities more frequently and had spent almost six times more on gambling than the general male population. Moreover, 15 per cent of the inmates reported committing a crime to finance gambling or gambling debts, and nine per cent reported being convicted for gambling-related crimes.

Gambling-related crime is usually limited to non-violent property crime, such as theft, shop lifting, embezzlement and misappropriation of money. Two recent studies have attempted to provide evidence to support this link through the examination of completed criminal prosecution files.

Crofts (2002) examined 2,779 cases heard by local and district courts in NSW between 1995 and 1999. The study examined a variety of property offences involving:

- fraud (for example, obtaining financial advantage by deception, making false statements with intent to obtain money or a financial advantage, or presenting cheques with insufficient funds);
- theft (for example, larceny, larceny by a clerk or servant, or stealing in or from a dwelling house, or motor vehicle theft);
- robbery and assault; and
- breach of apprehended violence orders.

These types of offence were selected as representing those most likely to establish a link between gambling and crime. Files involving these offences were made available at the NSW District Court in Sydney for inspection by researchers. The files provided a cross-section of property and violent crimes against people who had been dealt with by local and district courts in the five years in question. Pre-sentence reports and police reports were examined to find evidence of gambling or gambling-related

activities. An offence was classified as “gambling-related” if it was committed as a consequence of, or in order to support, or as a significant result of, or significantly related to the defendant’s desire, need or compulsion to gamble (Crofts 2002).

Crofts identified 105 cases (four per cent) that were gambling-related. Of these cases, 42 contained insufficient detail for further analysis, leaving 63 files which provided the basis for the final study. Of these 63 cases, 76 per cent of offences committed involved fraud, including larceny by clerks, obtaining financial advantage by false pretences, and cheque fraud. The 27 instances of larceny by a clerk were all gambling-related.

The AIC and PwC (2003) examined a sample of “serious fraud” prosecutions heard in 1998 and 1999 in Australia and New Zealand. The selection of files was largely undertaken by officers within the agencies concerned who located cases that fulfilled the criteria of serious fraud and which had resulted in a court determination in the two years in question. As with Crofts’ study, documentary files were examined by researchers and facts relating to some 60 data fields were extracted. The key documents examined were police charge documents, witness statements, pre-sentence reports, offenders’ prior criminal history transcripts, trial judges’ sentencing remarks, and appeal decisions. The sample comprised 155 separate files involving 208 accused persons, 183 of whom were convicted of charges specified in the instant case.

In order to investigate the relationship between gambling and the commission of fraud, the primary motivations of the 183 convicted offenders in this sample were examined. Information on offender motivation was usually available from the trial judges’ sentencing remarks, pre-sentence reports prepared on behalf of offenders, or in submissions made to the court on behalf of victims or prosecutors.

The study found that gambling (14.7 per cent) was the second most frequently identified motivation of convicted offenders, after greed (27.3 per cent). Of the 21 convicted offenders whose primary motivation for fraud was gambling, the vast majority (86 per cent) spent the proceeds of their crime on gambling itself.

The findings of these reports were consistent with those of a similar study by Marshall and Marshall (2003) in South Australia. The study, which examined court records and randomly selected police apprehension reports, found that:

- 1.3% of cases heard in the District and Supreme Court were gambling-related;
- 4.0% of Adelaide Magistrate Court files finalised in 2002 involving fraud offences were gambling-related; and
- 1.2% of Adelaide Magistrate Court files finalised in 2002 involving larceny offences were gambling-related.

While the findings of the studies discussed above are largely consistent, there are some uncertainties concerning the extent to which gambling drives criminal activity among problem gamblers in Australia. Many studies on the prevalence of gambling-related crime rely on self-reported evidence, which affects their reliability and validity. Some gambling-related offences, particularly those committed against family and friends, are under-reported. Even when allegations are reported, they do not always result in a conviction (CCCJ 2000). The prevalence of gambling-related crime amongst prison inmates, for instance, may often not be indicative of the true extent of the problem. Despite these difficulties, and the absence of evidence of a causal relationship between problem gambling and crime, the findings of these studies show that there is an important, consistent association between problem gambling and crime.

In summary, this section has confirmed some of the empirically observed causal links between gambling and criminal activity. Granted that problem gambling can lead some people to commit crime, when they do, is it because they are sick or because they are morally weak? This question is the focus of the next section.

2.6 Problem Gambling: Disease or Vice?

The literature on problem gambling shows that it is a difficult phenomenon to define and interpret, especially if we rely on readily observable characteristics. But it is reasonable to suggest that the way a problem is perceived rightly influences the type of solution and approach adopted to deal with it. If people, when coming before a court are seen as suffering from a disease that influences their offending, that should lead to outcomes different from offenders who do so with no compulsion. So is

problem gambling a disease as claimed by the proponents of the medical disorder/mental health approach to problem gambling?

The general claim is that some underlying pathology of the problem gambler makes them susceptible to developing the problem. Walker (1998) quoted in Productivity Commission Report (1999) expresses concern that if problem gambling is not seen as an illness, services tend to be directed towards counselling rather than therapies to control the disorders. The New Zealand Committee on Problem Gambling Management agree and states, following a rather high incidence of attempted suicide amongst problem gamblers (411 attempts out of a population of 1200 pathological gamblers engaged) that "... we see this disorder as fitting within mental health services where trained and registered clinicians working to best practice diagnostic standards are predominantly involved" (quoted in PC 1999).

In 1980, the APA included problem gambling in the third edition of the DSM (DSM-III), giving it official medical recognition as a disease. Since then, its definition has undergone some changes. Initially, the definition emphasised the damage and disruption it causes with little importance attached to the motive. Subsequently, the definition changed and the diagnostic criteria were revised to project the addictive nature of the disease. Issues of tolerance and withdrawal were emphasised to suggest a physiological basis for the disorder. With regard to the problem gambler, tolerance refers to their increasing need for gambling and usually gambling with greater risks to get the same emotional effect. Like chemical dependency, withdrawal is indicated by the pain and discomfort caused to the problem gambler by not practicing their behaviour. The WHO supports the medical view of problem gambling.

The APA, after more than a decade of research, analysis and consultation, is set to reclassify problem gambling alongside other addictive behaviours in the fifth edition of the DSM (DSM-V) in May, 2013. The rationale for this change is that the growing body of scientific literature, especially research on the brain's reward centre, has revealed many commonalities between pathological gambling and substance-use disorders, including cravings and highs in response to the gambling, alcohol or drug; the hereditary nature of all of these disorders; and evidence that the same forms of treatment, such as 12-step programs and cognitive behavioral therapy, seem to be effective for both gambling and substance-use disorders (Reilly, undated).

The DSM-V Work Group cited studies showing a high rate of concurring substance use disorders with pathological gambling including that based on the gambling data in the National Comorbidity Survey Replication (NSC-R), which were reported in section 2.4. To be diagnosed as a pathological gambler under DSM-IV, a person needs to have five or more out of 10 possible symptoms including a preoccupation with gambling; “chasing” one’s losses; lying to loved ones about gambling; and committing “illegal acts, such as forgery, fraud, theft or embezzlement to finance gambling.” The DSM-V Work Group has proposed eliminating the “illegal acts” criterion because it does not appear to be a decisive symptom for most people with gambling problems (APA, 2010, Reilly, undated).

Some commentators, however, have raised concerns about certain aspects of medical model. Blaszczynski and Nower (2002) caution against a narrow and simplistic perception of problem gambling merely as an addiction or disease, stating that “... problem gamblers are not a homogeneous group ...”. Neal, Delfabbro and O’Neil (2005) also notes that the “focus on preoccupation with gambling” is problematic because it fails to acknowledge the fact that, for some people, episodic bouts of gambling, rather than uncontrolled gambling can lead to their identification as problem gamblers.

It has also been argued that describing problem gambling as an addiction separates a person from having a sense of control over their behaviour, leading to their reliance on outsiders to intervene to resolve their problem. Others still claim that the question of whether gambling disorders comprise a single, sharply distinguished pathological entity or lie on a continuum or that gambling problems comprise a hierarchy of logically related but qualitatively different disorders is still unclear. The DSM definition, it is argued, does not adequately allow for the description of experiences of individuals who have not been diagnosed as pathological gamblers but nevertheless are experiencing adverse consequences as a result of their gambling behaviours (Neal, Delfabbro and O’Neil, 2005).

Furthermore, the question of who is a problem gambler is said to be context-related and that problem gambling cannot be adequately assessed in a psychological framework. Hence it is important that any model that seeks to classify people as problem gamblers considers their overall circumstances including their sociological

and cultural environment. Other critics have also made the point that the pattern of behaviours exhibited by problem gamblers do not consistently fit with typical conceptions of a genuine mental illness and ‘pathological’ gamblers do not appear to suffer a set of clearly defined mental symptoms which suggest a distinctive mental illness (PC, 1999).

Notwithstanding these concerns, to the extent that the medical disorder/ mental health model does not hold the problem gambler responsible for contracting the disease but sees them as “sick”, it makes it easy for them to seek assistance and thus work towards recovery without bearing the burden of excessive guilt. Besides, there is no theoretical model comprehensive enough to encompass all the possible aspects of problem gambling (Neal, Delfabbro & O’Neil, 2005). Ferris, Wynne and Single (1999) quoted in Svensen (undated) notes widespread support among psychiatrists, gambling self-help groups, the gambling industry and individuals with gambling problems for the medical model even though they still recognise the multiplicity of the forces underpinning problem gambling behaviour.

The current literature show how the medical approach sharply divides researchers and continues to generate intense debate and disagreement both in Australia and internationally. However, if one thing is clear, it is that not only is it increasingly gaining currency, particularly in North America but also very few of its critics, particularly in Australia, have challenged its theoretical basis and relevance in the public policy space for problem gambling.

This section has shown that the medical disorder/ mental health model is formidable and that the evolution of it has been helped by the ground-breaking findings regarding the comorbidity of problem gambling and the similarities that it shares with substance abuse and other addictive behaviours. These findings have informed the renaming of problem gambling as ‘gambling disorder’ and its reclassification under the DSM-V. The move has reaped praise and criticism from various commentators. Nonetheless, the changes in the DSM-V represent a significant change and indicate that this matter is gaining prominence. The stakeholders in the South Australian criminal justice system need to respond to these developments and devise means to treat problem gambling differently. And what better means is there to do this than within the context of therapeutic justice? This is the subject matter of part III.

3.0 THERAPEUTIC JUSTICE

3.1 Introduction

This section considers the role that therapeutic justice might play in better dealing with problem gambling. It defines therapeutic justice and the rationale for its recent emergence as an important concept in the criminal justice system. This is followed by consideration of its application within the South Australian context with particular emphasis on the TIP and its precursor, the Magistrates Court Diversion Program (MCDP). It ends with discussions of the stages and points within the criminal justice system where problem gamblers might be identified. It ends with a critical consideration of the tools for screening problem gamblers which can then lead to the provision of appropriate intervention services to them. All these issues are of practical importance to the recommendations that follow in part IV.

3.2 Therapeutic Justice: What Is It?

Therapeutic justice is borne out of the need to provide new responses to criminal activity by addressing the behaviour underlying it. It has emerged as an increasingly important concept in criminal justice due to the realisation that the present system not merely fails to address the underlying causes of offending conduct but can sometimes also entrench them, worsening outcomes for offenders and society.

The traditional role of courts have been to serve as governmental mechanisms of dispute resolution, resolving disputes between private parties concerning property, contracts, and tort damages, or between the government and an individual concerning allegations of criminal wrongdoing or regulatory violations. In this regard, courts typically have operated as neutral arbiters, resolving issues of historical facts or supervising juries engaged in the adjudicatory process (Winick, 2002).

The courts have in recent times been inundated with cases involving range of new kinds of problems, some of which are social and psychological in nature. A better approach to dealing with problems in the criminal justice system is to move beyond the resolution of the immediate issues and facts under dispute to attempt to deal with the underlying issues and/or problems that lead to the cases brought before the courts.

Limiting attention to the narrow dispute in controversy does little, if anything, to stop the repetition of the underlying problem and the consequence is what is termed as a "revolving door effect" in which offenders typically continue to offend and come through the criminal justice system over and over again (Wexler & Winick). A therapeutic approach to the delivery of justice was considered to be the way forward and it meant that crime be seen as a manifestation of the offender's illness in body or character and efforts be directed at the offender's rehabilitation and healing, and equipping them with a sense of accountability.

Therapeutic justice requires that correctional services providers, particularly courts, endeavour to understand and also establish the necessary mechanisms to address the underlying problem responsible for the immediate dispute, and to support the offenders that come through the courts to deal effectively with the problem in ways to avoid recurring court involvement. It represents a shift of focus from 'the problem', manifested by a person's behaviour; from punitive to rehabilitative, which means that, in some instances, criminal behaviour must be viewed in the context of any underlying physical, psychological, social or economic circumstances dealt with by effective social intervention rather than by harsher sentences (Topp, 2002).

Therapeutic jurisprudence is generally implemented along a continuum. At the individual level, judges ensure therapeutic outcomes through personal interactions with the individuals involved in a particular case. At the organizational level of the court, new procedures, information systems, and sentencing options, including special court programs or specialised courts are devised and links to social service providers to promote therapeutic outcomes are established. Finally "for some areas of law and court policy, the practice of therapeutic jurisprudence principles requires changes to State statutes or to court rules, policies, or procedures that apply across courts" (Rottman and Casey, 1999, p 14).

Problem-solving courts have emerged in the wake of the therapeutic jurisprudence 'movement' to deal with offenders with specific needs and problems that are difficult for the traditional courts to manage. These courts vary considerably from jurisdiction to jurisdiction and by different case types within a jurisdiction, but all focus on closer collaboration with the service communities in their jurisdictions and stress a

collaborative, multidisciplinary, problem-solving approach to address the underlying issues of individuals appearing in court. Some of the common elements shared by these courts include:

- Focus on Outcomes: they are designed to provide positive case outcomes for victims, society and the offender such as reducing recidivism or creating safer communities);
- System Change: they seek to promote reform in how problems such as drug addiction, mental illness and problem gambling are responded to;
- Judicial Involvement: Judges take a more hands-on approach to addressing problems and changing behaviours of defendants;
- Collaboration: these courts work with external parties to achieve certain goals such developing partnerships with help service providers;
- Non-traditional Roles: These courts and their personnel take on roles or processes not common in traditional courts. For example, some problem-solving courts are less adversarial than traditional criminal justice processing;
- Screening and Assessment: they generally use screening and assessment tools to identify appropriate individuals for admission into the courts;
- Early identification of potential candidates: Use of screening and assessment tools to determine a defendant's eligibility for the problem-solving court usually occurs early in a defendant's involvement with criminal justice processing.

(Bureau of Judicial Assistance (BJA), Casey & Rottman, 2003)

The first and perhaps the only problem-solving court in the world that deals specifically with problem gambling is the Amherst Gambling Treatment Court (AGTC) in New York. A summary of an article by the American Gaming Association (AMA) (2011) on the creation and operations of the AGTC is given below as follows:

It was created Judge Mark G. Farrell, a veteran of problem-solving courts after seeing a number of defendants in Amherst's traditional courts who appeared to have what he termed "out-of-control gambling problems." Modelled on the drug courts, AGTC handles cases involving substance-abusing offenders, combining comprehensive supervision, drug testing, treatment services and immediate sanctions and incentives. It focuses on early

intervention and employs the full power of traditional court authorities (judges, prosecutors, etc.) to force the offender to deal with their gambling problem. It receives referrals from judges of Amherst's traditional courts who recommend defendants they think would be a good fit. Participants who pass an initial screening process sign a contract with the court and its treatment agencies agreeing to participate in the program and abide by its rules, including pleading guilty and waiving all their constitutional rights. They then begin a multi-faceted treatment program that incorporates a broad range of services, including individual and group therapy, debt counselling and more.

Admitted participants return to the court room weekly to report their treatment progress to Judge Farrell, with visits becoming less frequent as they progress through the program. It relies on a system of sanctions and rewards to keep participants on track. The sanctions imposed on participants who fail to comply with program regulations range from more frequent court appearances to jail time, with repeated non-compliance attracting harsher sanctions. Alternatively, progress is rewarded by recognition from the bench during regular court visits, reduced supervision and less frequent court appearances. A successful completion of the program often leads to reduced or suspended jail time and reduced fines or fees. Since its inception in 2001, 27 out of a total of about 100 participants have graduated with only 3 rearrested for non-gambling related and no reports of gambling relapses among past graduates.

It is clear from the discussions in this section that therapeutic justice offers a better approach to dealing with issues that have psychological, pathological and social underpinnings within the criminal justice system. The criminal justice system should provide opportunities for healing, rehabilitation and restoration for the victims and the perpetrators of criminal offences and the community. This means key players working collaboratively to engender dignity, respect, usefulness, and safety in an area of human experience often characterized by pain, neglect, hopelessness, and frustration. The next section probes the question of how therapeutic justice has been applied in South Australia, and the possible lessons and opportunities for maximising the benefits that can be derived from it.

3.3 Therapeutic Justice: The South Australian Experience

Specialist courts constitute “the most obvious and recent manifestation of therapeutic jurisprudence in Australia”, offering an obvious option for decision makers to develop effective solutions through an intersection with service frameworks outside the justice system (Topp, 2002). In this regard, South Australia has played a pioneering role with the creation of the first family violence court in 1997. Over the years, it has evolved and expanded to deal with more issues including mental health and drug use. In line with these developments, a review of the current structure is necessary to determine how it can be made responsive to newly emerging issues and ever-changing circumstances under the purview of the criminal justice system.

The Australian criminal justice system has seen some reforms and innovations including a shift from restorative justice to therapeutic-based interventions in recent times in response to:

- community and political unease about perceived government failure to deal with crime and reduce offending rates;
- growing expectations of a more responsive and cost-effective criminal justice system;
- shifts in the intellectual paradigm concerning the roles and responsibilities of the criminal justice system in delivering therapeutic intervention.

(Payne, 2006).

Specialty courts, as defined by Payne (2006) are “new criminal court structures and procedures, developed to manage and deal with specific offender populations, where it is recognised that traditional criminal justice procedures have not been effective” (pp 1). Several variations of specialist courts have now emerged as working models, including drug and youth courts, domestic violence courts, koori courts (nunga courts in South Australia), mental health courts and bail conditions or specialist lists. “Some are courts in their own right or legislative instruments; others are diversion programs, lists or even divisions of the magistracy. The key features of them generally include early intervention, non-adversarial proceedings, supervision and collaboration and co-operation between the court and community treatment services” (Piper et al, 2004, p 72).

Several special courts and programs have been developed in the South Australian criminal justice system since 1997 to deal with specific issues. The Family Violence Court (FVC), the first of specialist courts, was intended to facilitate the provision of special assistance and support to the victims of family violence. The Violence Intervention Program, which was ran under the FVC, were operated by external agencies who offered information, advocacy and support services to victims and their children and provided a 24 week “Stopping Violence” group for men referred by the Court, as part of a condition of bail or a bond. The Abuse Prevention Program, which replaced the Northern Family Violence Program (NVIP) and the Central Family Violence Program (CVIP) in March 2011, is one component of a larger Integrated Response Model developed following the passage of the Intervention Orders (Prevention of Abuse) Act in 2009. The model aims to enhance the safety of victims of domestic violence and abuse by improving the way men communicate with their (ex) partners and children, teaching men to take responsibility for their behaviour and reducing the incidence of abusive behavior towards women and children.

The Drug Court, modelled after similar courts in the US but adapted to suit the peculiar needs and requirements of the community, service providers and particularly the legal system in South Australia was established in June 2000. It helps drug-abuse offenders break the cycle of drug abuse and crime through a combination of intensive judicial supervision, mandatory drug testing, escalating sanctions, and treatment and support services. Studies on post program completion re-offending undertaken by the Office of Crime Statistics and Research (OCSAR) suggests that the Drug Court program is having a positive effect on reducing the level and seriousness of re-offending.

The MCDP, formerly called Mental Impairment Court, started on a pilot basis in June 1999. However, following an independent evaluation by the OCSAR that confirmed the positive impact of the program in reducing re-offending, the Government made a commitment to fund the program on a recurrent basis in June 2001. It was designed to ‘better ensure that people with a mental impairment who come before the court have access to appropriate interventions that will assist in addressing their offending behaviour. In line with other courts of therapeutic jurisprudence, it therefore aims to use the defendant’s contact with the criminal justice system as a vehicle for ensuring

access to treatment and support programs designed to effect behavioural change” (OCSAR, 2004, p 1).

The MCDP provides an opportunity for eligible individuals who have been charged with minor indictable or summary offences to be heard in the Magistrates Court of South Australia, to address their mental health and/or disability needs and offending behaviours voluntarily, while legal proceedings are adjourned for approximately six months. During this time, the offender is linked with the relevant services in the community and their progress monitored. By facilitating the involvement of community based service providers in addressing the behaviours arising from impaired intellectual or mental functioning, which are linked to the offending, the program improves the responses of both the criminal justice system and the health and disability service system.

The person’s involvement and progress is reported back to the court and the Magistrate, police and defence lawyers may use this information in dealing further with the case. The Magistrate reviews the individual every two months to reinforce and reward compliance with treatment regimes and lifestyle changes and to take alternative action if the interventions are not working or if the individual is not complying with the interventions. The Magistrate may excuse the defendant from appearing in court for their reviews. However, all participants are required to appear for a final determination at the end of the adjournment period. At the final hearing, the Magistrate makes a determination taking into account the participant’s involvement in the Program. Depending on the nature of the offences, the Magistrate may dismiss the matter or convict without penalty. However, the fact that a person has performed badly or has failed to make satisfactory progress is not relevant to the sentencing process.

The MCDP targets offenders who have been charged with minor indictable or summary offences to be heard in the Magistrates Court of South Australia, and who have impaired intellectual or mental functioning arising from mental illness, intellectual disability, a personality disorder, acquired brain injury, or a neurological disorder including dementia. It also aims to achieve the following outcomes for offenders with a mental impairment:

- preventing further offending behaviour by providing access to early assessment and interventions that address mental health or disability needs of defendants and their offending behaviour;
- providing assistance to the court in the identification and management of people with a mental impairment in the court system;
- providing a diversion option in the Magistrates Court, for people who may otherwise plead a mental impairment defence under section 269 of the Criminal Law Consolidation Act (1935).

It also anticipates the following broader outcomes:

- the development of best practice techniques in dealing with mentally impaired persons, specialised court based personnel with in-depth knowledge of court processes, mental impairment, service providers and treatment regimes to manage people with an impairment;
- simplified and streamlined processes for dealing with people with a mental health and/or disability issue who come before the court;
- improved interface between health and justice systems, leading to shared outcomes for persons with a mental impairment and increased understanding of each sector and their systems;
- collection of data that will allow determination of trends and projections, and the impact on demand for services;
- incentives and opportunities for support services to respond pro-actively to issues impacting on their clients involved in the justice system;
- a greater understanding amongst service providers, and the public generally, of the needs of people with a mental illness or disability who have committed an offence, and issues impacting on the behaviour leading to that offence.

The TIP has replaced the MCDP in some court locations including Adelaide, Christies Beach and the Elizabeth Magistrates Courts. TIP is an integrated program, a combination of the MCDP and the 6-month Drug Treatment Program, for defendants with mental impairment and/or substance dependence. To be eligible a defendant must:

- have committed an offence whilst an adult (18 years of age or above at the date of commission of the offences);
- be charged with an offence that is related to drug use (but not necessarily a drug offence) and/or;
- have a mental impairment and be charged with an offence that is related to the mental impairment.

Underlying the creation of TIP was the realisation of a comorbid association between mental impairment and substance dependence, and best practice guidelines for working with people with mental disorder and substance use disorders which promote an integrated treatment approach. TIP integrates the substance disorder treatment approaches that have been proven to be effective for offenders in a criminal justice setting with referral to appropriate health services for treatment and management of mental impairment symptoms. It incorporates evidence based practices which have been shown to be effective in addressing recidivism as well as managing mental health symptoms.

Engagement in the treatment plan and no further offending on the program are usually considered to be indicators of a successful completion. There is limited evidence on the efficacy of adult mental health diversion programs in Australia and internationally. However, a 2004 study by OCSAR showed a reduction in the number of participants who offended post-program compared with pre-program, as well as a reduction in the actual number of incidents charged against this group. Two-thirds (66.2%) of program participants did not offend during their post-program year compared to only 7% pre-program (Skrzypiec et al, 2004).

Therapeutic justice has been successfully applied to the delivery of justice in the South Australian criminal justice system in dealing with the issues of mental health, drug use and domestic violence. However, there is no direct pathway for clients with problem gambling issues to be admitted into the MCDP and TIP in particular. This takes away from the objective of reducing recidivism. This section therefore reinforces the need to push the frontiers of TIP to include problem gambling, alongside other co-morbid addictions such as drug use and other mental health disorders. The next section discusses the points within the criminal justice system at

which to identify people who might be problem gamblers, with particular emphasis on the issues that currently make difficult their identification at the various stages.

3.4 Intervention Points

A vital first step in providing the appropriate therapeutic services and support to clients under criminal justice supervision is to identify offenders in need of those services. Then the appropriate responses can be provided. There are both opportunities and challenges at the pre-trial, trial and post-sentencing stages of the criminal justice process that can be explored to facilitate the successful identification of problem gamblers.

For the first time offender, arrest is their entry into the court system. The offender is usually apprehended by police and taken to the station for a formal interview. Without proper screening, the identification of problem gambling in suspected offenders during arrest, interview, taking of formal statement or initial investigations becomes problematic because its symptoms are not obvious. Since some of the people who are accused of criminal offence do not always get arraigned and charged before the courts, screening at the pre-trial stage of the criminal justice process is important in identifying individuals with problem gambling needs.

However, the South Australian police currently only screen offenders for problem gambling on a voluntary basis, usually relying on experience, observations, general questioning and suspicion to do so. Therefore if the police are not suspicious about an offender, they may not assess them for problem gambling. The situation tends to have adverse implications for the formal recognition of offenders as having a problem gambling behaviour, how they proceed through the criminal justice system, and whether they receive treatment.

The trial stage, including arraignment, bail and/or pretrial detention, plea bargaining, adjudication of guilt, sentencing and even appeals, can serve as important points for identifying offenders with problem gambling. This will, however, depend on the orientation of judges, lawyers and other correctional service providers about gambling and its possible implications for criminal behaviour, their sensitivity to the symptoms

and signs of problem gambling and the existence of an effective screening and assessment framework.

Currently, the Assessment and Crisis Intervention Service (ACIS) provides psychiatric assessment and advice for people who come through the South Australian criminal justice system with mental conditions. Since problem gambling is not routinely recognised as a mental disorder, this service is inaccessible to the majority of problem gamblers. Hence ACIS only picks up problem gamblers with other visible comorbid mental conditions, such as depression, who sometimes get referred to gambling help service providers and, on rare occasions, the mental health courts. Those who are not detected end up in prison or are acquitted without receiving the necessary treatment and support and with implications for recidivism.

With the proper screening tools, the imprisonment stage can become an important point for identifying problem gamblers especially those who go unnoticed during the early stages of the criminal justice process. Problem gamblers can be identified through a mandatory screening of prisoners at admission and pre-release stages, as well as random and periodic screening in between the two stages. Gambling within prison settings is a reality and a part of the prison culture. A study of imprisoned persons showed that 26% of males, and 28% of females reported gambling while in incarceration with majority of them reporting a high frequency of gambling and also citing various reasons for gambling including: to cope with boredom, pass the time, and that “it contributes to prison order”. The participation in gambling activities often leads to, and/or exacerbates gambling problems among prison inmates (Emshoff et al., 2008).

Currently, South Australian prisons generally do not systematically screen inmates for problem gambling. Therefore problem gambling among prison inmates is not treated and the consequence is that some of the inmates accumulate huge gambling debts thereby increasing their risk of reoffending upon their release to support their gambling behaviour or pay their debt.

This sub-section makes clear that, given the natural reluctance of people with gambling problems to own up, there is the need to maximise the opportunities at the

pre-trial, trial and post-sentencing stages of the criminal justice process for the gathering and assessment problem gambling information to facilitate the timely identification of problem gamblers. This process, to a large extent, depends on the effectiveness of the screening tools adopted. The next sub-section discusses the various screening tools recommended by experts and practitioners for the Australian context in more detail.

3.5 Screening Tools

In the criminal justice system, several tools can be used to screen and assess clients to ascertain their eligibility for treatment under various diversionary programs and suitability for particular treatment services and methods. The development of screens that are capable of correctly identifying problem gamblers in need of treatment, without generating many false positives, has become critical in the face of significant temporal and financial restrictions (basiconline.org, 2012).

The screens include the Brief Bio-Social Gambling Screen (BBGS), Canadian Problem Gambling Index (CPGI), Problem Gambling Severity Index (PGSI), Early Intervention Gambling Health Test (EIGHT Screen), the Lie-Bet Questionnaire, Massachusetts Gambling Screen (MAGS), the National Opinion Research Centre DSM Screen for Gambling Problems (NODS/ NODS-CLiP), South Oaks Gambling Screen (SOGS), Sydney Laval University Gambling Screen (SLUGS) and Victorian Gambling Screen (VGS) (refer to ‘Guideline for Screening, Assessment and Treatment in Problem Gambling’ by Shane et al. (2011) for a thorough evaluation of the various screens). The type of screen used generally depends on the willingness and capacity of the staff who administer it as well as the suitability of a particular screen for the particular stage of the criminal justice system. However, discussions with gambling help therapists and practitioners in South Australia show that they tend to prefer the NODS and EIGHT screens, which they think are very useful in criminal justice system settings because they enable them to rapidly determine whether there may be case of gambling problem with a particular client so that they can refer them on to the appropriate gambling help services.

In summary, part III has shown that therapeutic justice, by way of diversionary courts, has a very important role to play in reducing the rate of re-offending among problem

gamblers in the criminal justice system. The role emerges most forcefully in cases where an offender's gambling is both a contributing factor in the offending and can be thought of as pathological. It is obvious from the literature that any mechanism that is established to deal with mental health, drug use or domestic violence needs to be attuned to the needs of clients with what is likely to be a range of co-morbidities that will require a range of interventions. A multiple-issue approach is therefore a *sine qua non* if the TIP is to fully achieve its objectives. The new thinking about the specific strategies and mechanisms that may be helpful to effective management of problem gambling in the criminal justice system is the focus of the next section.

4.0 NEXT STEPS

4.1 Introduction

There are opportunities for improving the management of problem gambling behaviours in the criminal justice system. The success achieved by the AGTC in particular and other diversionary programs indicates that stakeholders should start looking at problem gambling differently and adopting different attitudes, practices, procedures and policies for managing it within the criminal justice system. This section therefore focuses on the reforms that are required in the criminal justice system in South Australia to bring it up to speed with current trends and best practices.

4.2 Recommendations

The under-listed measures are recommended for adoption and implementation to move towards the effective management of problem gambling in the South Australian criminal justice system.

1. Further research into issues and areas which are germane to the ongoing debate about the best approach to dealing with problem gambling.

Specific actions recommended include:

- Comprehensive study on the nature and extent of the link between gambling and crime in South Australia;
- A state-level comorbidity study based on the preliminary findings of the national comorbidity study currently being undertaken to establish the nature and extent of the comorbid relationship between problem gambling and other mental disorders;
- A holistic evaluation of the MCDP, TIP and other therapeutic programs in South Australia to determine their impact and any lessons learnt that may be used to enhance the effectiveness of similar mechanisms established to deal with problem gambling.

2. A clear, consistent policy in the South Australia on gambling that reflects current thinking and best practices both in Australia and internationally.

Specific actions recommended include:

- Ongoing development and support of legislation and other public policy initiatives that recognise and respond to the link between problem gambling and crime within the context of the criminal justice system;
- Enactment of legislation detailing the procedures for a mandatory screening of offenders who are taken into police custody and/or come into contact with the courts and correctional system for problem gambling to identify those who require comprehensive assessment to ascertain their eligibility for the various services;
- Extending the ‘therapeutic hand’ to problem gamblers by expanding eligibility criteria for the TIP to cater for offenders who may be diagnosed as ‘pathological’ gamblers, with the ultimate aim of establishing a separate court, modelled after Amherst Gambling Treatment Court, to deal with all summary offences committed by offenders identified as such;
- Collaboration between the Office for Problem Gambling (OPG), Independent Gambling Authority (IGA), the Courts Administration Authority, Magistrates/Judges, the Attorney General’s Office, the Legislature and other parties to share and publicize current literature on the effective management of problem gambling, and comprehensive analysis of the impact of therapeutic models for dealing with problem gambling and other related issues such as the AGTC in New York, MCDP and TIP in South Australia;
- Diligent collection and shared utilization of data across state and community-based organizations – related to gambling.

3. A holistic and culturally competent view to dealing with problem gambling in the criminal justice system.

Specific actions recommended include:

- Giving due cognisance to the other perspectives apart from the medical view on and the socio-cultural underpinnings of problem gambling;
- Engaging minority and culturally and linguistically diverse (CALD) groups in discussions on problem gambling and the criminal justice system, while increasing support to existing coalitions to encourage their focus on gambling-related issues;

- Ongoing public education and strategies should recognize and address the needs of minorities and CALDs involved in the criminal justice system due to their problem gambling behaviours.

4. Increased education for the public, policy makers, and law enforcement and criminal justice professionals with the view to changing perspectives and attitudes towards problem gambling, and causing them to support a proactive approach to it.

Specific actions recommended include:

- Developing and delivering educational initiatives customized for law enforcement, defence lawyers, prosecutors and judges on screening and identification of problem gamblers and options for sentencing and restitution.

5. A solid system for identifying offenders with gambling problems at all levels within law enforcement and criminal justice.

Specific actions recommended include:

- Developing screening mechanisms to identify problem gambling at appropriate points in an offender's progress through the law enforcement and criminal justice system, from the initial investigation through arrest, booking to arraignment, and trial, sentencing and incarceration;
- Training law enforcement personnel, defence and prosecuting lawyers, and judges on screening, identifying and responding to problem gamblers, both in traditional and therapeutic justice settings;
- High quality problem gambling treatment options should be consistently available at sentencing, in both traditional and therapeutic justice court settings.
- Encouraging existing drug, mental health and domestic violence courts and programs to screen current participants for problem gambling and establishing a process for those who fall outside the scope;
- Developing gambling courts along the model of drug courts, in jurisdictions where the level of problem gambling related cases warrant such specialised approach;

- Effective utilisation of learning from the experiences of existing gambling courts or treatment referral programs to develop appropriate forms, protocols and policies.

6. Improved access for all incarcerated offenders to trained problem gambling counsellors and other gambling help services.

Specific actions recommended include:

- Developing state-wide resource networks for judges and probation officers to support offender access to education and treatment services;
- Establishing Gamblers Anonymous groups in prisons and jails;
- Seeking funding that will help expand the access of offenders to certified counselling and other gambling help services.

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