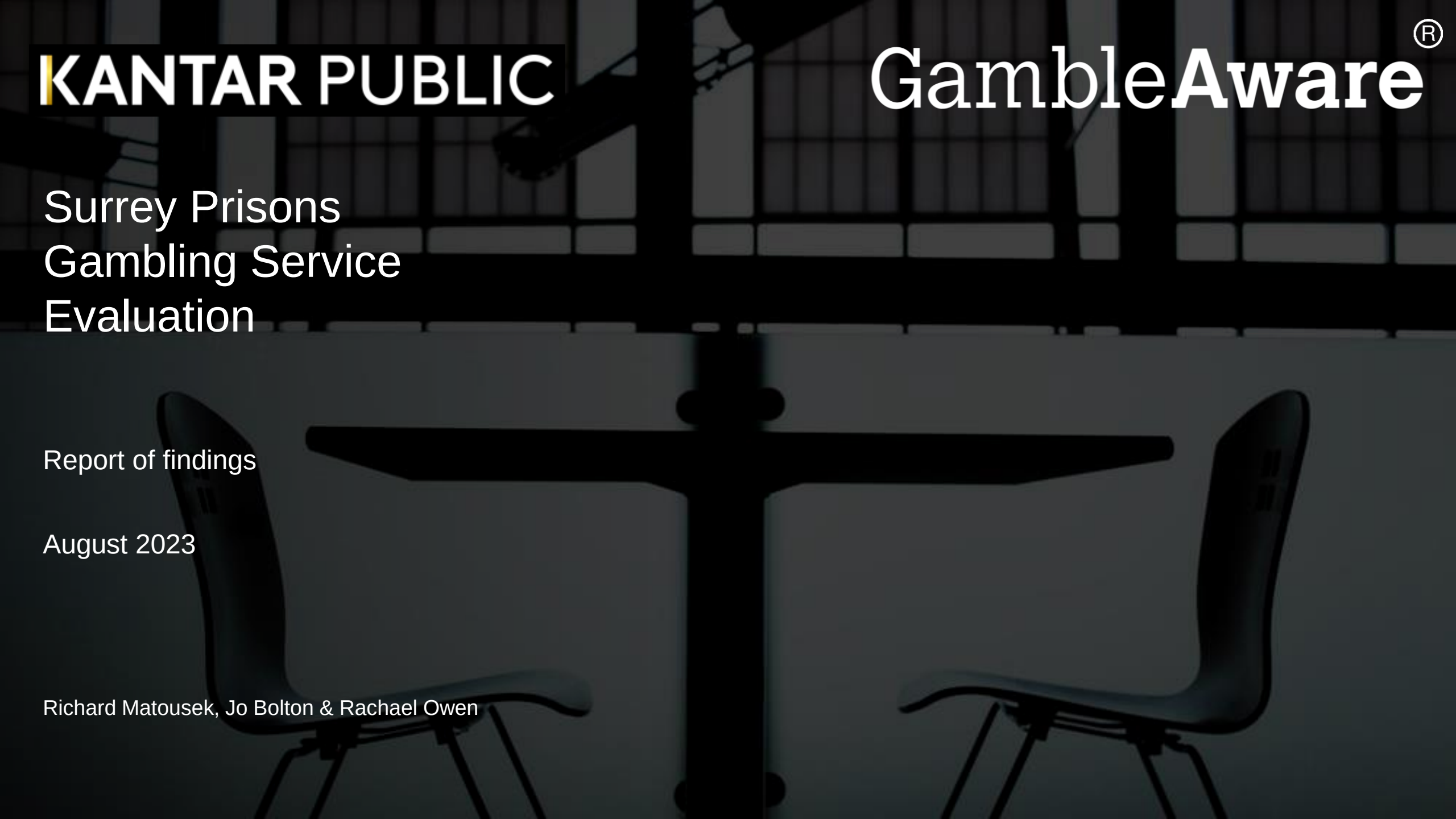

KANTAR PUBLIC

GambleAware®

# Surrey Prisons Gambling Service Evaluation

Report of findings

August 2023

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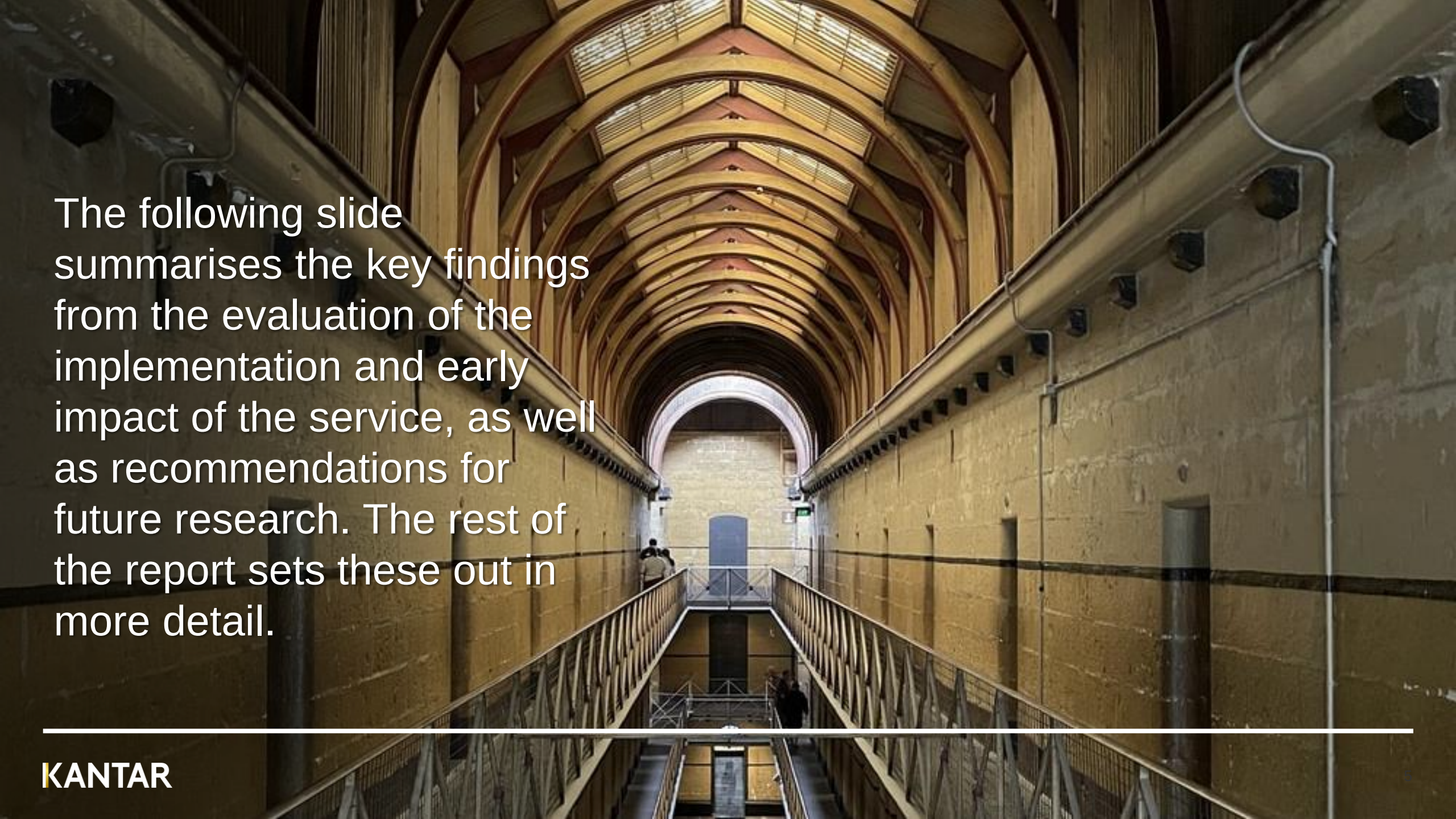
# Contents

This report sets out Kantar Public's findings from its evaluation (commissioned by GambleAware) of the impact and implementation of the pilot Surrey Prisons Gambling Service.

# 1 Executive summary



The following slide summarises the key findings from the evaluation of the implementation and early impact of the service, as well as recommendations for future research. The rest of the report sets these out in more detail.

# Despite barriers, SPGS has now been implemented in two prisons and early anecdotal data suggests some positive impacts for service users

Key findings from the evaluation:

Implementation is complete in Coldingley and Send, demonstrating that the treatment model can operate in prisons, despite barriers (including COVID-19)

Prevalence of gambling harm in UK prisons remains unclear but anecdotal evidence indicates a need for the service (especially in men's prisons)

Implementation of the service has been slow (partly due to the pandemic) but there have been learnings regarding barriers and facilitators around access and recruitment of service users

The treatment model has been adaptable to service user needs and different prison settings. Average course times are far higher than the default 6 weeks which may suggest tailoring to need

Early anecdotal and PGSI data suggests that those who complete the service are positively impacted regarding their gambling addiction in the short term

Follow-up research with service users post-release is recommended to capture longer term impact data

# 2
# Service overview

The Surrey Prisons Gambling Service (SPGS) seeks to improve understanding of gambling harm in prisons, and to help prisoners and staff mitigate it.

# Service design

The Surrey Prisons Gambling Service (SPGS) is a pioneering pilot project in the UK, initially funded by GambleAware, and run by CNWL.[1]

Little is understood about gambling in the UK prison population, including:

- The prevalence of gambling harm (defined by a score of 1+ on the PGSI)[2]
- The prevalence of gambling within prisons (with any currency)
- The efficacy of treatment interventions that work in the community.

GambleAware commissioned CNWL to run the SPGS for three years (from July 2020), within five Surrey prisons it operates in (see next slide for details).

The aims of the service are to improve understanding of the prevalence of gambling harm among prisoners and the efficacy of treatment methods, and to develop treatment pathways to treat gambling harm effectively in these prisons.

[1] CNWL stands for the Central and North West London NHS Foundation Trust and it runs the National Problem Gambling Clinic (NPGC): https://www.cnwl.nhs.uk/services/mental-health-services/addictions-and-substance-misuse/national-problem-gambling-clinic

[2] Problem Gambling Severity Index https://www.gamblingcommission.gov.uk/news-action-and-statistics/Statistics-and-research/Problem-gambling-screens.aspx

# Profiles of the five original target prisons that CNWL operates in within Surrey

**HMP & YOI Bronzefield**

Female
527 capacity

**HMP & YOI Downview**

Female
355 capacity

**HMP Coldingley**

Male training prison, for those with under 2 years until release
513 capacity

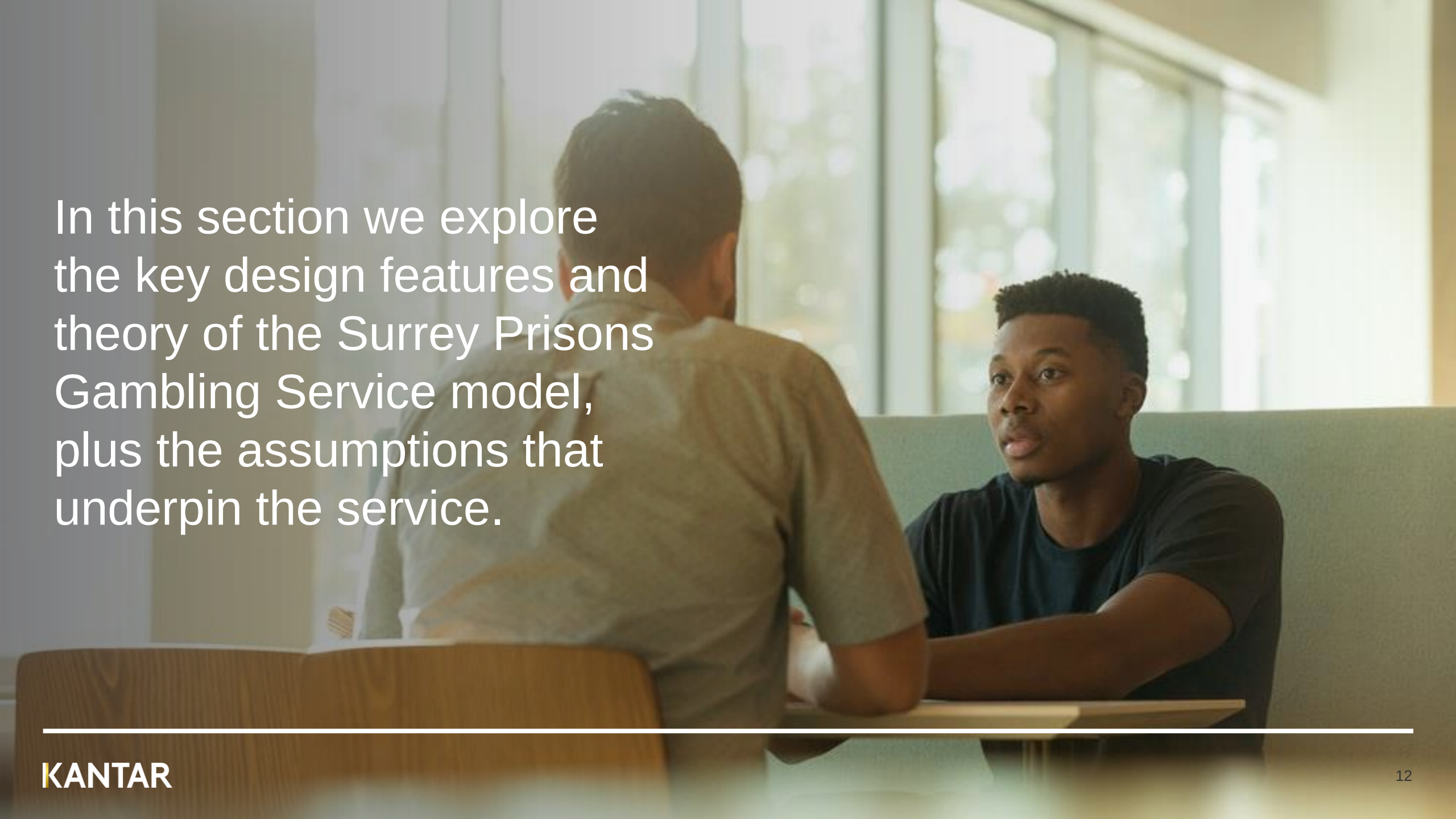
**HMP Send**

Female training prison
282 capacity

**HMP & YOI High Down**

Male local prison
1200 capacity

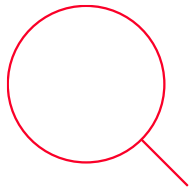
# 3
# Service design, logic model and assumptions



In this section we explore the key design features and theory of the Surrey Prisons Gambling Service model, plus the assumptions that underpin the service.

# Key components of service delivery

The key components that define SPGS and make it unique are:



## Screening and measuring prevalence of gambling harm among prisoners

Screening is the key way those at-risk of or experiencing gambling harm (who would score as 1+ on the PGSI) will be identified and referred to treatment activity. Gambling-harm prevalence measuring has not been done on this scale in UK prisons before.

## In-prison treatment targeting gambling harms

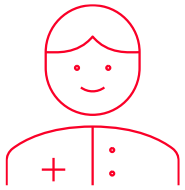
This will largely consist of cognitive behavioural therapy, delivered face-to-face. The treatment interventions will be based on the interventions CNWL uses at its National Problem Gambling Clinic but adapted to prisons as SPGS generated learnings.

## Engaging a variety of stakeholders

In order to operate effectively in prisons, the service relies on engaging a wide variety of stakeholders (outlined in the next slide). These help ensure that referral pathways and greater awareness of the issue of gambling harm are a sustained legacy of the service.

# Service stakeholders

Apart from the delivery team, SPGS has a number of stakeholders and beneficiaries

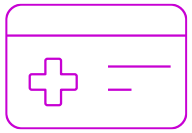


## Offender healthcare professionals

Healthcare professionals often employed by CNWL or the Forward Trust who treat prisoners.[1] These can include GPs or educational professionals.

## Service users

Prisoners who are at-risk of or experiencing gambling harms (scores of 1+ on the PGSI)



## Prison Heads of Healthcare

CNWL staff who manage healthcare in each prison

## Prison governors

'Heads' of prisons who can have a say in certain health decisions during post-incident adjudications and who are key to cascading learnings to other prison staff

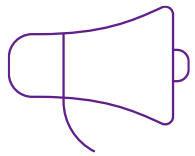
## Prison officers

Prison staff at the frontline who know service users



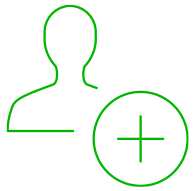
[1] CNWL provide for the general healthcare needs of the five prisons whereas Forward Trust provide substance misuse services

# Overview of the Surrey Prisons Gambling Service theory of change



Awareness-raising

of gambling harm and how to screen, signpost and refer those ‘at risk’ and experiencing ‘problem gambling’ (who would score 1+ on the PGSI) among staff and prisoners



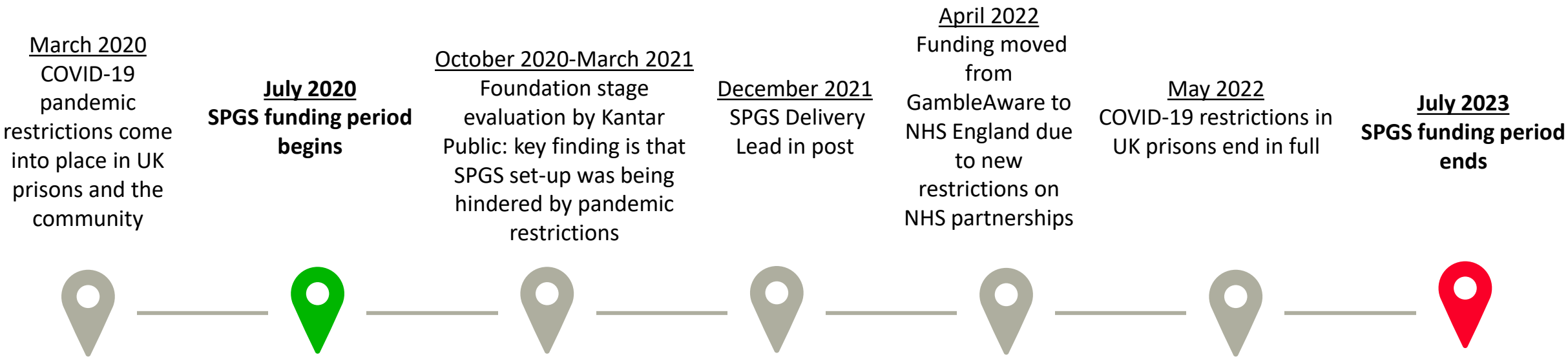
Treatment

of gambling harms among service users, with the aim of service users maintaining treatment gains

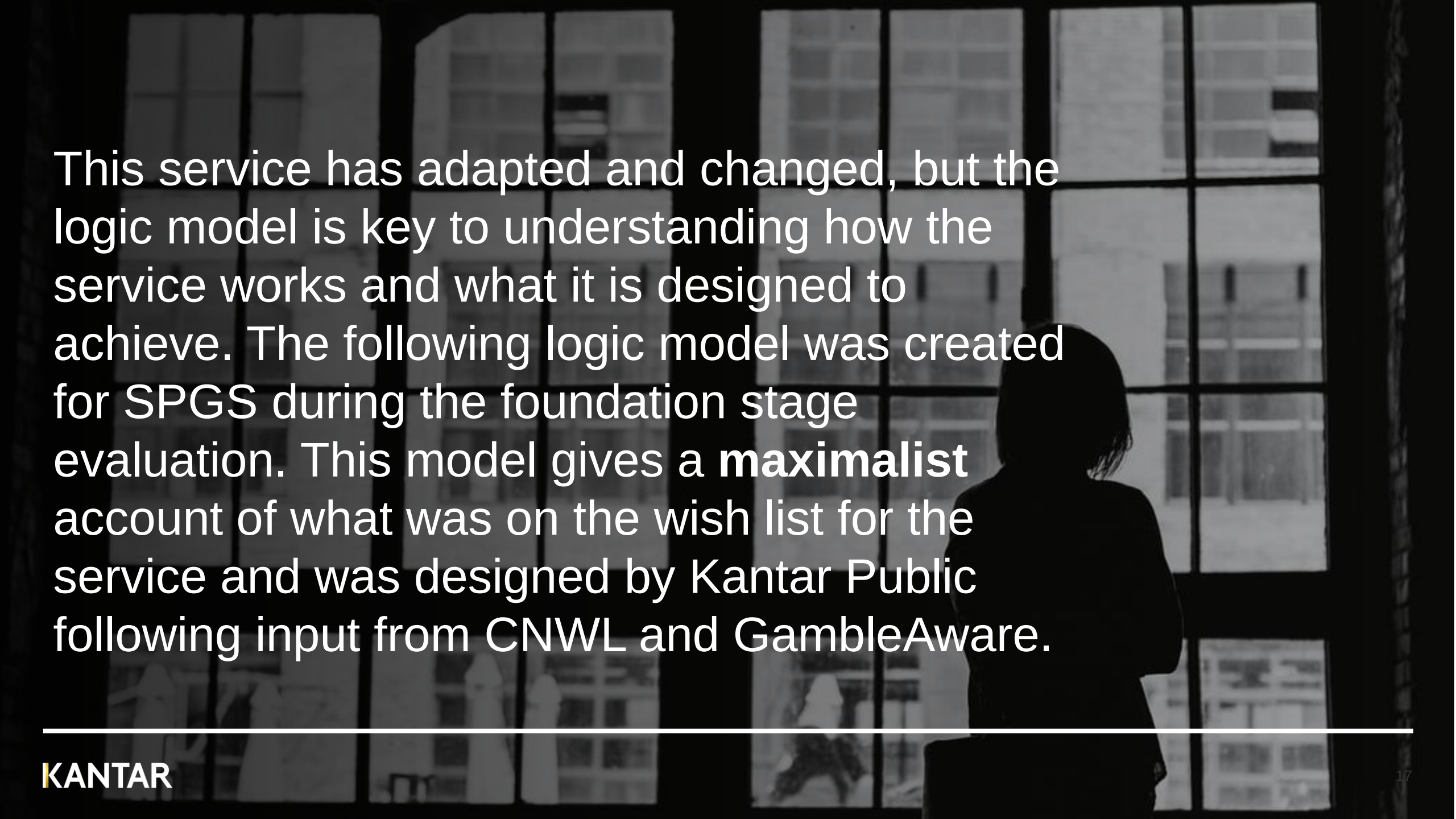
Formulation

of a standardised and transferrable treatment model (including via data collection), in order to maintain learnings and effective referral pathways

# The service was commissioned during the pandemic and its funding period ran until July 2023



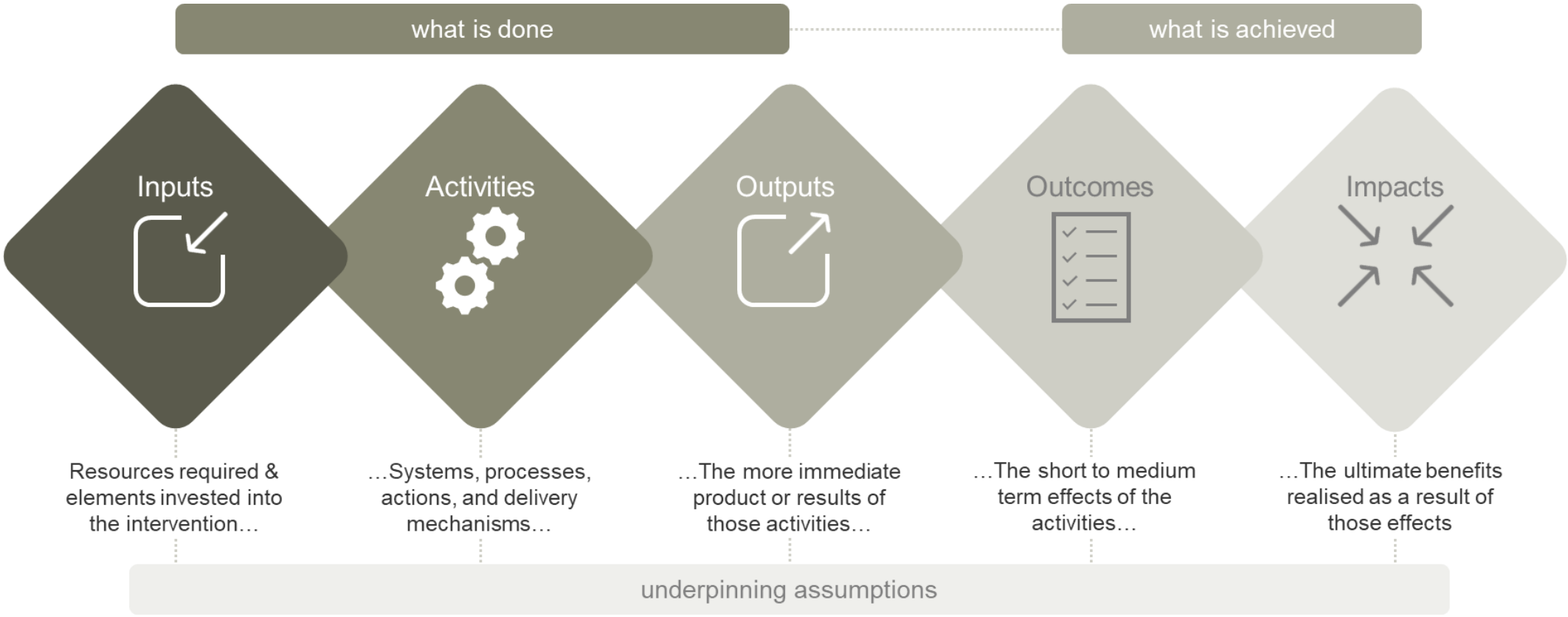

Delays to the Service have meant that it is behind schedule, which should be considered when evaluating the numbers of service users who have undergone intervention.

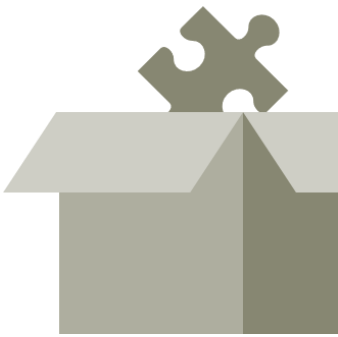


This service has adapted and changed, but the logic model is key to understanding how the service works and what it is designed to achieve. The following logic model was created for SPGS during the foundation stage evaluation. This model gives a **maximalist** account of what was on the wish list for the service and was designed by Kantar Public following input from CNWL and GambleAware.

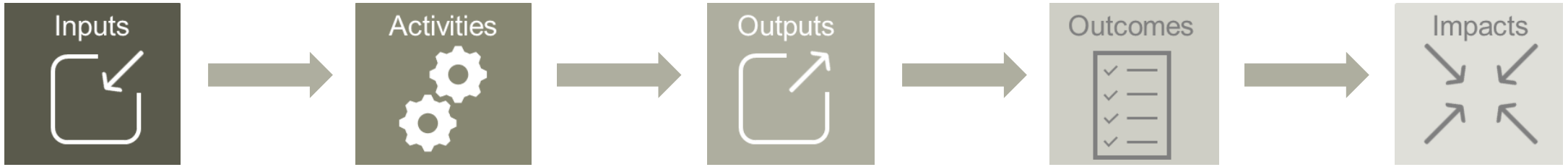
# Logic model

A logic model captures our understanding of a policy or programme. It helps illustrate the mechanisms for change and how activities are translated into impacts.



# SPGS logic model summarised




**Four categories of input:**

- Time from a range of stakeholders
- Grant money
- Existing knowledge, experience, relationships
- Tele-medicine facilities (in at least one prison)

**Awareness raising**
- Consultations
- Engagement/comms
- Training

**Treatment**
- Screening & signposting
- Treatment delivery

**Formulation**
- Data collection
- Performance monitoring
- Consolidating learning

**Awareness raising**
- Senior stakeholders
- Frontline staff
- Healthcare staff

**Treatment**
- Screening stage
- Treatment delivery

**Formulation**
- Data collection sources:
  - Service monitoring data
  - System data
  - Survey/feedback data

**Awareness raising**
- x6 short-term
- x3 medium-term

**Treatment**
- x3 short-term
- x3 medium-term

**Formulation**
- x0 short-term
- x2 medium-term

**Awareness raising**
- x2 impacts

**Treatment**
- x3 impacts

**Formulation**
- x1 impacts

**Awareness-raising** **Treatment** **Formulation**

# The service logic model outlines the key components of SPGS in detail

| Inputs | Activities (in chronological order) | Outputs | Short-term Outcomes | Medium-term Outcomes | Impacts |
|---|---|---|---|---|---|
| SPGS staff time | Consultations with Heads of Healthcare (and other senior stakeholders) (SPGS management team) | Stakeholders (governors, officers, prisoners, healthcare staff) engaged with the service | Prison staff (including prison healthcare providers) have increased awareness of gambling harms | Senior stakeholders e.g. prison governors are bought into the idea of investing in reducing gambling harm | More accurate data forming evidence base for awareness of the prevalence of 'gambling harms' (1+ scores on the PGSI) among prisoners |
| 1x psychologist ( *subject to recruitment outcomes* ) and 4x assistant psychologists | Engage and train stakeholders: | Stakeholders (governors, officers, prisoners, healthcare staff) know how to signpost patients to the service | Prison staff (including prison healthcare providers) have increased awareness (some via training) of how to identify those 'at-risk' (1-7 PGSI score) and experiencing 'disordered gambling' (8+ PGSI score) | SPGS establish a standardised awareness-raising process for staff in prison settings | Improved knowledge of best practice among healthcare staff for screening and treating 'gambling harms' ' (1+ scores on the PGSI) among prisoners, potentially including new skills acquired through trainin |
| £1m grant from GambleAware | •Engage prison governors via Male and Female health partnership boards quarterly meetings (CNWL) | CNWL staff trained to deliver reception screening | Prison staff (including prison healthcare providers) know how and feel confident to signpost those 'at-risk' (1-7 PGSI score) and experiencing 'disordered gambling' (8+ PGSI score) (partly through training) | The service raises the profile of problem gambling across the Surrey prison estate | Established gambling service alongside other healthcare services in five prisons |
| Knowledge & expertise (including from National Problem Gambling Clinic) | •Engage officers to raise awareness of gambling harms (the extent to how much is likely to vary as there are many and their view on how much signposting is their remit differs) | All incoming (and many/all existing) prisoners screened at reception | CNWL reception staff have the training to screen and refer prisoners | Service users scoring 1+ on the PGSI recognise the gambling harms they are experiencing | Maintenance of treatment gains whilst in custody |
| Existing CNWL presence and contacts in prisons | •Train prisoner healthcare professionals (especially those focused on mental health) to raise awareness of gambling harms (typically employed by CNWL or the Forward Trust) | Target population engage with interventions | Prisoners with positive screens know that they are 'at-risk' (1-7 PGSI score) or experiencing 'disordered gambling' (8+ PGSI score) | Treatment gains occur: service users show a reduction in PGSI scores (including post-release) | Maintenance of treatment gains following discharge from prison |
| Newly-established telemedicine facilities in at least one prison | • Engage CNWL reception staff to raise awareness of gambling harms and train them on the Lie-Bet screening and referral procedure | Data collection: | Prisoners have increased awareness of gambling harms, treatment available and how to self-refer | Treatment gains occur: service users show an improvement in wellbeing survey scores following treatment | A Standard Operating Procedure for managing care pathways in (Surrey) prisons regarding problem gambling including embedding screening |
| | •Engage prisoners via NHS service user groups e.g. Epic and User Voice (employing former prisoners) and train them up on how to self-refer using in-cell packs including the GASTG screening questions | •Completed screening questionnaires (by all prisoners) | SPGS staff identify those 'at-risk' (1-7 PGSI score) and experiencing 'disordered gambling' (8+ PGSI score) | Feedback responses are analysed to improve treatment model, using a Quality Improvement procedure | |
| | Conduct 2-stage screening: | •Completed PGSI questionnaires (by target population) | SPGS establish clear referral pathways to its service | Staff obtain data on the prevalence of 'gambling disorder' (for those scoring 8+ on the PGSI) and of being 'at risk' of these (scoring 1-7) among prisoners in five Surrey prisons | |
| | • CNWL reception staff in prisons ask screening questions (Lie-Bet) to new arrivals (and existing population at first)<br>• CNWL reception staff in prisons refer prisoners who screen positive to SPGS<br>• SPGS psychologists ask PGSI questions to those who screen 'positive' at reception | •Anonymised statistics on the prevalence and severity of gambling among the prison population (on SystemOne)<br>•Anonymised management information<br>•Completed NHS 'Friends and Family' feedback surveys by service users (SystemOne)<br>•Completed wellbeing and during-treatment questionnaires (TBC) | The adapted treatment models operate successfully in the prison settings | | |
| | Other signposting to SPGS: | | | | |

**Please open this worksheet to view the full SPGS logic model:**

# Assumptions

Examining assumptions that underpin a programme is an important part of evaluating outcomes, so these should be set out explicitly.

It is important to bear in mind that **SPGS is a pilot service and an NHS Quality Improvement project, meaning it has always been likely to change once delivery began**.

Through discussions with SPGS and GambleAware, we have captured:

**Theoretical assumptions** about the theory and logic behind the programme's design

**Practical assumptions** related to the specifics of implementing the programme

# *Theoretical* assumptions underpinning the Logic Model

## Prevalence of gambling harm

Prisoners experience higher rates of problem and pathological gambling compared to the general community (Sullivan et al (2007); Nixon et al (2006))

Gambling harms are experienced in prisons (supported by anecdotal evidence that gambling with various currencies happens in prisons)

## Transferring interventions

Some interventions that work in the outside world are appropriate in the prison setting too e.g. sentence times don't impact these treatments, women-only treatment groups are effective

## Delivery

The programme is adaptable for delivery to the different populations in the five prisons

Adaptations made do not become a barrier or change the programme sufficiently

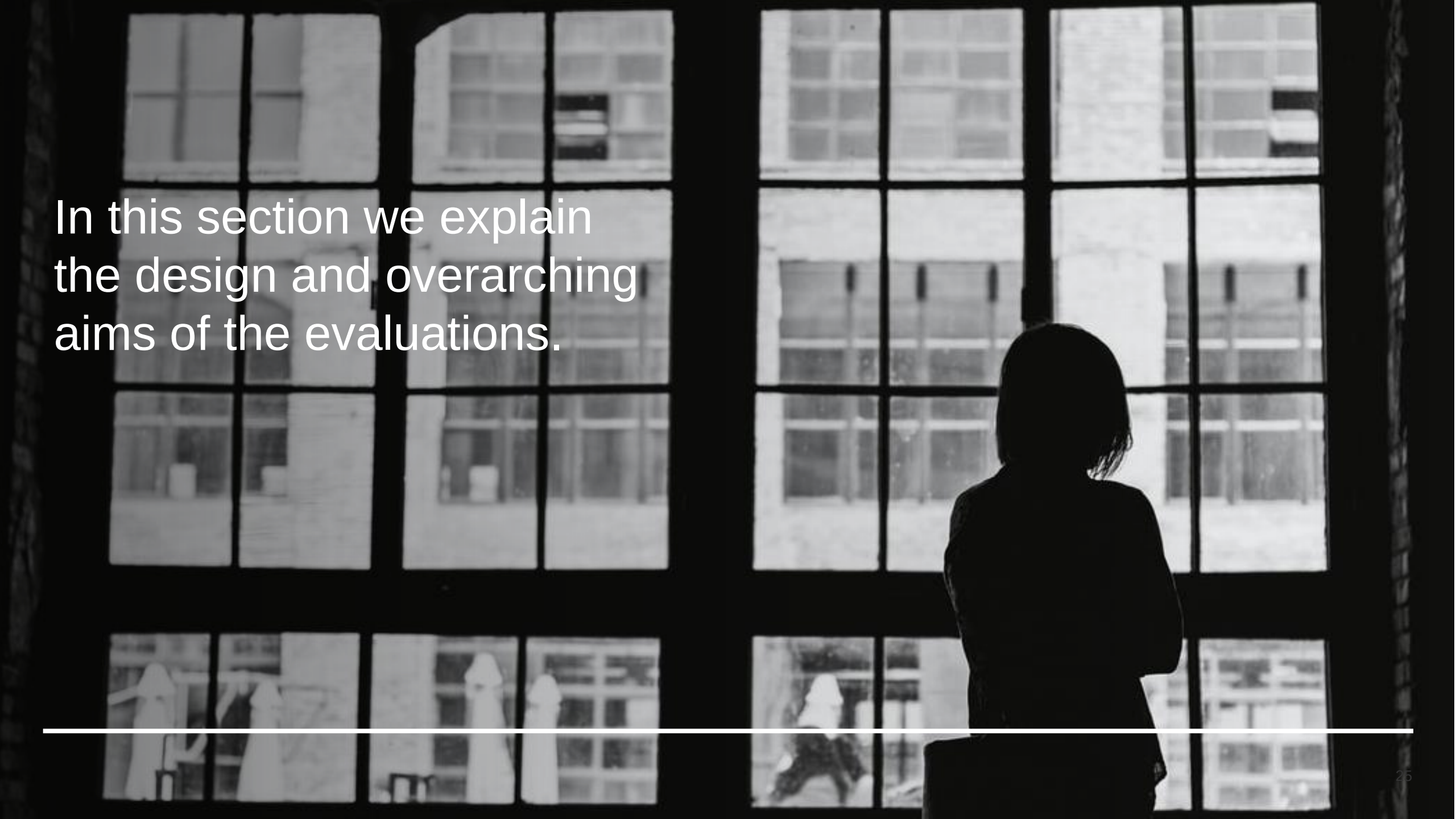
Delivery of SPGS treatment is feasible in prisons because:

- NHS services are already delivered in prisons
- Technology/regulations are not a constraint

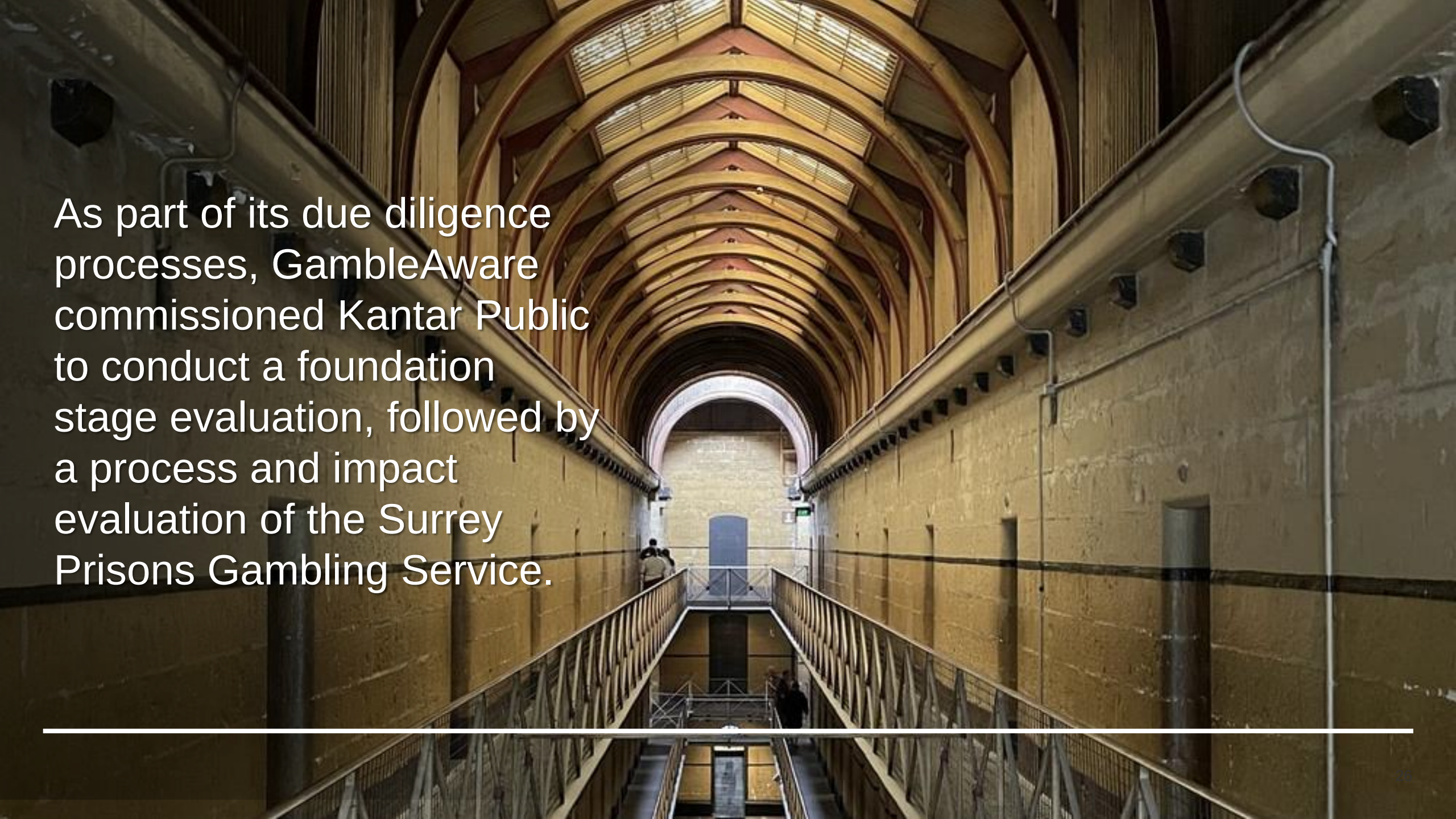
# *Practical* assumptions underpinning the Logic Model

| Screening | Staff | | Service Users |
|---|---|---|---|
| PGSI questions are sensitive enough to identify the severity of gambling harms | Prison staff and healthcare professionals within prisons are receptive to addressing the issue of problem gambling | Prison staff and healthcare professionals within prisons are receptive to the programme | Prisoners respond honestly to screening questions |
| Screening questions are incorporated into System One consistently across the five prisons | Reception staff know how to refer prisoners who screen positive to SPGS (or will receive training) | CNWL frontline staff have the capacity to ask screening questions to every arrival | Prisoners answer PGSI questions honestly |
| | Psychologists or staff making decisions about service adaptations make appropriate choices | Psychologists are trained and deliver the programme consistently | Prisoners are receptive to treatment and engage sufficiently for it to be effective |

# 4
# Evaluation design



In this section we explain the design and overarching aims of the evaluations.



As part of its due diligence processes, GambleAware commissioned Kantar Public to conduct a foundation stage evaluation, followed by a process and impact evaluation of the Surrey Prisons Gambling Service.

# Foundation stage evaluation objectives

The original **foundation stage evaluation** (October 2020-March 2021) aimed to:

Create an **evaluation framework** to guide the design and delivery of the future evaluation

Provide **materials and guidance for tender documents** for future evaluations of the programme.

Develop the Surrey Prisons Gambling Service (SPGS) programme's **logic model** and map outcomes and impacts

Assess the **feasibility of evaluation methods**, including a data review, highlighting risks/limitations, mitigations and solutions

Make **clear recommendations about the methodology** of future process and impact evaluation strands

# The foundation stage evaluation comprised a scoping and a main stage

## Scoping stage

### Scoping workshop
Workshop with 3 members of SPGS management and design team

### Scoping depth interview
x1 30-minute video call with the Service Manager at CNWL's National Problem Gambling Clinic (NPGC)

### Document review
Review of documents relating to the gambling therapy, the criminal justice system, related research and SPGS specifically

## Main stage

### Logic Model (LM) and evaluation outline drafting
Based on analysis from the scoping stage

## Main stage

### SPGS LM and evaluation workshop
Workshop with 2 members of SPGS team and 2 from GambleAware to gain feedback on findings so far

### CNWL stakeholder interviews
x3 30-minute video & telephone interviews with senior CNWL staff

### Development of LM and evaluation framework
Refinement and further development based on feedback from SPGS; includes liaison with SPGS staff

### Reporting findings
Reporting back to SPGS and GambleAware with findings and recommendations to gain feedback on feasibility of recommendations

# Evaluation objectives

The original objectives for the evaluation (commissioned October 2022-August 2023) were as follows:

The **process evaluation** focused on implementation of the project, seeking to understand:

- The extent to which prisoners 'at risk' or experiencing 'gambling harms' (1+ PGSI score) are being identified by the screening & referral process.
- How Covid-19 has impacted the delivery of treatment interventions, and how interventions have been adapted since.
- The barriers and facilitators to service users engaging with treatment interventions.
- The extent to which treatment interventions are appropriate for service users.

The **impact evaluation** sought to:

- Investigate and report on the early effect the programme has on service users' health and gambling treatment in prisons.

# Evaluation methodology

## Scoping stage

**Scoping depth interviews**
x2 60-minute video calls with the Service Managers at CNWL's National Problem Gambling Clinic and SPGS (Summer 2022)

**Logic Model (LM) review**

With SPGS stakeholders to update on changes to the project since design (2022)

## Main stage

**CNWL/HMPS stakeholder interviews**
x8 60-minute video interviews with CNWL staff, assistant psychologists and HMPS staff (April-June 2023)

**Analysis of findings**

Systematic analysis of qualitative research, with feedback from SPGS (May-June 2023)

**Quantitative data analysis**
Analysis of quant data sent by SPGS (June 2023)

**Reporting findings**
Initial presentation back to SPGS and GambleAware with findings to present rapid evidence to aid with funding applications (today)

# Due to unforeseen issues stemming from COVID-19 delays and barriers to accessing and conducting research within prisons, the evaluation was rescoped in 2022


Since this initial rescoping, research has expanded to include some HMPS and MoJ staff, and to HMP & YOI High Down.

# 5 Findings around gambling harm in prisons pre-intervention

# Gambling harm was generally not registered or prioritised in prisons as much as other addictions prior to SPGS

## Gambling harm in prisons

- **Little sense of the prevalence** of gambling harm among UK prisoners.
- View that gambling harm is **less of an issue in female prisons**.
- Gambling was sometimes **a factor in prisoners' sentenced crime** (although prison staff not always aware).
- Gambling in prison can have **high stakes** e.g. bets via people outside and using food as currency.

*"It's a bit of niche issue that doesn't necessarily present itself in custody."*
- HMPS social worker

*"Yes there is a bet on a game of pool and things like that, but I don't ever hear of it being a problem."*
- HMPS substance misuse service manager

# Gambling harm was not registered or prioritised in prisons as much other issues (i.e. alcohol misuse, mental ill health) prior to SPGS

## Prison staff perceptions

**Prison staff generally didn't look for gambling** or feel they knew if it was an issue.

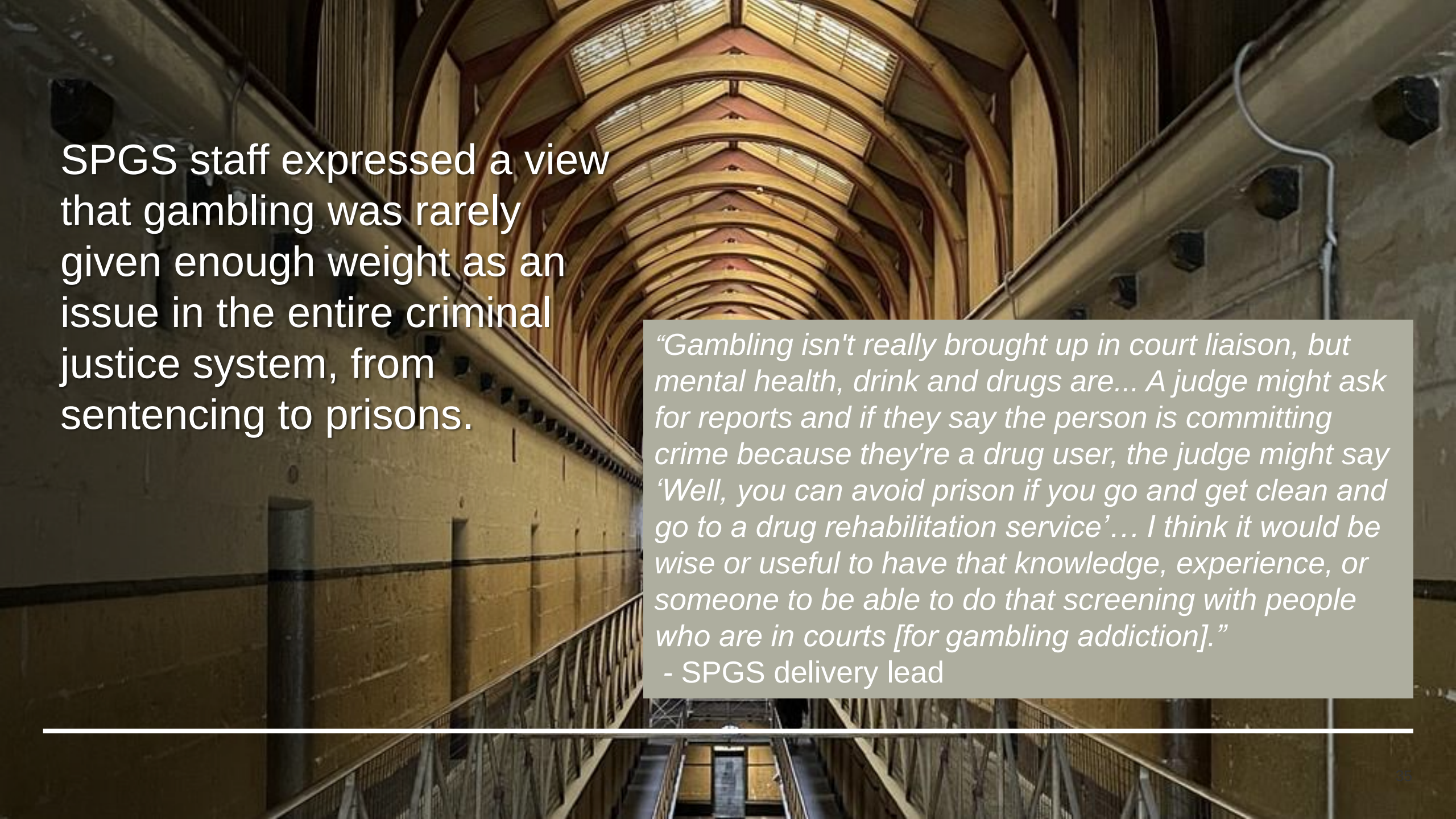
The detrimental impact **less visible** in prisons, e.g. not caused rent arrears, and gambling with money is more difficult.

View by some prison staff that **gambling could be an innocuous** way to pass the time.

It was **not identified to staff as an issue** - most are only aware of a handful of people for whom it's been a significant issue.

Prior to SPGS, gambling harm **wasn't being treated systematically** (or measured), but **Gamblers Anonymous offered support** via fellowship groups**.**

*"It's matchstick betting, it's not 'we're going to get all your canteen food'. It doesn't cause any issues or violence in the prison."*
- HMPS social worker



SPGS staff expressed a view that gambling was rarely given enough weight as an issue in the entire criminal justice system, from sentencing to prisons.

*“Gambling isn't really brought up in court liaison, but mental health, drink and drugs are... A judge might ask for reports and if they say the person is committing crime because they're a drug user, the judge might say ‘Well, you can avoid prison if you go and get clean and go to a drug rehabilitation service’… I think it would be wise or useful to have that knowledge, experience, or someone to be able to do that screening with people who are in courts [for gambling addiction].”*

- SPGS delivery lead

# CNWL psychologists expressed concern around gambling in prisons

They expressed concern that gambling in prisons:

| | | |
|---|---|---|
| **Fuelled gambling disorder** | **Caused harm** through loss, e.g. hunger over food, or financial losses if placing bets through relatives outside | Contributed to **violence**, albeit rarely, through violence over losses, violence to bet on, or violence as a currency. |

*“Playing card games, pool, a lot of them gamble on the wings in the daytime just to pass the time. They'll gamble their canteen because a lot of them don't have money in prison. A lot of them are able to gamble through family members or friends on the outside while they're still in prison, through phone calls they'll tell them to bet on blackjack or sports games, things like that.”*
- SPGS assistant psychologist

# 6
# Process evaluation findings: implementation

# Service set-up

CNWL began setting up the SPGS by organising a delivery team, recruiting assistant psychologists, engaging with Heads of Healthcare and administering screeners in prisons.

The service was affected by COVID-19 and recruitment delays (for a delivery lead and assistant psychologists) and adapted to tighter pandemic regulations around prison visiting. However, following the relaxation of COVID-19 restrictions, the service was able to be delivered face-to-face rather than via online or telemedicine facilities.

# Prison phasing

Due to setbacks in set-up caused by the COVID-19 pandemic, SPGS prioritised implementation in the following prisons:

**HMP Coldingley**

Male training prison
513 capacity
Resettlement focus

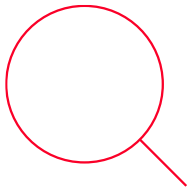
**HMP Send**

Closed female training prison
282 capacity
Focus on work, education and physical activity

Once the service was implemented in these two prisons, SPGS began implementation in HMP & YOI High Down during 2023.

# Key components of service delivery

The key components that define SPGS and make it unique are:



### Screening and measuring prevalence of gambling harm among prisoners

Screening is the key way those at-risk of or experiencing gambling harm (who would score as 1+ on the PGSI) were identified and referred to treatment activity. Gambling-harm prevalence measuring has not been done on this scale in UK prisons before and the statistics will be of wider interest once the service is established.

### In-prison treatment targeting gambling harms

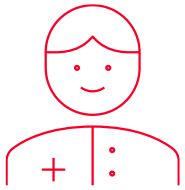
This largely consisted of cognitive behavioural therapy, delivered face-to-face. The treatment interventions were based on the interventions CNWL uses at its National Problem Gambling Clinic but were adapted to be more relevant in the prison context.

### Engaging a variety of stakeholders

In order to operate effectively in prisons, the service relied on engaging a wide variety of stakeholders (outlined in the next slide). This helped ensure that referral pathways and greater awareness of the issue of gambling harm are a sustained legacy of the service.

# Service stakeholders

Apart from the delivery team, SPGS has a number of stakeholders and beneficiaries

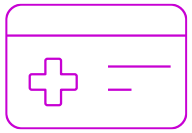


## Offender healthcare professionals

Healthcare professionals often employed by CNWL or the Forward Trust who treat prisoners.[1] These can include GPs or educational professionals.

## Service users

Prisoners who are at-risk of or experiencing gambling harms (scores of 1+ on the PGSI)



## Prison Heads of Healthcare

CNWL staff who manage healthcare in each prison

## Prison governors

'Heads' of prisons who can have a say in certain health decisions during post-incident adjudications and who are key to cascading learnings to other prison staff

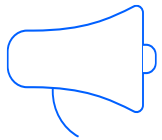
## Prison officers

Prison staff at the frontline who know service users



[1] CNWL provide for the general healthcare needs of the five prisons whereas Forward Trust provide substance misuse services

# How the SPGS service was delivered



## Awareness-raising

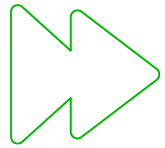
SPGS carried out a range of awareness-raising initiatives with prison staff, inmates, and services such as healthcare, the Forward Trust, and peer mentors. SPGS staff went on wings to talk to officers and prisoners, spoke at inductions for new prisoners, and put up posters about the service

## Identification and Referral

Self-identification and referral was made by individual prisoners via a range of routes, including answering a question on problem gambling added to the health screening questionnaire for new arrivals, and completing a referral form provided in various locations, including on wings, and in problem gambling education booklets provided to all prisoners

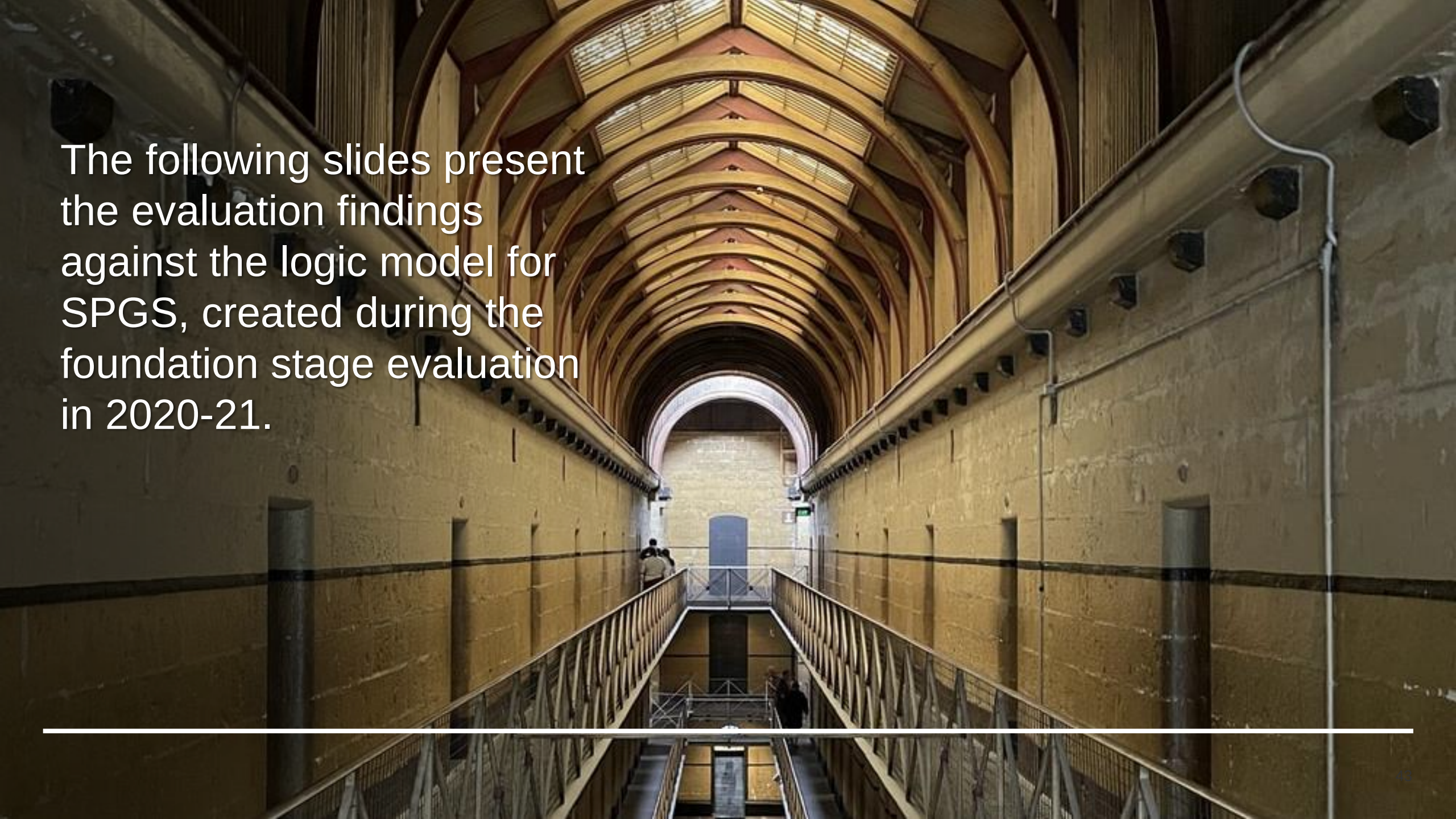
## Assessment and Treatment

New referrals were assessed for problem gambling. Treatment was then provided according to need, and could include psychoeducation and/or a minimum of 6 weekly sessions of CBT, delivered either 1-1 or in groups, depending on numbers in treatment at the time



## Onward referral

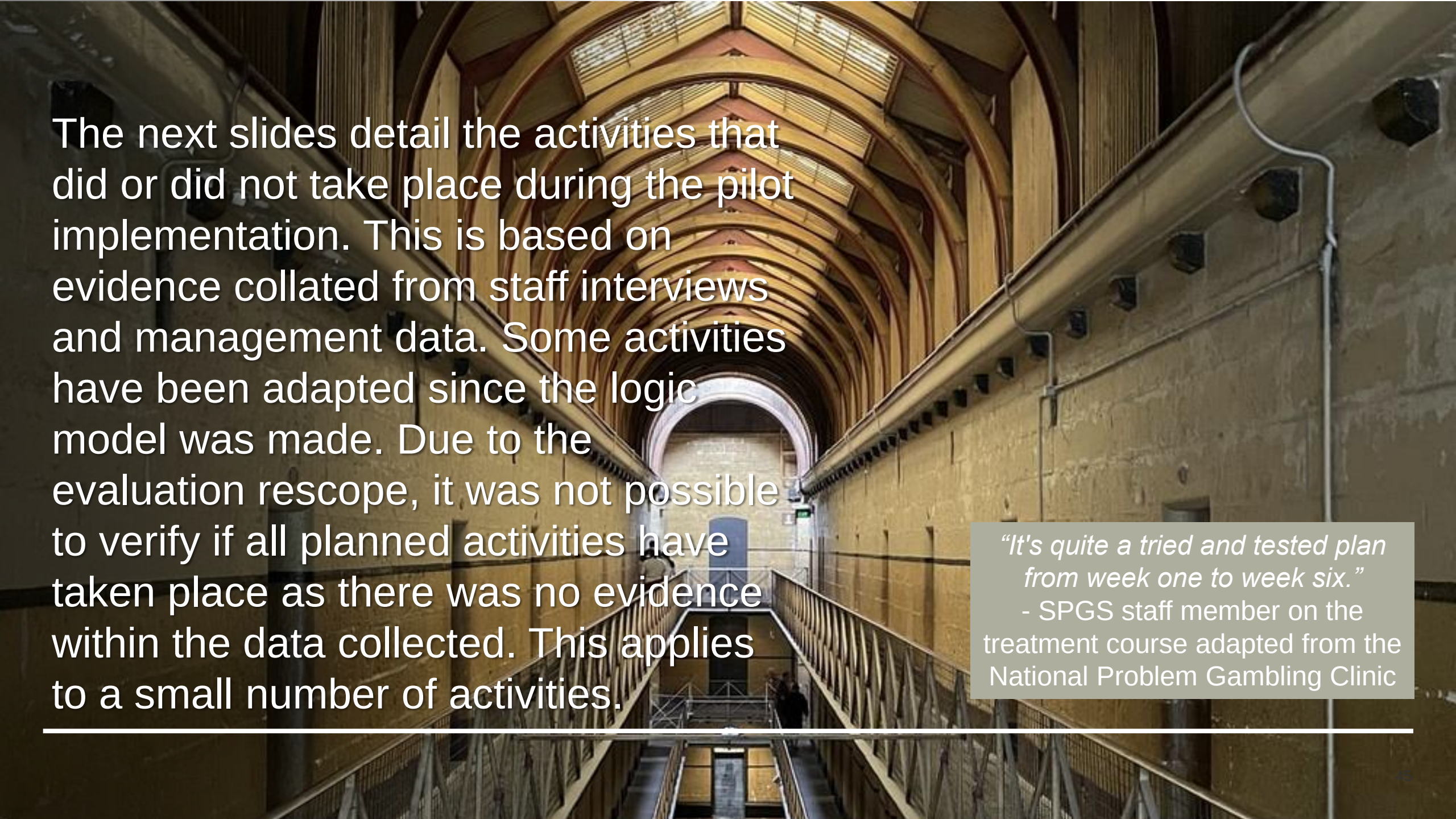
SPGS could refer clients to other prison services e.g. mental health, where needs were identified. Clients nearing their release data were signposted to treatment services available in the community



The following slides present the evaluation findings against the logic model for SPGS, created during the foundation stage evaluation in 2020-21.

# The inputs are not an assessed part of the logic model. However, they are worth recapping before evaluating the implementation of the intervention

| Inputs |
| --- |
| SPGS staff time |
| 1x psychologist (*subject to recruitment outcomes*) and 4x assistant psychologists |
| £1m grant from GambleAware |
| Knowledge & expertise (including from National Problem Gambling Clinic) |
| Existing CNWL presence and contacts in prisons |
| Newly-established telemedicine facilities in at least one prison |



The next slides detail the activities that did or did not take place during the pilot implementation. This is based on evidence collated from staff interviews and management data. Some activities have been adapted since the logic model was made. Due to the evaluation rescope, it was not possible to verify if all planned activities have taken place as there was no evidence within the data collected. This applies to a small number of activities.

*"It's quite a tried and tested plan from week one to week six."*
- SPGS staff member on the treatment course adapted from the National Problem Gambling Clinic

| **Activities** (I) (in chronological order) | **Evaluation findings** |
|---|---|
| Consultations with Heads of Healthcare (and other senior stakeholders) (SPGS management team) | Implemented in several prisons |
| Engage stakeholders:<br>• Engage prison governors via Male and Female health partnership boards quarterly meeting (CNWL)<br>• Engage officers to raise awareness of gambling harms (the extent to how much is likely to vary as there are many and their view on how much signposting is their remit differs)<br>• Engage offender healthcare professionals to raise awareness of gambling harms (typically employed by CNWL or the Forward Trust)<br>• Engage CNWL reception staff to raise awareness of gambling harms<br>• Engage offenders via NHS service user groups e.g. Epic and User Voice (employing former offenders) | Implemented apart from the lived experience groups, which was never a confirmed activity of the original plan. |
| Train up CNWL reception staff on the Lie-Bet screening and referral procedure | Implemented, albeit with a version of the PGSI instead of Lie-Bet. |
| Conduct 2-stage screening:<br>• CNWL reception staff in prisons ask screening questions (Lie-Bet) to new arrivals (and existing population at first)<br>• CNWL reception staff in prisons refer prisoners who screen positive to SPGS<br>• SPGS psychologists ask PGSI questions to those who screen 'positive' at reception | Implemented, albeit with a version of the PGSI instead of Lie-Bet. |
| Other signposting to SPGS:<br>• Psychologists and GPs refer their relevant patients<br>• Governors refer patients at adjudication sessions<br>• Officers refer patients<br>• Offenders self-refer | Implemented for health professionals and self-referrals. Signposting via governors and officers could not be verified without access to governors, officers or service users. |

***Key***

*Implemented in at least one prison (potentially adapted)*

*Not implemented*

*Unable to verify in this evaluation*

| **Activities** (II) (in chronological order) | **Evaluation findings** |
|---|---|
| SPGS staff (including psychologists) adapt treatment interventions to the prison setting [psychological sessions, commitments] | Implemented across Send, Coldingley and High Down. |
| SPGS team deliver treatment interventions to service users (8-session course, details TBC):<br>• Motivational interviewing<br>• Cognitive behavioural therapy<br>Treatment will be phased into the 5 prisons, starting with HMPs Coldingley and Send | Implemented and adapted to service users. However, intervention has occurred in 3 prisons and not all 5 due to delays caused by factors outlined in later slides. |
| TBC* (likely): SPGS staff administer tracking surveys such as PGSI during treatment | Implemented relatively consistently. Findings presented in later slides. |
| TBC* (likely): SPGS staff administer wellbeing surveys with service users (e.g. CORE10, GAD, PHQ) | Implemented for the GAD and PHQ. Findings presented in later slides. |
| SPGS staff administer NHS 'Friends and Family' feedback surveys | Evaluation did not verify whether this was taking place or not. |
| SPGS staff signpost service users to be released towards therapy in the community where relevant e.g. with the National Problem Gambling Clinic | Signposting to community services such as the National Problem Gambling Clinic was occurring according to staff interviews. |
| TBC*: SPGS staff work with organisations such as the Probation Service and Through the Gate to help ensure service users receive relevant support after they leave prison | SPGS was working with the Probation Service, often to refer patients to SPGS. |
| TBC*: SPGS track certain service users after release using a survey such as the PGSI | This has not been implemented yet but was never a certain part of the original plan. |



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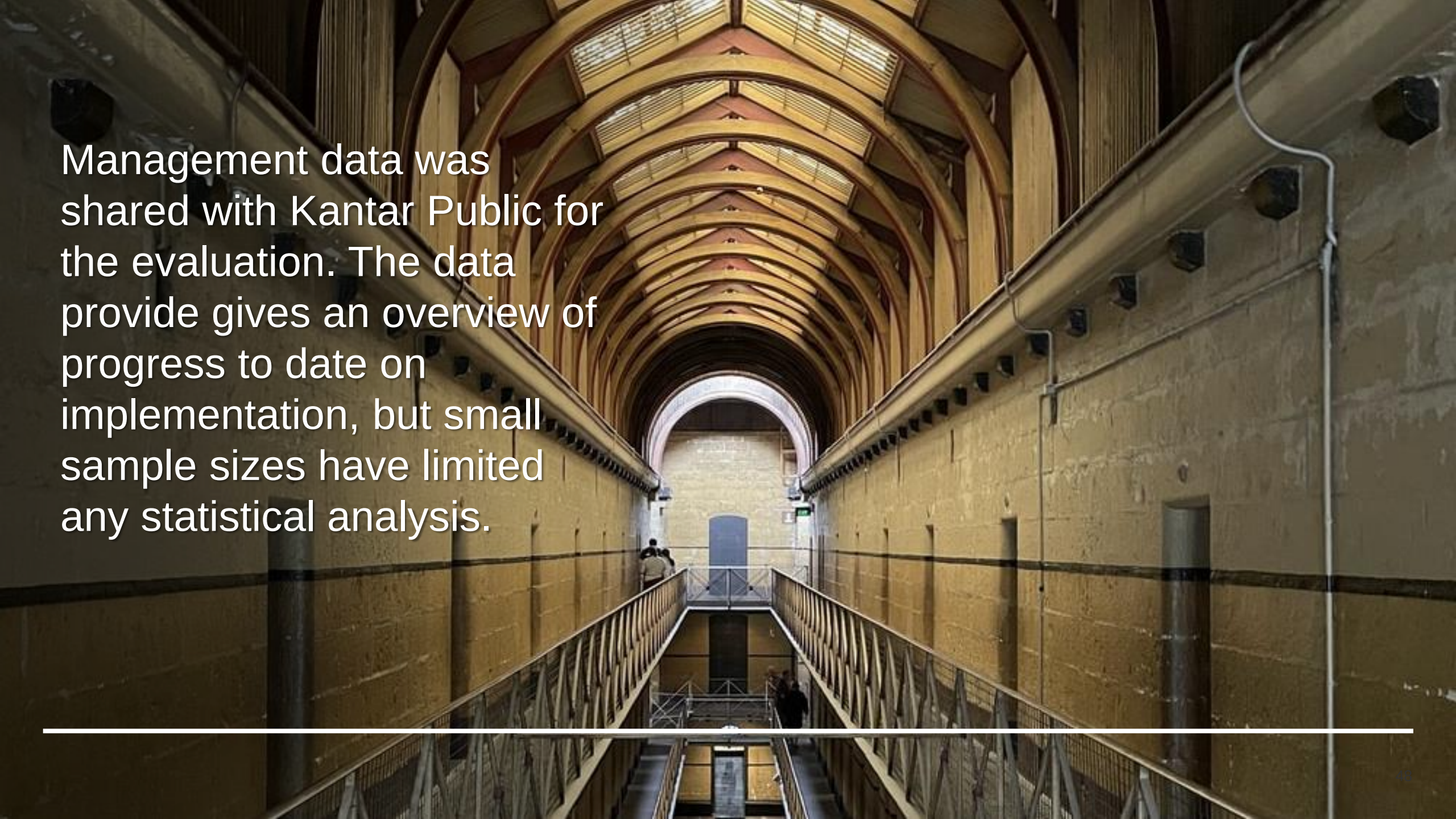
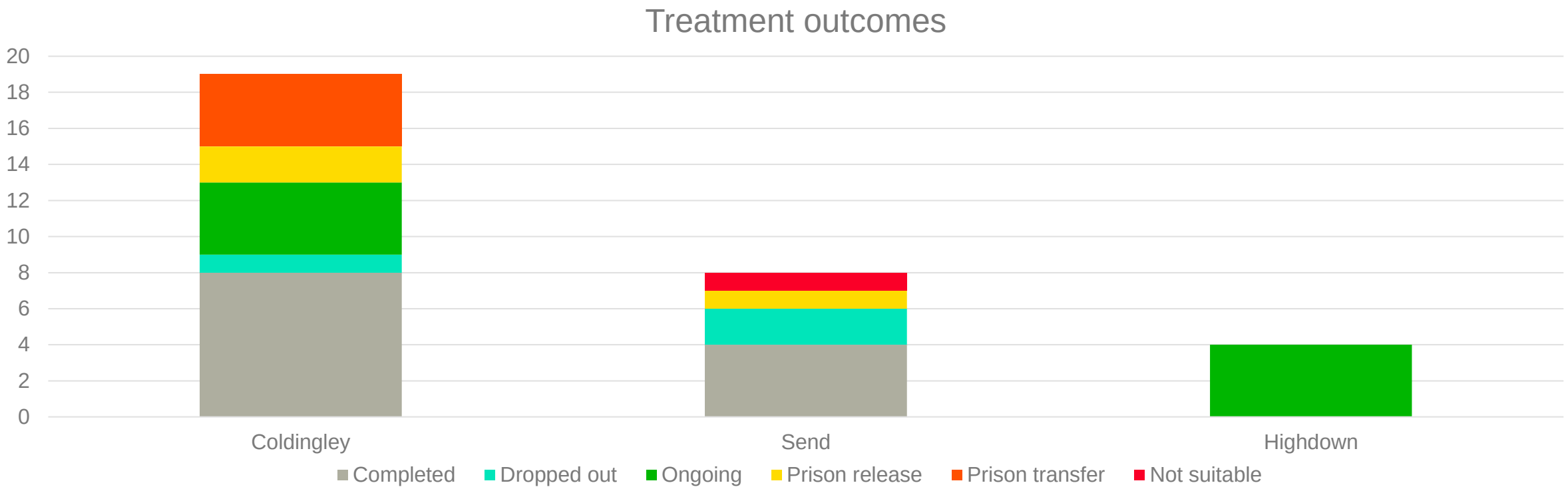
*Implemented in at least one prison (potentially adapted)* *Not implemented* *Unable to verify*

*TBC (to be confirmed) refers to proposed activities that were not as certain as others during the service design.



Management data was shared with Kantar Public for the evaluation. The data provide gives an overview of progress to date on implementation, but small sample sizes have limited any statistical analysis.

# The numbers completing treatment started to gain momentum towards the end of service delivery (currently 12 completed, with a further 8 ongoing)

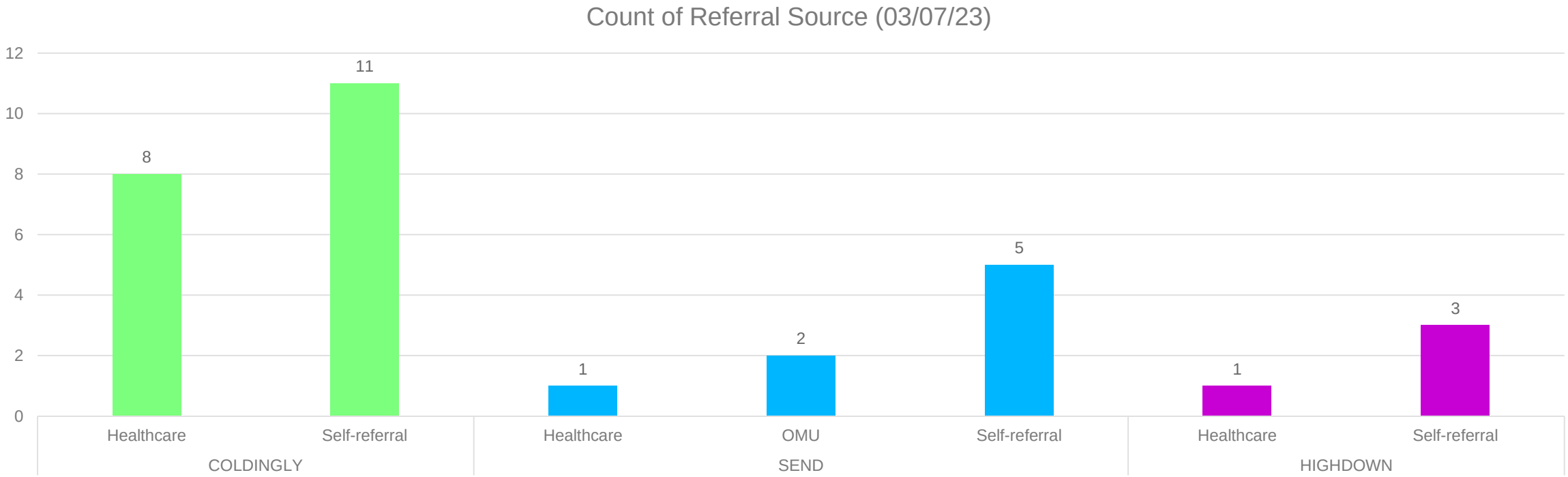



Qualitative findings indicate that due to delays in implementation, it was only in the final months of the service that numbers completing treatment started to pick up. Evaluation of this data should be done with consideration of this wider context. Furthermore, the number of users proportionate to prison size is higher than what GambleAware would expect from the general population.

# Average treatment courses last longer than the default 6 weeks which may signify tailoring to meet user needs

| Data title | Days | Sample size |
|---|---|---|
| Average wait time before starting treatment | 18 | Unknown |
| Average length of treatment for those completing successfully in Coldingley | 77 (11 weeks) | 6 |
| Average length of treatment for those completing successfully in Send | 58 (~8 weeks) | 4 |

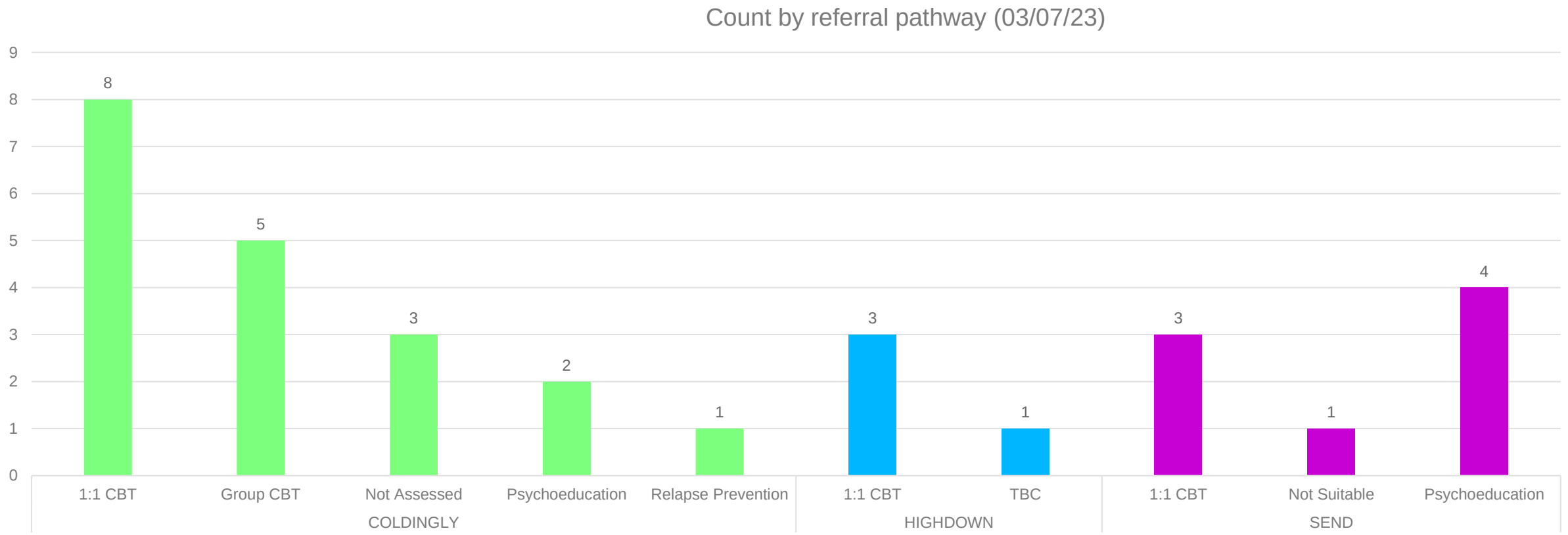
# Self-referral is the main referral source in all prisons, followed by referrals from healthcare



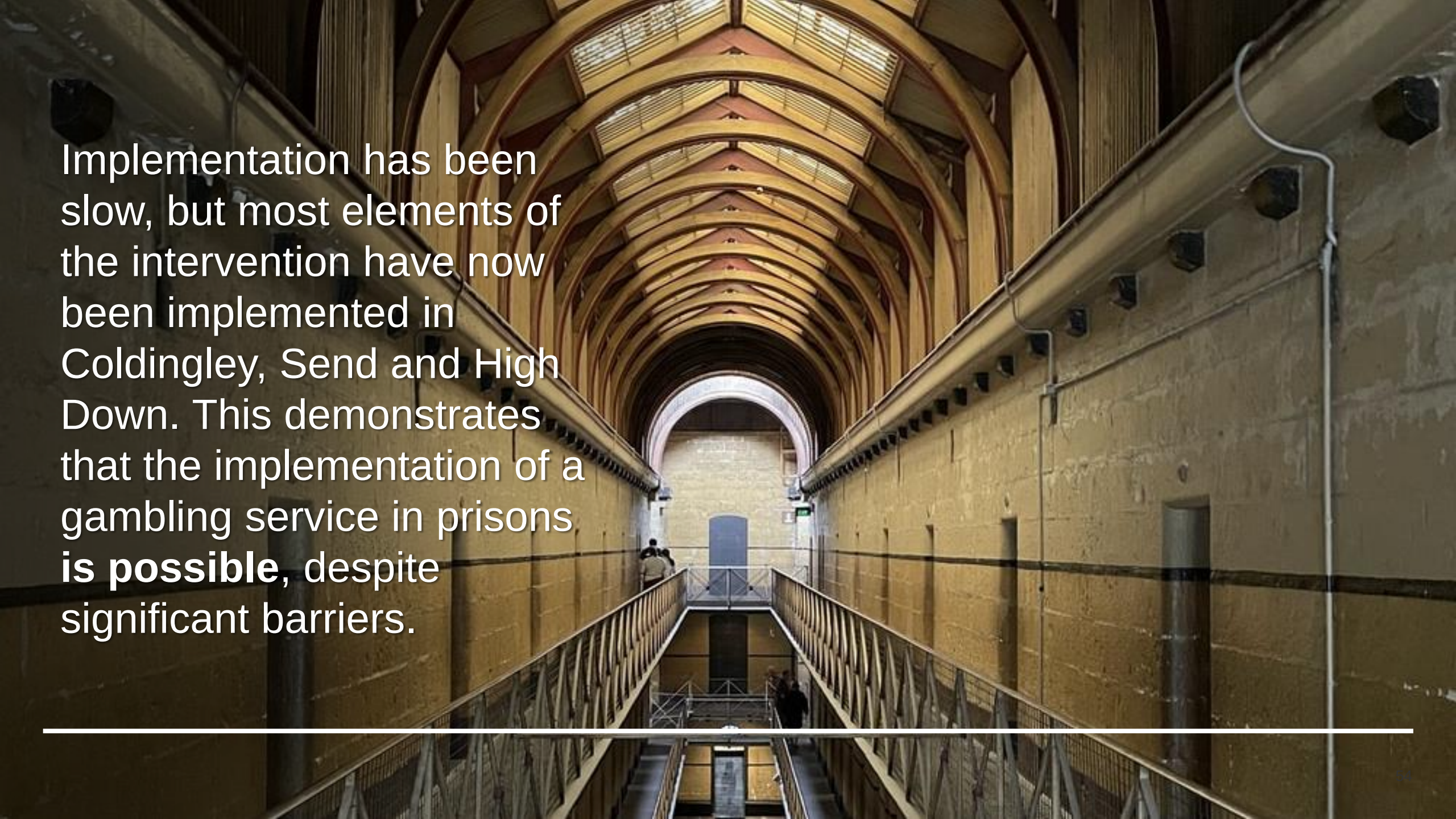

OMU refers to the Offender Management Unit – who are the main support for prisoners around their probation and preparing for release. All prisoners will be allocated a POM (prisoner offender manager, who works in OMU department) when they first come into prison and will discuss any issues with them e.g. financial difficulties and gambling.

# Treatment pathways varied across service users

**Psychoeducation** was particularly popular in Send (the only women's prison where SPGS has been implemented, reportedly to pass on learnings to friends and family experiencing gambling harm in the community).



# 7
# Process evaluation findings



Implementation has been slow, but most elements of the intervention have now been implemented in Coldingley, Send and High Down. This demonstrates that the implementation of a gambling service in prisons **is possible**, despite significant barriers.

# Service is now implemented in Coldingley, Send and High Down

## HMP Coldingley

- Male training prison - 513 capacity
- Resettlement focus

**STATUS**
Screening and treatment intervention up and running.

## HMP Send

- Closed female training prison
- 282 capacity
- Focus on work, education and physical activity

**STATUS**
Screening and treatment intervention up and running. Demand for psychoeducation for prisoners' family and friends in the community.

## HMP & YOI High Down

- Male local prison
- 1200 capacity
- 362 receptions/mo

**STATUS**
Screening and treatment intervention up and running.

# Implementation of SPGS faced a number of barriers from inception

- **COVID-19:** The pandemic prevented SPGS from being able to access prisons to both set-up and deliver the service until after lockdown restrictions had ended, which caused a significant delay to implementation.
- **The internal governance structure of prisons:** A new service delivered in a prison is required to gain approval and buy-in from a number of different internal stakeholders, which is a process that has taken more time than anticipated.
- **Recruitment of SPGS staff**: Recruitment of the SPGS Delivery Lead, a role that was key to implementation of the service, did not happen until 18 months after the planned inception of the service. Recruitment of the Assistant Psychologist was also delayed early in the set-up.

*"Prisons are quite a closed realm and there's a lot of people to get approval from."*
- SPGS Staff member

*"Had they got the funding before Covid it would have been better. We'd have had more ability to achieve numbers."*
- HMPS substance misuse service manager

# Implementation of SPGS faced a number of barriers from inception

- **Prison staff's lack of understanding of the service:** Challenges with raising awareness and understanding of the SPGS and its aims among the prison staff in each prison was another barrier to implementing the service. This may have impacted referrals as the service model relies on prison staff to identify and support individuals with problem gambling to refer themselves to the service. We spoke to one staff member who did not realise SPGS was different to the Gamblers Anonymous Fellowship meetings for instance.

- **A lack of buy-in from prison staff:** Even when there was awareness of the service among prison staff, they did not always see the service as a priority for prisoners, particularly compared with drug and alcohol services offered in prisons.

- **Prison schedules:** Availability of service users to attend treatment sessions was restricted by prison schedules. For example, in one prison only half of the prisoner population were available to attend treatment sessions at any one time of day, and those who were available might have other commitments that prevented them from being able to attend SPGS sessions, such as education sessions.

# Learnings from implementation

There is evidence that some learnings from the initial implementation of the service within Coldingley and Send have been implemented in the subsequent roll-out of the service within High Down.

The facilitators of the SPGS fall into three categories:

**Increasing engagement**

**Exogeneous aspects of the prison system**

**Flexibility in treatment**

# Proactivity and using partners increased engagement of stakeholders and service users

**Increasing engagement** of staff working with prisoners and prisoners themselves was found to be key to increasing referral numbers to the service. Over time, SPGS learnt how, when and where to engage with a range of different partners in the prisons. For example, SPGS Assistant Psychologists attended weekly induction meetings to talk to new prisoners about the service.

The **Forward Trust, the Probation service, and chaplaincy** were found to be particularly helpful partners to engage with. By raising their awareness of the SPGS, they were prompted to tell prisoners who they felt might benefit from the service about what it offered and encourage referrals to the service.

**Proactive, direct contact between SPGS staff and prisoners** was found to be particularly effective in encouraging referrals to the service. SPGS staff spent time on wings talking to prisoners and staff, and attended Gamblers Anonymous meetings to raise awareness of the service.

*"We are getting better at learning who to speak to, how and where to speak to them, like Gamblers Anonymous, Probation and those sorts of things internally. That it's now getting a bit easier and we're learning from our mistakes, and improving our ability and quality, so it's getting a bit quicker and easier."*
- SPGS Staff member

*"Once staff recognised us then the prisoners recognised us more."*
- SPGS Staff member

# Adapting treatment to user needs was viewed as useful to increasing retention and impact

There were several ways the intervention was adapted to meet user needs and constraints

**Flexibility in treatment**

**Pace**

Treatment was paced to meet user needs so courses could last longer than the default 6 weeks (and often did). Some courses were also lengthened because service users did not attend every week.

**Group vs. 1-1**

Those with special requirements such as high anxiety could have sessions alone with a psychologist if deemed beneficial for the individual.

**Mental health needs**

Sessions could cover mental health needs such as anxiety, as well as, or before, gambling harm.

**Session times**

Offering flexibility over session times meaning more prisoners can attend e.g. evenings were better in High Down to accommodate when prisoners in treatment had active 'uptime'.

# This pilot showed that the prison system, whilst presenting barriers to implementation, also provided facilitators that aided treatment

**Exogeneous aspects of the prison system**

**Captive audience**

Having fewer stimulants and time pressures than in the community enabled recruitment of service users who might not participate in treatment in the community.

**Limited triggers**

“Like a rehab centre” to reduce the likelihood of relapses and allow treatment to be more unhindered.

# 8
# Impact evaluation findings

# Qualitative evidence suggests treatment has had positive outcomes but that this is also difficult to test in prison

Below are anecdotal findings around impact from the interviews:

PGSI improvements are reportedly **better than those in the community** setting so far

The **mental health of prisoners with long sentences is reportedly benefitting from their focusing on their life post-release,** which is covered within the course

Service users have reportedly **stopped gambling while on the course**

*"Once people are in treatment I think they've got a lot out of it, particularly those who are coming up to release and are worried about gambling after release. Also those on long sentences have benefitted from thinking about the future long term."*
- SPGS Staff member



Only SPGS staff commented on impact so all quotes in this section are from SPGS staff

# Qualitative evidence suggests treatment had positive outcomes but that this is also difficult to test in prison

Below are anecdotal findings around impact from the interviews:

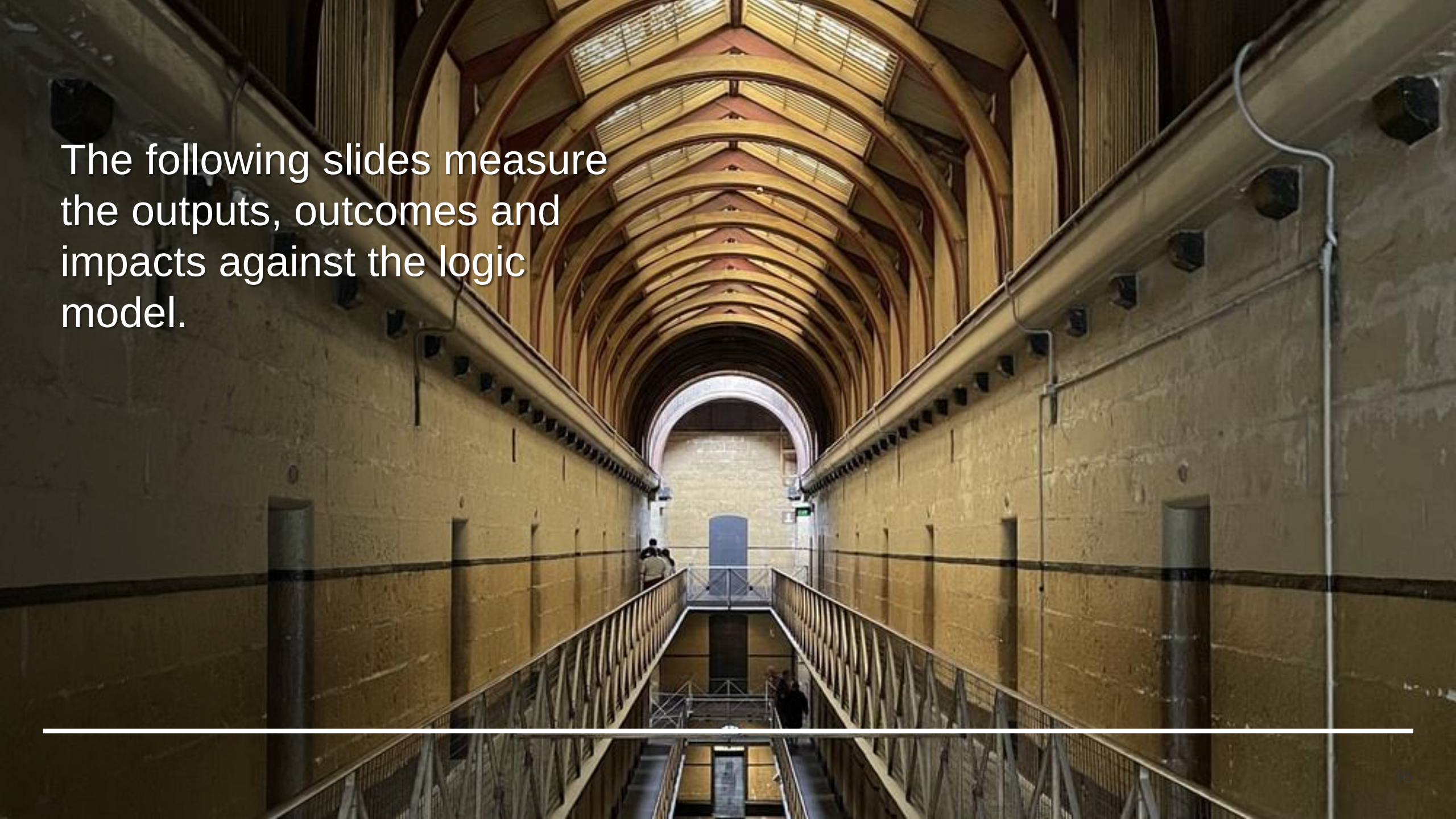
Interviewees found it **difficult to be confident about the success of treatment** without follow-ups with prisoners post-release. The prison environment has **fewer triggers,** so relapse resilience is difficult to test.

It is **unclear from the data collected in this evaluation how successful the service has been at measuring prevalence**. Anecdotal evidence identified some need within the prison setting, but this is not directly linked to evidence of prevalence.

*"The impact has been that it has shown there is a need for gambling addiction services in prisons and within court liaison services, so it's early days but we've started to prove that the need is there. And it's supporting several prisoners who've been through it and several who've left prison and as far as we know, are still abstaining from gambling. We would have to wait a year or two before we can get any decent data from that. But the early indications are that it's worth a service being commissioned and run effectively across the whole of the UK."*
- SPGS Staff member



Only SPGS staff commented on impact so all quotes in this section are from SPGS staff



The following slides measure the outputs, outcomes and impacts against the logic model.

# Limitations of the data means current evidence around the impact of the service and model is not conclusive

## Limitations that were acknowledged from the start

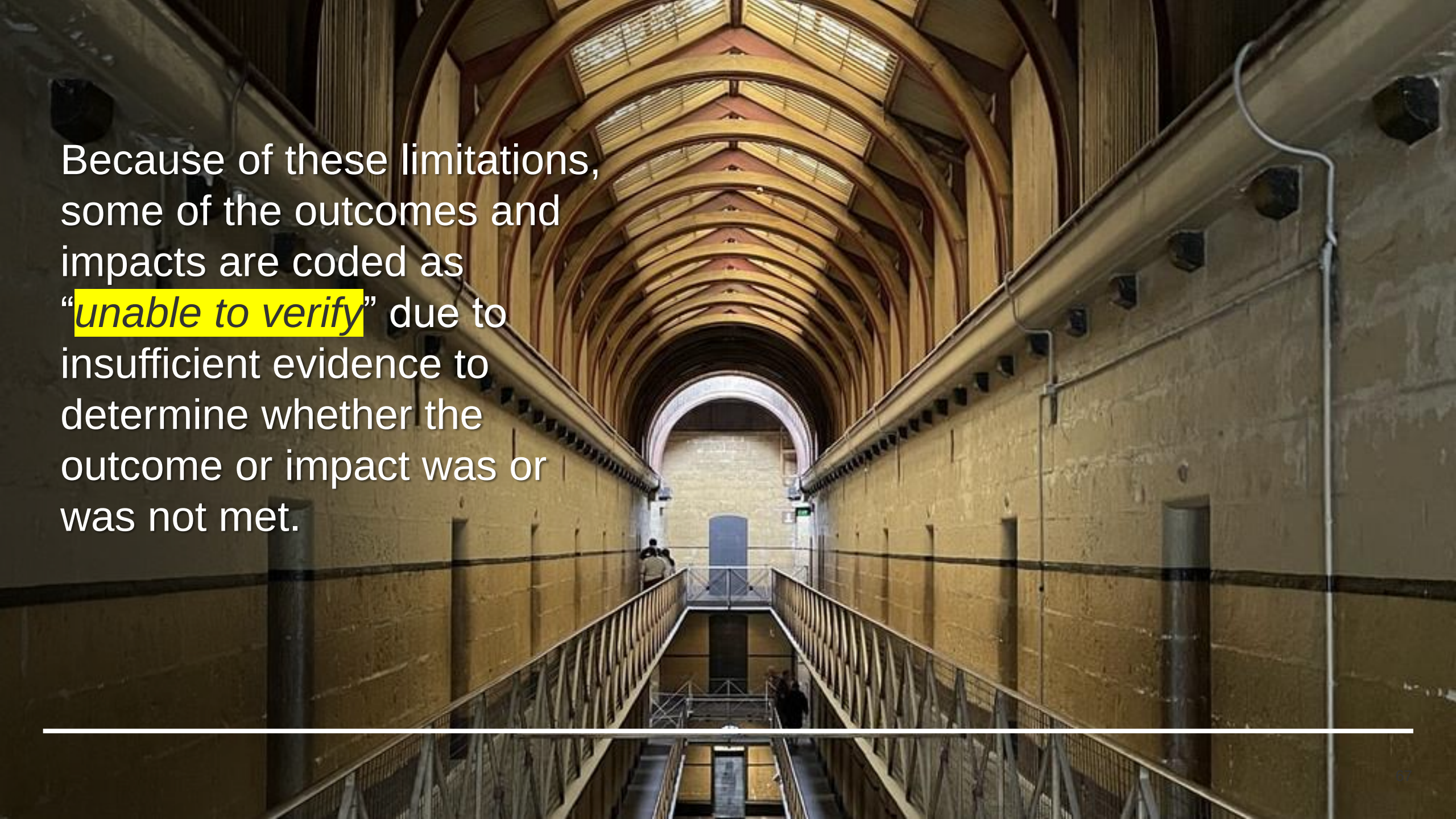
- The evaluation was **not designed to capture longer-term impacts**, such as the longevity of treatment outcomes post-release.

## Limitations due to re-scoping

- **Lack of access to service users**. This means that views on the impact of the service on service users only comes from the delivery team rather than those receiving the treatment.
- **Limited access to prison staff** means there is no objective measurement of the impact of awareness-raising activity on wider prison staff. Prison staff participating in the research were likely skewed to those who had most contact with SPGS.

## Limitations due to delays in implementation

- **Limited time for impacts to be realised** and observed/measured.
- **Limited quantitative management data** available.
- Although treatment sample size is not necessarily small given expectations of prevalence within the population, **service user numbers are currently too small to conduct statistically robust quantitative analysis**.



Because of these limitations, some of the outcomes and impacts are coded as "*unable to verify*" due to insufficient evidence to determine whether the outcome or impact was or was not met.

| Outputs | Evaluation findings |
|---|---|
| Stakeholders (governors, officers, offenders, healthcare staff) engaged with the service | Evidence of this from the interviews |
| Stakeholders (governors, officers, offenders, healthcare staff) know how to signpost patients to the service | Interviews and management data suggest referral is taking place to an extent but without access to officers and service users, the evaluation was not able to verify whether these stakeholders felt they had the knowledge to signpost patients. |
| CNWL staff trained to deliver reception screening | Evidence of this from the interviews |
| All incoming (and many/all existing) prisoners screened at reception | The evaluation could not verify this |
| Data collection:<br>• Completed screening questionnaires (by all prisoners)<br>• Completed PGSI questionnaires (by target population)<br>• Anonymised statistics on the prevalence and severity of gambling among the prison population (on SystemOne)<br>• Anonymised management information<br>• Completed NHS 'Friends and Family' feedback surveys by service users (SystemOne)<br>• Completed wellbeing and during-treatment questionnaires (TBC) | Several aspects of data collection were taking place, but we could not verify whether the anonymised statistics on the prevalence and severity of gambling among the prison population, or whether Friends & Family surveys were being collected. One reason was the lack of access to SystemOne. |
| Target population engaged with interventions | Evidence of this from the interviews in Send and Coldingley, and management data for Send, Coldingley and High Down |

# There are three groups of outcomes and impacts

**Awareness-raising**: of gambling harm and how to screen, signpost and refer those ‘at risk’ and experiencing ‘problem gambling’ (who would score 1+ on the PGSI) among staff and prisoners

**Treatment**: of gambling harms among service users

**Formulation**: of a standardised and transferrable treatment model

| Short-term Outcomes | Evaluation findings |
|---|---|
| Prison staff (including prison healthcare providers) have increased awareness of gambling harms | Without access to prison staff further from SPGS we could not verify this. |
| Prison staff (including prison healthcare providers) have increased awareness of how to identify those 'at-risk' (1-7 PGSI score) and experiencing 'disordered gambling' (8+ PGSI score) | Without access to prison staff further from SPGS we could not verify this. |
| Prison staff (including prison healthcare providers) know how and feel confident to signpost those 'at-risk' (1-7 PGSI score) and experiencing 'disordered gambling' (8+ PGSI score) | Without access to prison staff further from SPGS we could not verify this. |
| CNWL reception staff have the training to screen and refer prisoners | Evidence of this from the interviews |
| Prisoners with positive screens know that they are 'at-risk' (1-7 PGSI score) or experiencing 'disordered gambling' (8+ PGSI score) | Without access to service users, we could not verify this. |
| Prisoners know that treatment is available and know how to self-refer | Without access to service users, we could not verify this. |
| SPGS staff identify those 'at-risk' (1-7 PGSI score) and experiencing 'disordered gambling' (8+ PGSI score) | There is evidence of this from the management information, but the evidence is not strong enough to verify whether identification is consistent. |
| SPGS establish clear referral pathways to its service | Without access to service users, we could not verify this. |
| The adapted treatment models operate successfully in the prison settings | Evidence of this from the interviews and the pre- and post-treatment PGSI scores |



Awareness-raising | Treatment | Formulation

*Implemented in at least one prison (potentially adapted)*
*Not implemented*
*Unable to verify*

| Medium-term Outcomes | Evaluation findings |
|---|---|
| Senior stakeholders e.g. prison governors are bought into the idea of investing in reducing gambling harm | Without access to governors and senior stakeholders we could not verify this. |
| SPGS establish a standardised awareness-raising process for staff in prison setting | Without access to prisons and officers we could not verify this. |
| The service raises the profile of problem gambling across the Surrey prison estate | Without access to prisons and officers we could not verify this. |
| Service users scoring 1+ on the PGSI recognise the gambling harms they are experiencing | Without access to service users, we could not verify this. |
| Treatment gains occur: service users show a reduction in PGSI scores | There is evidence of this from the management information, but the numbers are not high enough for a significant level of statistical confidence. This is partly due to delays in the Service implementation caused by issues outlined earlier. |
| Treatment gains occur: service users show an improvement in wellbeing survey scores following treatment | There is evidence of this from the management information, but the numbers are not high enough for a significant level of statistical confidence. This is partly due to delays in the Service implementation caused by issues outlined earlier. |
| Feedback responses are analysed to improve treatment model, using a Quality Improvement procedure | We could not verify whether this was occurring from the evaluation. |
| Staff obtain data on the prevalence of 'gambling disorder' (for those scoring 8+ on the PGSI) and of being 'at risk' of these (scoring 1-7) among prisoners in five Surrey prisons | We could not verify whether enough prisoners were being screened to capture prevalence. |

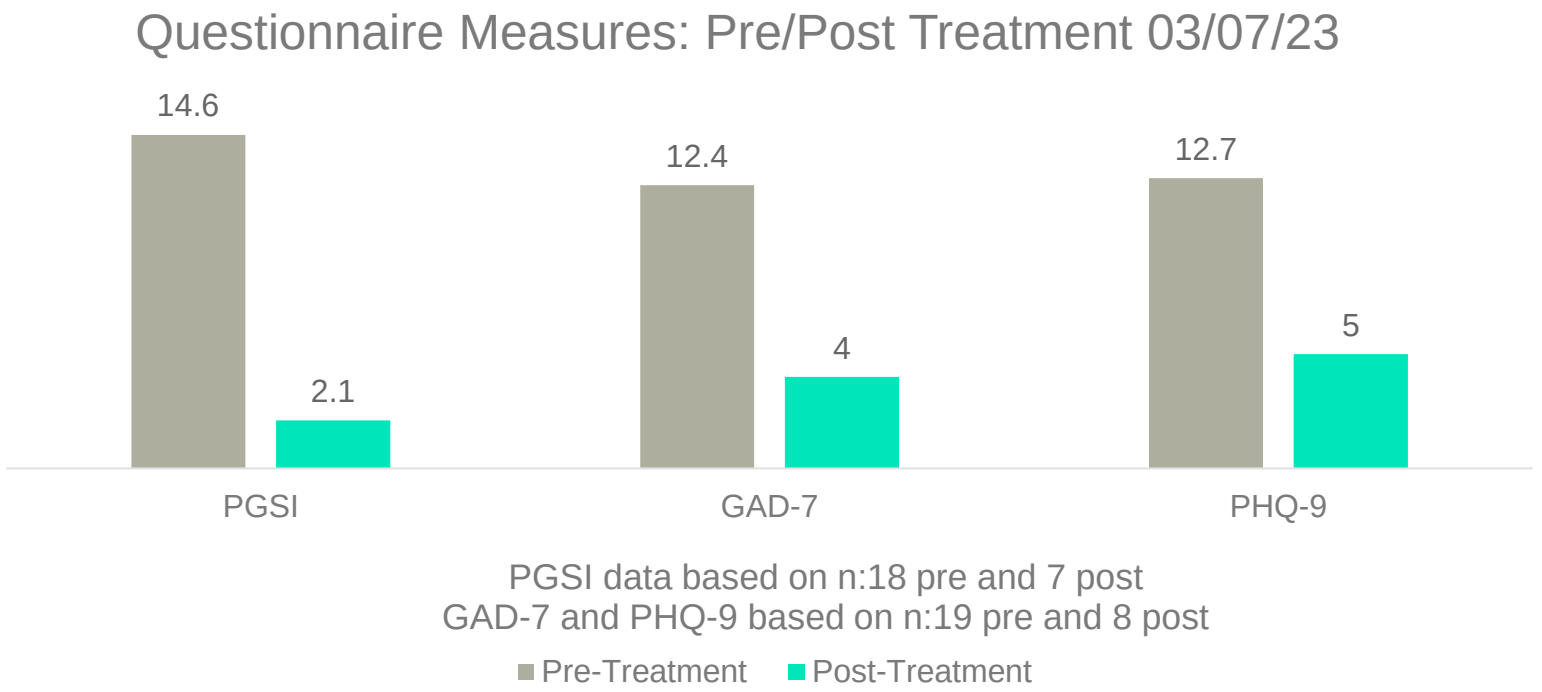
## There is emerging evidence of some medium-term outcomes based on improved post-treatment assessment scores

Treatment gains occur: service users show a reduction in PGSI scores

Treatment gains occur: service users show an improvement in wellbeing survey scores following treatment

**Responses among treatment population to assessment scales:**

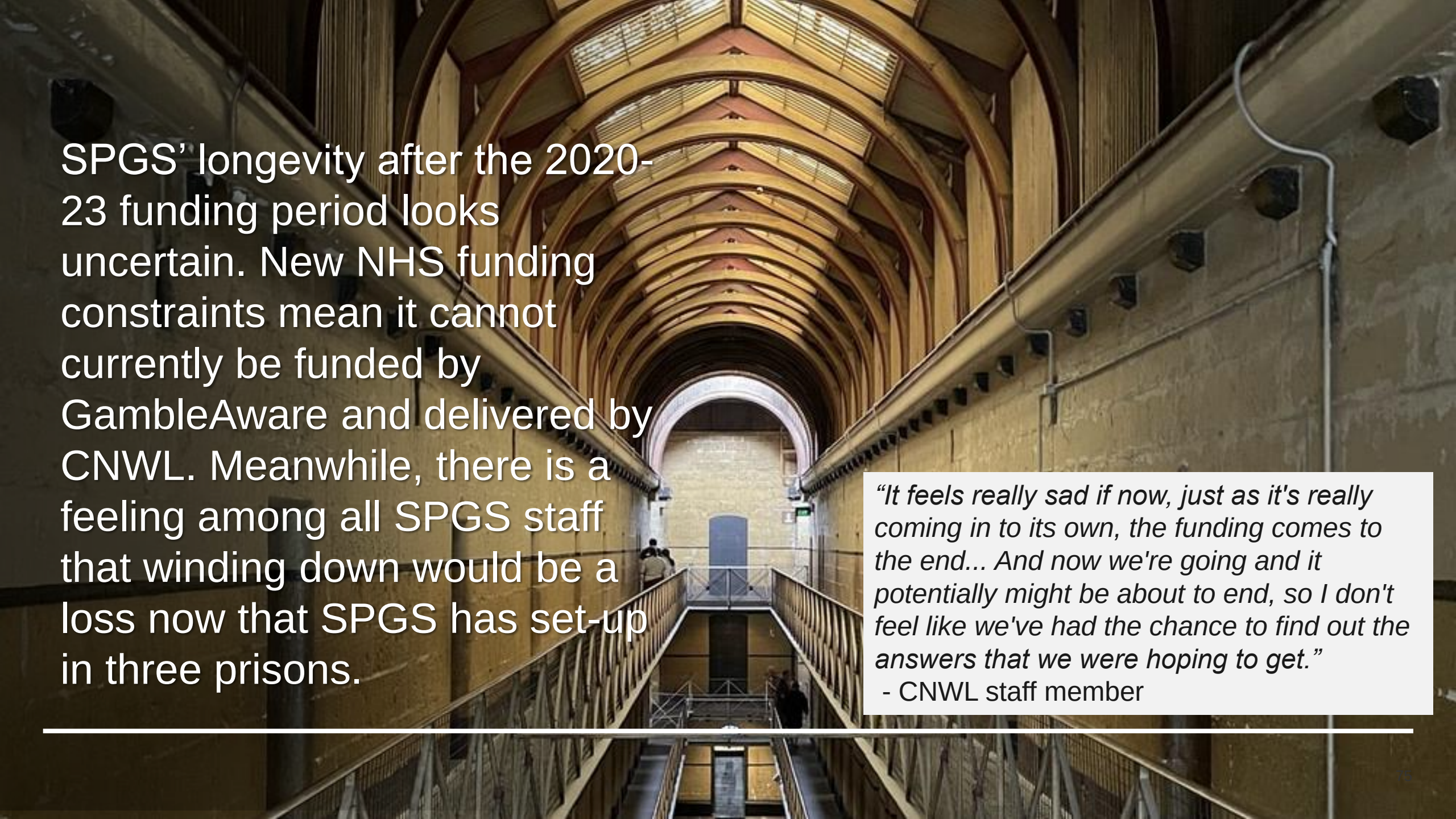
PGSI (Problem Gambling Severity Index); GAD7 (Generalised Anxiety Disorder scale); PHQ9 (Patient health questionnaire)




*Scores of 10 or higher for the GAD-7 and PHQ-9 are typically seen as highlighting issues of concern. A score higher than 1 for the PGSI indicates gambling harm*

| Impacts | Evaluation findings |
|---|---|
| More accurate data forming evidence base for awareness of the prevalence of 'gambling harms' (1+ scores on the PGSI) among prisoners | We could not verify whether enough prisoners were being screened to capture prevalence. |
| Improved knowledge of best practice among healthcare staff for screening and treating 'gambling harms' ' (1+ scores on the PGSI) among prisoners | We could not verify whether this was the case, largely as more time is needed for observing what best practice looks like, but also because without speaking to non-SPGS healthcare staff in the prisons, we could not verify the extent of the dissemination of knowledge around this. It was not in the scope of this evaluation. |
| Established gambling service alongside other healthcare services in five prisons | This is outstanding and dependent on future funding decisions. It was not in the scope of this evaluation. |
| Maintenance of treatment gains whilst in custody | This was not in the scope of this evaluation. |
| Maintenance of treatment gains following discharge from prison | This was not in the scope of this evaluation. |
| A Standard Operating Procedure for managing care pathways in (Surrey) prisons regarding problem gambling including embedding screening | This is outstanding and dependent on future funding decisions. It was not in the scope of this evaluation. |

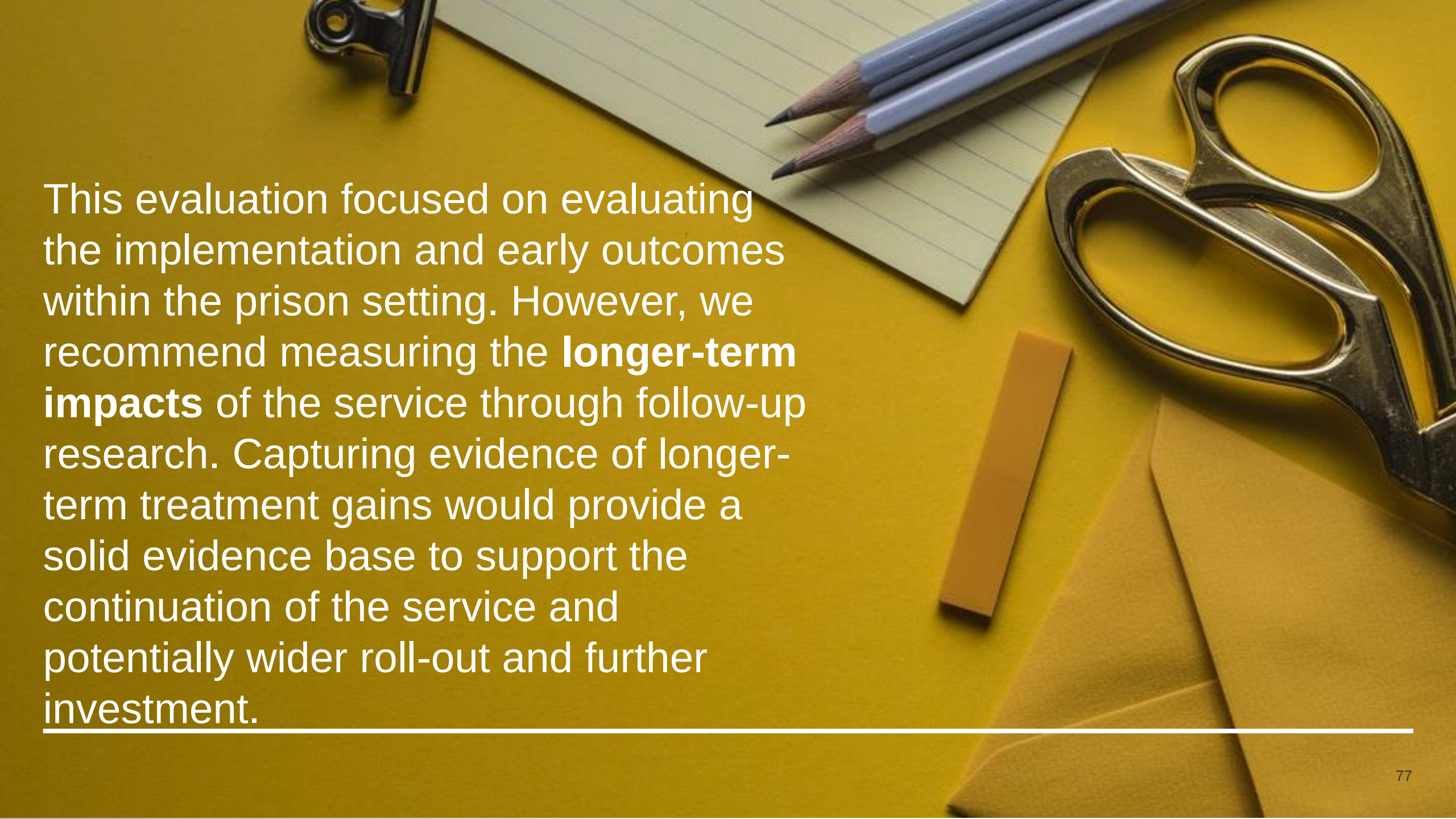
# 9 Longevity



SPGS' longevity after the 2020-23 funding period looks uncertain. New NHS funding constraints mean it cannot currently be funded by GambleAware and delivered by CNWL. Meanwhile, there is a feeling among all SPGS staff that winding down would be a loss now that SPGS has set-up in three prisons.

*"It feels really sad if now, just as it's really coming in to its own, the funding comes to the end... And now we're going and it potentially might be about to end, so I don't feel like we've had the chance to find out the answers that we were hoping to get."*
- CNWL staff member

# 10 Recommendations



This evaluation focused on evaluating the implementation and early outcomes within the prison setting. However, we recommend measuring the **longer-term impacts** of the service through follow-up research. Capturing evidence of longer-term treatment gains would provide a solid evidence base to support the continuation of the service and potentially wider roll-out and further investment.

# Further research and evaluation of the service would strengthen the evidence base by capturing longer term impacts among a broader sample

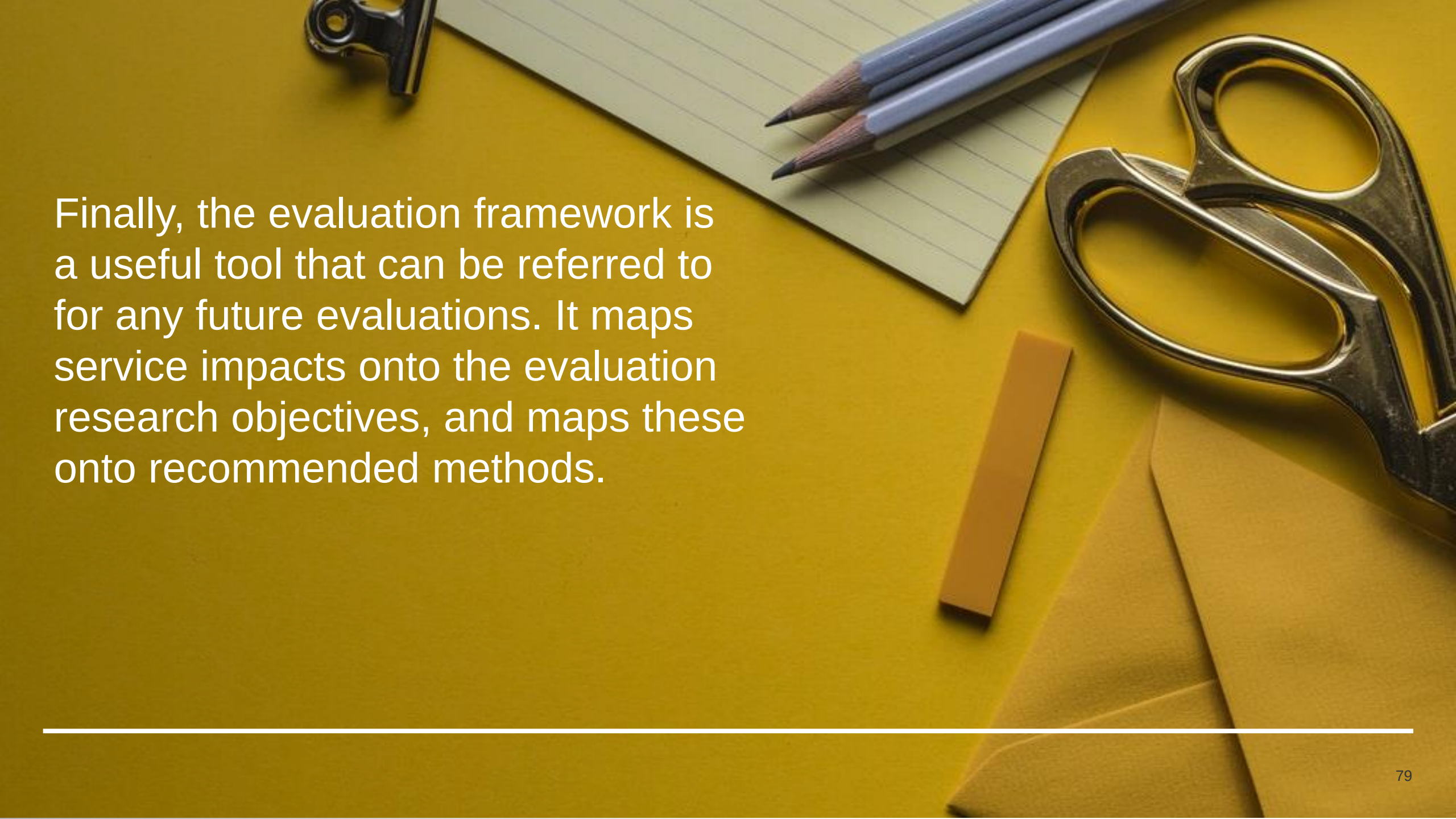
**Longer timescale**

Significant delays in implementation, combined with the intended design of the current evaluation, have meant that just initial indicators of impact have been captured to date. Further evaluation in the future will allow time for SPGS to be rolled-out and embedded in more prisons. Conducting research over a longer timescale will enable a more comprehensive evaluation of the impacts of the service. It is expected that the number of service users will increase, enabling additional analysis of treatment outcomes from a bigger sample.

**Broader sample**

We recommend that further research encompasses additional participant groups to obtain a more holistic perspective on the programme. These should include:

- **Service users**
  - **Current prisoners** who have engaged/are engaging with the service to understand their experiences and views on the service, and to qualitatively explore maintenance of treatment gains while in custody
  - **Released service users** who engaged with the service whilst in prison to provide insight into the longer-term impact of the service outside of the prison environment
- **Additional staff groups**
  - **Prison officers and governors** to understand their awareness, perceptions and views on the delivery and impact of the service
  - **Staff from other prison services** who might be involved in signposting prisoners. They would provide insight on both the process of individuals engaging with the service and its impact on individual prisoners who they work with
  - **Friends and family** of prisoners who have engaged with the service



Finally, the evaluation framework is a useful tool that can be referred to for any future evaluations. It maps service impacts onto the evaluation research objectives, and maps these onto recommended methods.

# The linked evaluation framework maps impacts onto research questions and data sources

**Please open this worksheet to view the evaluation framework (and how research design links to the logic model)**:

| Research question | Impact | | # | Data source |
|---|---|---|---|---|
| I1. What impact has the programme had on service users' health? | Maintenance of treatment gains | **What proportion of service users maintained treatment gains after a certain time period e.g. 3, 6 and 12 months (benchmarks for** | **I1a** | PGSI after treatment |
| | Maintenance of treatment gains following discharge from prison | Did this change after service users left prison? | I1ai | Survey/PGSI with service users after release |
| | Maintenance of treatment gains whilst in custody | **Were there differences in health outcomes between service users who completed treatment and non-service users?** | **I1b** | Survey with service users (and if possible prisoners who refused treatment); wellbeing surveys (by CNWL) |
| | | What factors influenced these differences (e.g. age, gender, sentence length, treatment type)? | I1bi | Survey/interviews/focus groups with service users |
| | | To what extent can these differences be attributed to the programme? What mechanism(s) causes them? | I1bii | Interviews/focus groups with service users and with prison and CNWL staff |
| | All short-term outcomes (for formative evaluation) | **Which short-term outcomes have been achieved or appear on track to be achieved?** | **I1c** | All primary data collection strands |
| | All medium-term outcomes (for formative evaluation) | **Which mid-term outcomes have been achieved or appear on track to be achieved?** | **I1d** | All primary data collection strands |
| I2. What impact has the programme had on gambling treatment in prisons? | A Standard Operating Procedure for managing care pathways in (Surrey) prisons regarding problem gambling including embedding screening | **Has a Standard Operating Procedure for 'gambling harm' (1+ scores on the PGSI) mitigation been created?** | **I2a** | Interviews with senior prison healthcare staff |
| | | To what extent is it being followed consistently across the five prisons? | I2ai | Interviews with senior prison healthcare staff and officers |
| | More accurate data forming evidence base for awareness of the prevalence of 'gambling harms' (1+ scores on the PGSI) among prisoners | **To what extent is screening for 'gambling' harm' (1+ scores on the PGSI) embedded in the five prisons and are there differences** | **I2b** | Interviews with senior prison staff or CNWL reception staff |
| | Improved knowledge of best practice among healthcare staff for screening and treating 'gambling harms' ' (1+ scores on the PGSI) among prisoners | **What impact has the programme had on key stakeholders' knowledge, awareness and practice around 'problem gambling' in the** | **I2c** | Interviews with key senior stakeholders |

| Research objective | Research question | # | Data source options |
|---|---|---|---|
| P1. To what extent is the programme being implemented as planned | **To what extent are prisoners 'at risk' or experiencing 'gambling harms' (1+ PGSI score) being identified by the screening and referral process?** | **P1a** | Interviews with prison healthcare staff; performance dashboard data (to see proportion of patients from each referral route) |
| | What proportion of the prisons' population is being screened e.g. all incoming and existing prisoners)? What factors influence variation across prisons (e.g. sta | P1ai | Interviews with prison healthcare staff; performance dashboard data |
| | Are offenders answering screening honestly? How does the context of when screening takes place impact this? | P1aii | Interviews with prison healthcare staff and SPGS delivery team |
| | How often are prison and healthcare staff identifying and referring prisoners 'at risk' or experiencing 'problem gambling' (1+ PGSI score)? | P1aiii | Performance dashboard data + interviews with key prison staff |
| | What is the prevalence of prisoner self-referral and when does this most commonly occur (by PGSI score)? | P1aiv | Interviews with prison healthcare staff and SPGS delivery team |
| | **How often are service users completing treatment?** | **P1b** | Interviews/focus groups with SPGS psychologists and service users |
| | How well are service users engaging with treatment interventions? | P1bi | Interviews/focus groups with SPGS psychologists and service users |
| | What are the barriers and facilitators to accessing the service? How does this differ amongst prisoners? | P1bii | Interviews/focus groups with SPGS psychologists and service users |
| | **How has COVID-19 impacted SPGS delivery? What opportunities and challenges has it presented?** | **P1c** | Interviews with SPGS delivery team |
| | How has remote treatment been carried out (e.g. chaperoned)? What impact has this had? | P1ci | Interviews/focus groups with SPGS psychologists and service users |
| | Has the amount of remote treatment offered changed from planned? | P1cii | Interviews/focus groups with SPGS psychologists and service users |
| | **How have any changes or adaptations been implemented across the five prisons and why?** | **P1d** | Interviews with SPGS delivery team |
| | **To what extent are treatment interventions appropriate for service users?** | **P1e** | Interviews/focus groups with SPGS psychologists, prison healthcare staff and service users |
| | What treatment interventions are offered to different types of service users? How are decisions made for their treatment plans and to what extent does this va | P1ei | Interviews with SPGS psychologists |
| | Are the methods and content of sufficient quality and suitability to prison settings and different service users? | P1eii | Interviews/focus groups with SPGS psychologists and service users |
| | To what extent is peer support being delivered and experienced? | P1eiii | Interviews/focus groups with SPGS psychologists and service users |
| | How are follow-up check-ins with service users during and post-treatment being delivered? | P1eiv | Interviews/focus groups with SPGS psychologists and service users |
| | How effective are post-treatment follow-up check-ins at supporting and preventing relapse amongst service users? | P1ev | Interviews/focus groups with SPGS psychologists and service users |
| P2. How has the programme been received by key stakeholders (officers, offenders, governors, CNWL and Forward Trust healthcare professionals, others), and why? | **To what extent do staff feel able to deliver the programme and how does this vary across prisons?** | **P2a** | Interviews with SPGS psychologists, CNWL reception staff, prison healthcare staff, prison officers and governors |
| | How well is the programme resourced to support delivery? | P2ai | Interviews with SPGS psychologists, CNWL reception staff, prison healthcare staff, prison officers and governors |
| | To what extent is training of CNWL reception staff to screen prisoners effective and consistent? | P2aii | Interviews with CNWL reception staff |
| | **What lessons have key stakeholders, including the SPGS delivery team, learnt from piloting the programme?** | **P2b** | Interviews with SPGS psychologists, CNWL reception staff, prison healthcare staff, prison officers and governors |
| | What lessons are there about best practice for clinicians and practitioners to mitigate against 'problem gambling' in prisons? | P2bi | Interviews with prison healthcare staff |
| | What lessons are there about how to effectively roll the programme out to prisons outside the Surrey prisons estate, including adaptations that should be mac | P2bii | Interviews with SPGS staff and governors as well as analysis from all primary fieldwork strands |

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