help for problem gamblers

gordon moody association

Impact Report

for the year ended
31 March 2015

Introduction

The purpose of the analysis contained in this Impact report is to provide a continued measurement of the effectiveness of the Gordon Moody Association residential treatment programme. This year saw the long awaited commencement of our pilot treatment programme for women, the details of which are also included at the end of this report.

The outcome information on the residential treatment programme covers the twelve month period, 1st April 2014-31st March 2015 and all 72 male residents who entered for treatment during this time. In addition, this report includes cumulative profile figures which have been created by incorporating previous years' findings therefore profiling 299 people going through treatment.

Information gathered from the standard application forms provides a profile of the resident group including their geographical location, ethnicity, gambling behaviour and the age they started gambling. In addition there is an analysis in the report of the annual amounts residents claim to have spent on gambling alongside their annual incomes.

In addition to the information gathered from the initial application forms, all residents complete a set of questionnaires, including the Christo inventory, PHQ-9, GAD-7, health and social functioning and SOGS. These collectively measure their physical health, gambling activity and its severity, as well as levels of depression, quality of life and anxiety. These are completed at the beginning and end of treatment and provide outcome measurements demonstrating the change achieved and the effects of engaging in residential treatment. Post treatment, individuals are then asked to complete the same questionnaires at regular intervals. This post treatment assessment continues to build further evidence of the longer term effectiveness of the Gordon Moody Association residential programme. An analysis of the CORE-10 which is completed each week of their stay is included in addition to information we have amalgamated from the Psychlops measurement outcomes.

The Gordon Moody Association

The Gordon Moody Association, a registered charity, has been helping to rehabilitate compulsive gamblers through its residential treatment programme since 1971. The treatment programme has been developed over the 40 plus years of working with this client group. The treatment is specifically gambling focused and offers an intense level of support, addressing the extremes of associated behaviours and aiming to rehabilitate individuals by giving them the skills to reintegrate into society without the need to gamble.

The treatment programme has reduced in length over the years from nine months to six months to the current 12 weeks plus two weeks residential assessment (14 weeks in total). The cost of a residential treatment programme is approximately £10,000 per resident and pressure is always on to identify ways of ensuring best practice, effectiveness and value for money. However, the cost to both the individual and to society can be much greater if left untreated. Poverty, family breakdown, criminality, ill health, unemployment and homelessness can all be consequences of the associated behaviours of living with a gambling addiction. By helping the individual to attain long term recovery the cost and negative social impacts are dramatically reduced.

The Treatment Programme

The Gordon Moody Association therapeutic programme for addicted gamblers is recognised internationally as providing a valuable contribution to the treatment of gambling addiction. The support concentrates on identifying the underlying reasons for each individual's compulsive gambling and the associated behaviours. The therapist and client together look for ways of dealing with these issues and devise strategies that enable the individual to avoid a return to addicted gambling. Group living and group therapy act in further support.

It can be a very emotionally intrusive and demanding process and, prior to embarking on the 12 week programme, each individual undertakes an extensive residential assessment over a two week period including a life audit, and other written and oral exercises, that help to explore the particular issues underlying his gambling addiction.

Group meetings help to provide a platform for the individual to learn about his addiction, his own coping styles and techniques, and how they may have helped or hindered him. Residents become familiar with the concept of the need to change and are given new coping tools to help them do so. All are encouraged to support, challenge and question the strength of each other's motivations, commitment to recovery and willingness to change.

Every individual engages in a retrospective process of self-examination openly expressing and exploring the reasons behind his gambling addiction. In addition to this he starts to take responsibility for his own (in many cases criminal) behaviour and the damage done to most of his relationships.

The Gordon Moody Association treatment programme has been developed through years of experience of people living with a gambling addiction. It is based on a cognitive behavioural approach that helps the individual to understand how his thoughts, emotions and behaviour are all connected. Further, it helps him to understand how his coping behaviours have developed, leading up to and within his addiction, and it uses real life experiences of others to educate him and to help him come to terms with his life and make the necessary changes.

Individuals refer themselves, or are referred by friends, family, probation, social or health workers. During their time in the treatment programme residents can expect help and support to address all their problems related to gambling, including health, legal, career, accommodation and debt advice.

The Therapeutic Community

The residential community at Gordon Moody Association is a key feature of the therapeutic process. It provides support for residents who may have destroyed all the relationships they have had in life or are struggling in dysfunctional ones.

The support of others who understand exactly what they are feeling and experiencing helps them to come to terms with who they have become. It helps them to separate judgement of their behaviour from a global judgement of themselves.

Being part of a community allows them to accept and work towards trusting the therapeutic process particularly if other residents are able to share their experiences with them. If they can see them adopting new behaviours and benefitting from the process they are more likely to engage in it themselves.

Good and problematic relationships and dynamics in a therapeutic community enable the individual to identify and explore his own communication and behaviour. Some of these he may be in denial of but in a supportive environment and without feeling judged he is able to reflect on other relationships he may have had and why they broke down.

There are usually many skills that individuals have not developed or that have been damaged by years of living with a gambling addiction. They may lack practical and/or social skills which can be a source of shame or embarrassment to them. Within the supportive residential environment they are helped to overcome these feelings, and are helped to learn and to grow by people who may have experienced similar problems themselves.

This in outline is the theory behind the Gordon Moody Association treatment programme. Does it work? The following analysis attempts to show that it does.

Outcome Measures

When entering the assessment phase of the treatment programme all residents are asked to complete a set of questionnaires with a view to assessing their gambling behaviours, the consequences of them, and their emotional and physical state as well as their level of functioning. Members of staff also complete a questionnaire before the commencement of treatment to record the resident's physical appearance, and his general level of mental and emotional wellbeing. This process is repeated at the end of treatment with a view to capturing how the therapeutic process has improved his overall wellbeing.

The following information has been collected from the case notes of 72 residents treated during the period April 1st 2014 to 31st March 2015. It captures the recorded levels of functioning and emotional state of all the men both at the beginning and end of treatment, together with the average improvement of those who started and completed treatment during that time.

For the post treatment outcomes the same questionnaires have been completed by ex-residents at regular intervals after they have left the residential programme.

The Psychlops measurement was administered at the beginning of the therapeutic process (during assessment), midway (at 6 weeks) and end of therapy (12 weeks).

The CORE-10 questionnaire has been used weekly and residents have been asked to complete this at the beginning of the weekly "'how's your week been" meeting.

Changes shown in outcome measures

Christo Inventory

When residents enter the treatment programme they are evaluated by their residential therapist on the Christo scale. This screen is a rough indicator, based on opinion through observations of the individual, about how he is functioning socially, his general health, gambling activity, psychological functioning, his occupation if any, his financial and legal situation, whether there is thought to be any substance abuse, what support he may currently have, what he is like to work with and how compliant he appears to be at that point. This screening tool is also used at the end of the programme by the same member of staff; at which point it would be hoped to see an improvement across all measures, as a representation of progress each resident has been able to make in his recovery.

Figure 1

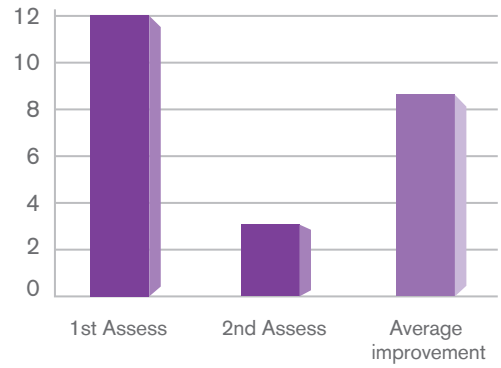


Figure 1 shows that individuals who were resident between 1st April 2014 and 31st March 2015, scored on average 12 on the Christo scale upon entering the programme (assess 1) and 3.3 upon completion of the treatment programme (assess 2).

For the 43 residents that completed during this period the average improvement score on this assessment was 8.56

PGSI – Problem Gambling Severity Index

This self-report screening tool is completed by the individual as part of his assessment on arrival for treatment, and again when he has completed the treatment programme. It is designed to capture a snapshot of the individual's gambling behaviour over the last six weeks, and some of the consequences of it.

The score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "never," "sometimes," "most of the time," and "almost always," respectively, and adding together the scores for the nine questions.

The higher the score the greater the risk that the person's gambling is a problem.

0 = Non-problem gambling, 1-2 = Low level of problems with few or no identified negative consequences, 3-7 = Moderate level of problems leading to some negative consequences, 8 or more = Problem gambling with negative consequences and a possible loss of control

Figure 2

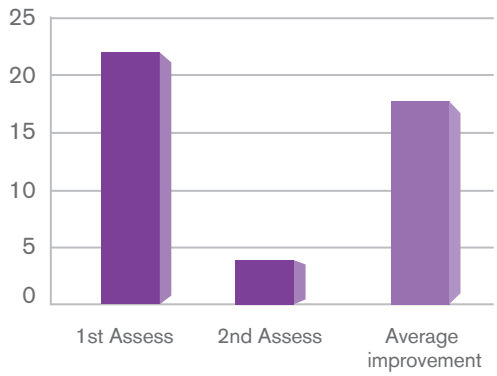


Figure 2 shows that individuals who were resident between 1st April 2014 and 31st March 2015, scored on average 22.24 on the PGSI score upon entering the programme and 4.0.on completion of the treatment programme.

For the 43 residents that completed during this period the average improvement score on this assessment was 18.24

PHQ-9 – Patient Health Questionnaire

The Patient Health Questionnaire (PHQ-9) helps identify depressed individuals and was designed as a tool to determine the level of treatment required for patients in the primary care setting. It is a nine-item depression assessment which relies on the self-report of the individual. In the context of the Gordon Moody Association assessments it asks the individual to report on the last two weeks. The score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively, and adding together the scores for the nine questions.

Scores of 5-9 indicate minimal symptoms, 10-14 minor depression to major depression with mild symptoms, 15-19 major depression with moderate/ severe symptoms, and > 20 major depression- severe.

This is completed upon entry to the programme and again on completion of the treatment programme.

Figure 3

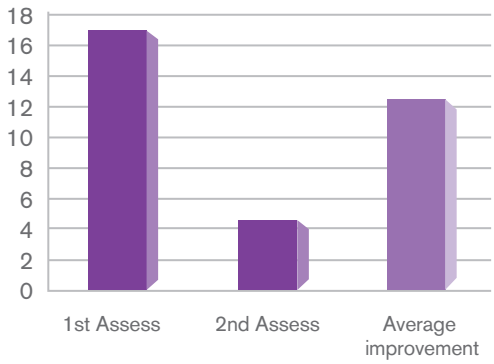


Figure 3 shows that individuals who were resident between 1st April 2014 and 31st March 2015, scored on average 17.04 on the PHQ-9 scale upon entering the programme (assess 1) and 4.56 upon completion of the treatment programme (assess 2).

For the 43 residents that completed during this period the average improvement score on this assessment was 12.48

GAD-7

This self-administered patient questionnaire is a screening tool and severity measure for generalized anxiety disorder. It consists of 7 questions which are designed to capture the level of anxiety that the individual has been experiencing over the last two weeks. The score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively, and adding together the scores for the seven questions.

Scores of 5, 10, and 15 are taken as the cut off points for mild, moderate, and severe anxiety respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Figure 4

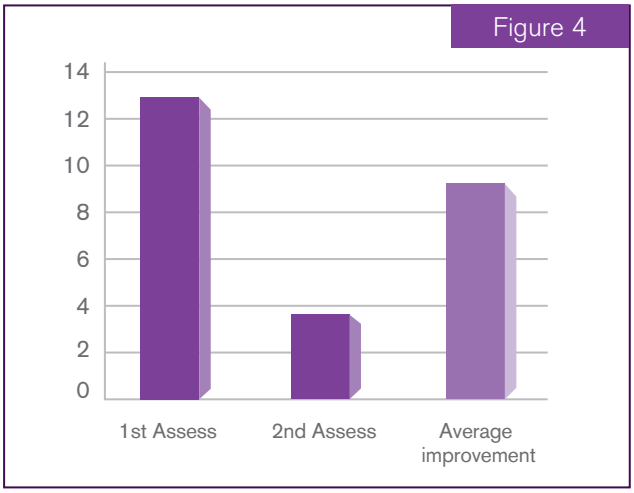


Figure 4 shows that individuals who were resident between 1st April 2014 and 31st March 2015, scored on average 13.2 on the GAD-7 scale upon entering the programme (assess 1) and 3.86 upon completion of the treatment programme (assess 2).

For the 43 residents that completed during this period the average improvement score on this assessment was 9.4

Subjective Health and Social Functioning

This is a screen that asks the individual to rate their overall psychological and physical health and their quality of life. In the context of the Gordon Moody Association programme the individual is asked to answer with regards to the last 28 days. It is a scale that was adapted from the TOP questionnaire (treatment outcomes profile) that was developed through working with people with substance abuse issues. Here, the higher the score at assess 2 shows that the individual feels they are doing better in these areas.

Figure 5

Figure 5 shows that individuals who were resident between 1st April 2014 and 31st March 2015, scored on average 23.2 on the Health and Social functioning Scale upon entering the programme (assess 1) and 46.83 upon completion of the treatment programme (assess 2).

For the 43 residents that completed during this period the average improvement score on this assessment was 23.6

SOGS – The South Oaks Gambling Screen

SOGS is a 23-item questionnaire based on DSM-III criteria for pathological gambling. It asks a series of questions to determine the severity of the gambling behaviour of the person completing it. The scores on the SOGS are determined by scoring one point for each question that shows the "at risk" response indicated and adding the total points. The maximum score being 20, 0 = no problem with gambling, 1-4 = some problems with gambling, 5 or more = probable pathological gambler.

Figure 6

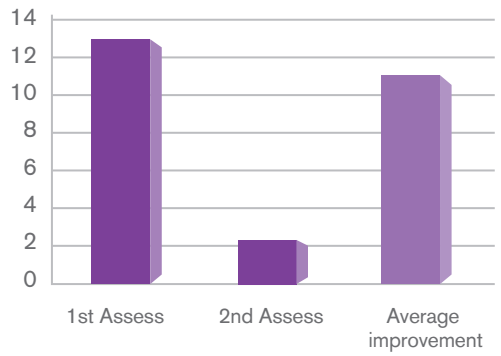


Figure 6 shows that individuals who were resident between 1st April 2014 and 31st March 2015, scored on average 13.06 on the SOGS Scale upon entering the programme (assess 1) and 2.3 upon completion of the treatment programme (assess 2).

For the 43 residents that completed during this period the average improvement score on this assessment was 11.08

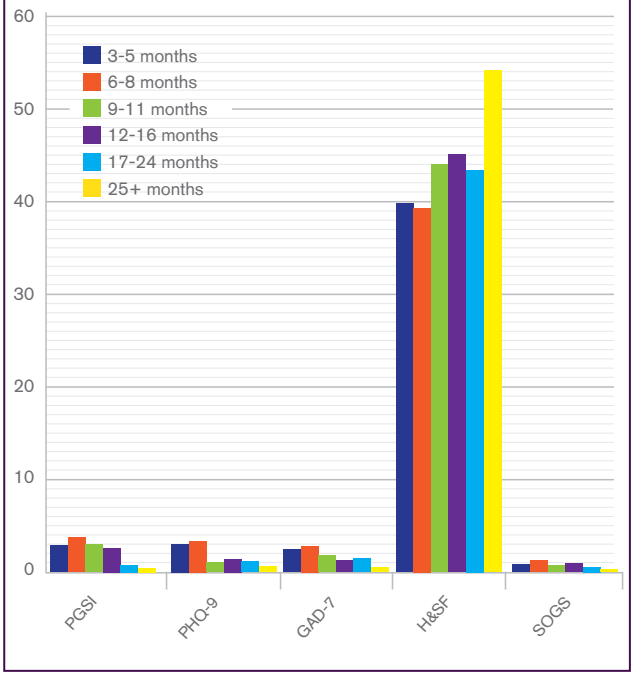
Longer Term Impact

It is evident that our outcomes demonstrate an improvement on measures during and at the end of the treatment programme. However, it is important to establish evidence of what happens to people once they leave and whether they are able to sustain the changes in lifestyle and the positive impact on their behaviour. It is with this evidence that we are able to determine the real value of our treatment and its effectiveness.

76 people in total have now given us post treatment measurements by completing the questionnaires, thus helping us to build a clearer picture of the longer term impact of our treatment programme.

Figure 7 below illustrates the average scores recorded at intervals following treatment.

Figure 7



These figures demonstrate that the outcome measures achieved at the end of treatment are sustained. Of course it is more likely that those who are doing well in their recovery may be happier to complete the questionnaires and therefore the figures are representative of those people who have responded and not all those who have completed treatment.

Not all 76 responders completed questionnaires at every interval and the graph is representative of the following:

66 responses at 3-5 months post treatment.

39 responses at 6-8 months post treatment

26 responses at 9-11 months post treatment

22 responses at 12-16 months post treatment

16 responses at 17-24 months post treatment.

7 responses at 25+ months post treatment

We continue to collect these outcomes and over time

the figures will provide a more robust picture. However even with this limited data it appears that many people who engage in our treatment programme are learning long term coping strategies that are impacting positively on their overall health and wellbeing and quality of life in general.

Psychlops Measurement outcome

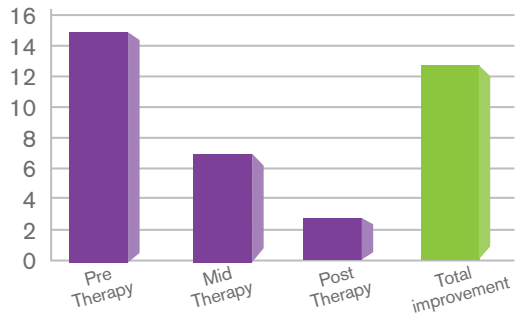
The Psychlops questionnaire collects information on each individual's specific issues; then throughout the therapeutic journey it measures how they change in relation to their issues. The questionnaires are administered pre-therapy (before the intervention begins), mid-therapy (halfway through, in this case 6 weeks) and end of therapy (when the intervention is coming to a close, in this case 12 weeks).

This measure introduced in 2012 has provided additional insight into the effectiveness of the treatment programme in dealing with and supporting each client's needs as identified by the individuals themselves. Based on the issues they specified, the individuals all showed a marked improvement in terms of how they felt throughout their therapeutic journey. The graph below illustrates the average pre-, mid- and end scores together with the average total change score.

Scores on Psychlops Measures

Figure 8 below shows the average scores of the group at each stage, i.e. pre, mid and end of therapy. It also shows the average total change in score pre and post therapy.

Figure 8



Calculating the Psychlops change score

The change score is the central quantitative outcome measurement of Psychlops. The change score is the difference between the total pre-therapy score and the post-therapy score. If the score falls then the client has improved, if it rises they have deteriorated (in terms of this form of self-report).

The average pre-therapy score for the group during this year was 15.39 Their average post-therapy score was 2.77 indicating an average total change of 13.09.

Calculating the Psychlops effect

The effect size is the way in which change can be quantified and compared to other outcome measures. An effect size of 1.0 means that the mean Psychlops score has reduced by one standard deviation following therapy. In health service research it is considered that an effect size above 0.8 is large.

Effect Size

The results showed, with a standard deviation of 4.15 an effect size of 3.04 thus demonstrating a hugely significant improvement in scores across the therapeutic process.

CORE – 10

The CORE 10 evaluation form is administered every week at the beginning of the 'how's your week been' meeting.

It is a short 10 item questionnaire that is used as a screening tool and outcome measure and it covers the following items:

Anxiety (2 items), depression (2 items), trauma (1 item), physical problems (1 item) functioning (3 items - day to day, close relationships, social relationships) and risk to self (1 item). The measure has 6 high intensity/severity and 4 low intensity/severity items.

CORE 10 allows us to verify/ gauge how residents are feeling at points where they may not necessarily verbalise it. Each resident is able to review his progress on a timeline graph throughout his journey and is able to see the progress he is making; he can also observe emotional patterns against life events which reinforces the notion that they are connected.

For the purpose of this report an illustration of the typical patterns of total score throughout the recovery journey has been included; figure 9 below shows the average of the scores of residents at weekly intervals. The first two are the assessment weeks (plus a 3rd assessment week for the few who needed an extra week to settle in) followed by each treatment week. In using this tool in practice the scores would be calculated and entered on a graph. Any score under 10 comes below clinical cut off and below 5 is classed as healthy and 3 comes under risk cut off. A score of 40 would be classed as severe, 25 = moderate severe, 20 = moderate and 15 = mild.

It is noted that our residents are scoring just under moderate within their first week in residential assessment. This potentially could represent the fact that they are in treatment and feeling more supported. However as we do not have any data prior to entry we could not confirm this.

By week 12 the average score of our residents in this period is 4.85, showing a definite reduction in score across all items.

Figure 10 shows the continued record of individuals after they have completed the residential treatment programme. It is inclusive of those who were in halfway accommodation in Dudley and Beckenham and those who attended outreach appointments. The graph shows that the average scores throughout, apart from week 11,16,18, remain under the healthy score. Potentially the spikes could represent crisis points in which they have been affected adversely by life events. However, the fact that the scores come back down quickly would suggest that their coping responses are effective and they are maintaining an emotional equilibrium.

Figure 9

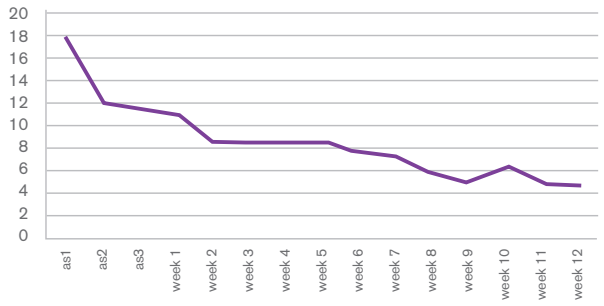
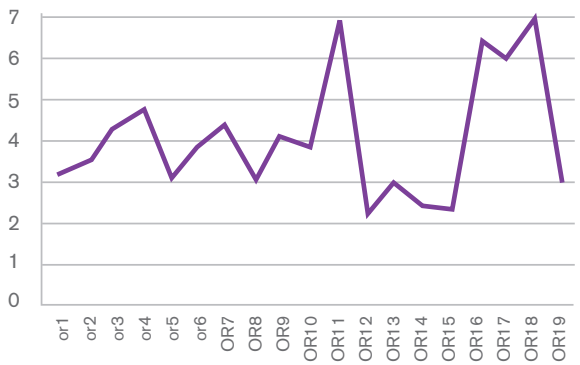


Figure 10



Profiles of Gamblers assessed April 2011 to March 2015

During the application process monitoring information is collected about prospective residents. The information gathered not only allows the therapeutic team to assess each applicant's suitability for the treatment programme but also generates a picture of general trends within this client group. This information has been taken from all those who have been resident at both residential centres during 2014/15 and added to the figures from last year's report to create a cumulative figure of 299 people throughout 2011/15.

Age started Gambling

During the time period involved in this report the age range of the residents was from 19 to 57 with the average age being 33.

Upon entry we record the age when they report they started gambling and the results are shown in figure 11 below. Most would have started gambling as a social pastime with friends and family which then progressed to them using gambling as a means to escape. For some this may have happened quite rapidly but for others this will have developed over a period of years. The point at which it became a problem varies but for most it coincides with a period of trauma or stress, created by external pressure that for various reasons they do not have the capacity to deal with.

Figure 11

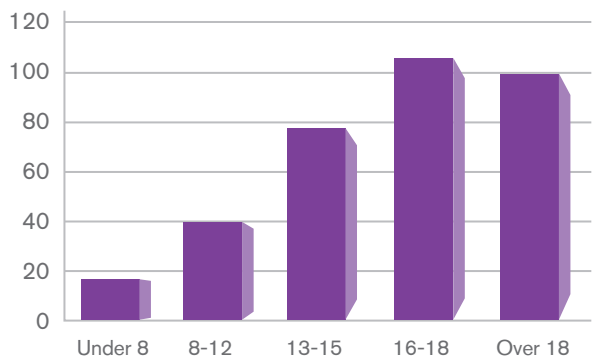
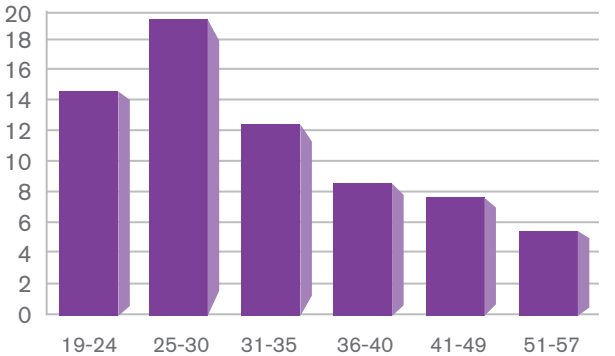


Figure 12 shows the age of people when they entered treatment.

Figure 12



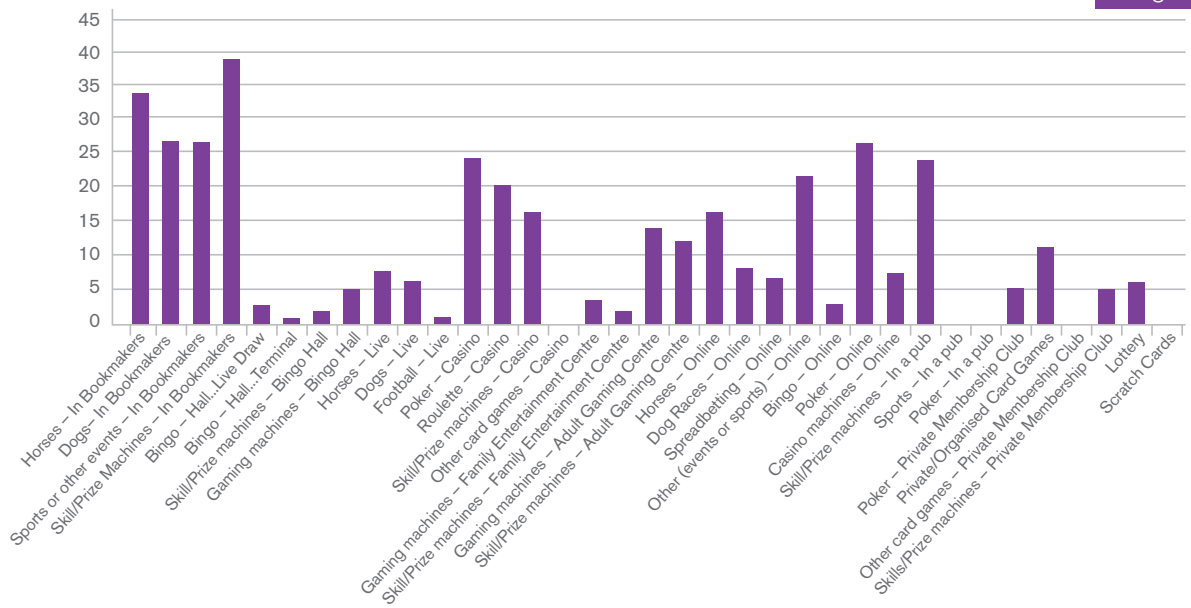
Gambling Styles

In previous years it has not been possible to report on this due to the absence of clear and agreed terminology that ensures accurate reporting; however now this has been established we are able to include the recorded gambling styles for the residents who entered for treatment during the period included in this report. We will endeavour to add to this figure over the coming years in order to contribute to the body of knowledge of this client group.

One of the questions asked at application stage is what styles of gambling individuals typically use. Most of the residents record several styles of gambling and some will

gamble on any available source; however most of them will demonstrate a preference for a particular style of gambling. The graph (Figure 13) below represents the styles recorded upon application for treatment.

Figure 13

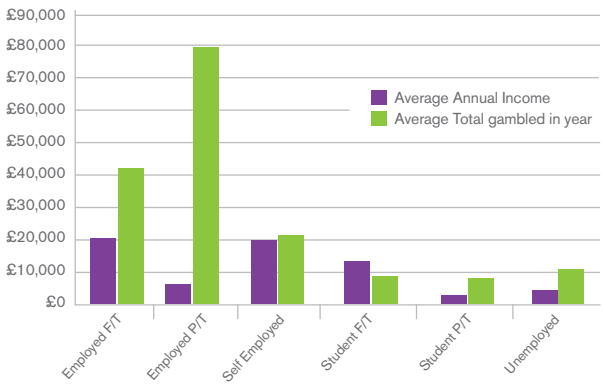


Employment Status and Amount Spent on Gambling Per Year 2014/2015

Figure 14 illustrates the recorded amounts gambled per year against employment status of all residents who responded to this question in 2014/15; a total of 54 people.

When people come into treatment we typically discuss the amounts they have been gambling over a timeline as a percentage of their income (rather than actual amounts). This can help with giving them perspective of the extent of their problems and also identify acceleration points in their history. It can also be useful to demonstrate the potential cost to society as anything over 100% may suggest the level of debt they would be accruing and or crime to fund their gambling.

Figure 14



Obviously this can vary – some just manage to stay within their income but often they are gambling with 80-100% and still have to find the money to live on. Of the 54 people who stated their income and gambling amount for this period the average amount gambled was 1.3 times their income prior to coming into treatment.

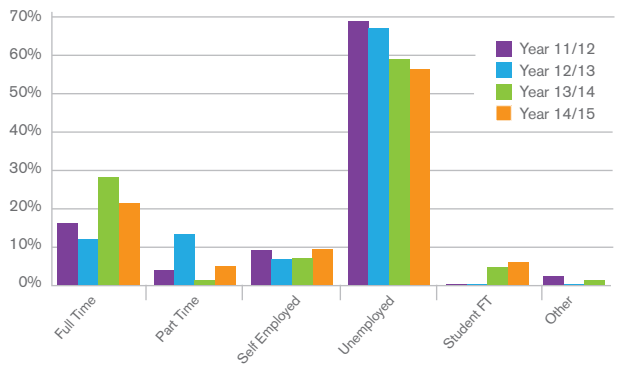
For the year April 14 to March 15 the actual reported amount gambled by the 54 people who answered was £170,615.38 with a total recorded debt amongst them of £1,795,286.

To include the figures from the people involved in previous years, the total reported amount gambled between 2011-2015, by the 245 people who disclosed the information included in these reports is, £6,791,699.

Last year we mentioned that we may be seeing an indication of change in the employment status of those coming into treatment. As you can see in figure 15 over the last 3 years there has been a steady decline in the percentage of clients who are unemployed and a corresponding increase in those in employment. During this period this trend appears to have continued in that there are less unemployed and although the full time employed number has gone down there is a rise in part time, self employed and student figures.

It would be interesting to learn whether this is an indication that people might be seeking treatment sooner and before they have reached the point where they are unable to keep a job.

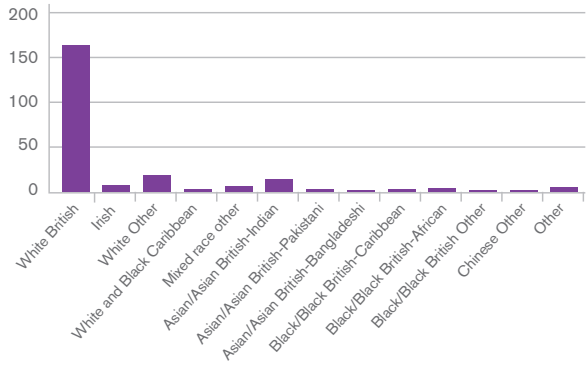
Figure 15



Ethnic Origins

The self-reported ethnicities of the applicants are recorded and the ethnic mix of those people that have received help from the Gordon Moody Association residential treatment programme over the combined years 2011/2015 are shown in Figure 16. The majority of our client group are White British which may be representative of the prevalence of problem gambling in Great Britain or it may be that this group find it easier to access our service. Whilst national data is not collated in terms of ethnicity for problem gambling the Gambling Prevalence Survey 2010 records that gambling as an activity was highest among male respondents who were White/White British.

Figure 16

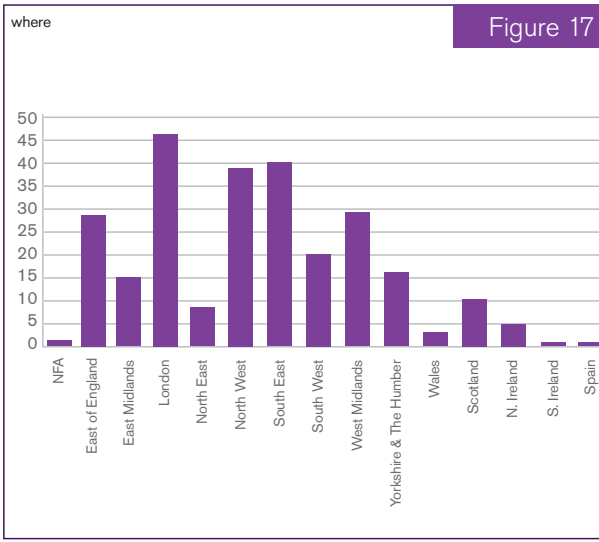


Where Residents were living prior to entering Treatment

The residential centres are located quite a distance apart from each other and wherever possible residents are placed in the centre at a distance from where they normally live, with a view to enabling them to create a very different life for themselves. Being away from the environment and the people who may be contributing to or reinforcingn their gambling lifestyles can be part of helping them to change their behaviour.

Figure 17 illustrates all the people coming into treatment 2011/2015 and their geographical location prior to coming into Gordon Moody Association.

Figure 17



Cost to Society

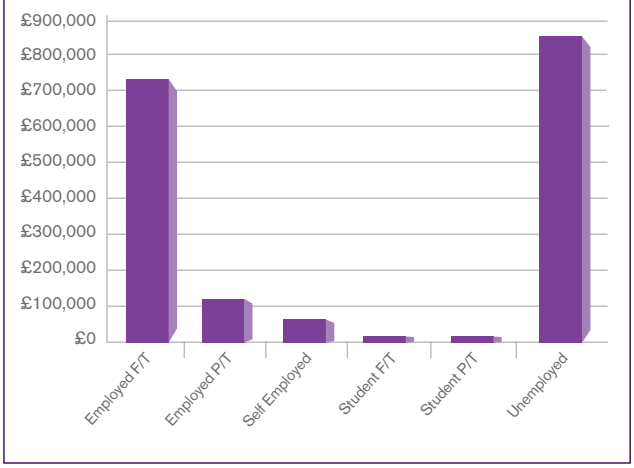
The cost to society should not only be counted in terms of the financial cost to individual problem gamblers and their families but should also be measured in terms of the devastating impact on mental and physical health, family relationships, employment and quality of life thus demonstrating the wider social impact of problem gambling.

Financial cost

The total amount of debt reported by the 54 people recorded this year is £1,795,286.

Figure 18 illustrates the total amount of debt for each category in this period.

Figure 18



13 in employment showed a combined debt of £721,136 - an average of £55,136 per person. With an average annual income of £24,212.

2 in part time employment reported a combined debt of £127,550 - an average of £63,775 per person. With an average annual income of £8,000.

4 were self employed and showed a combined debt of £77,250 - an average of £19,312.50 per person. With an average income of £23,500.

2 were students and showed a combined debt of £17,480 - an average of £8,740 per person. With an average income of £10,500.

33 of the people recorded in this year's report were unemployed and had a combined debt of £851,870 This is an average of £26,723 debt per person with an average annual income of £5,435.

These are sizeable amounts in comparison to their income to have to find on top of living expenses, and will have been borrowed from family and friends, high street money lenders, pawnshops and loan sharks.

Many Gordon Moody Association residents also report that families remortgage their houses and go into debt themselves in order to try and help sort out the problems of their son, partner or brother.

Some may choose or be forced into bankruptcy and society then carries the rest of the debt. If court costs are involved this adds to the total financial cost.

Criminality

Many resort to illegal activities to fund their addiction including stealing from their loved ones and their employers as well as turning to other illegal ways of making the money to gamble.

If a problem gambler turns to crime then police time, court costs, probation services and prison services and other support services need to be factored into the cost to society. The average cost per prisoner was estimated by NOMS in 2013/14 to be £33,785.

Health services

Whilst problem gambling has not until recently been recognised as a health issue and no funding is currently available for treatment from the NHS, health services are often involved as many problem gamblers develop physical and mental health issues as a result of stress, anxiety, depression and the effects of other risk taking behaviours. Research in the US, Canada and Australia suggests that there is a higher rate of suicide amongst problem gamblers.

It is clear to see that the issues and costs associated with any problem gambler can extend far beyond what they physically spend on gambling and helping the recovery of one individual will have a much wider social impact.

Affected Others

In addition to the financial implications of a problem gambler, when we are working with residents we are also always acutely aware that as desperate as things are for them in terms of how badly their lives have been affected, there are always others who have been equally affected. This may be directly in the case of significant others and their families, these are the people who have probably suffered the most. They will have been lied to manipulated and been at the receiving end of some very erratic and, in a lot of cases, quite hostile and abusive behaviour. At the very least their loved one is likely to have been absent both physically and emotionally.

The effects of the poverty caused by the gambling on their children can be devastating as has been mentioned, low economic status is well documented as contributory to developmental issues and the behaviours that stem from that.

The criminality of a parent, which has also been mentioned from a financial perspective, can also have a devastating effect on the life path of a developing child.

In 1996, Farrington, Barnes and Lambert interviewed juvenile offenders and found that 53% of them had a family member with a criminal conviction, suggesting that children who have experienced criminal activity within their family have a high potential for offending behaviour themselves.

Lack of love, lack of supervision, family disruption, criminal behaviour, substance and mental health problems in parents have all been found to be contributory factors in themselves to offending behaviour in adolescents (Turner et al,2009).

Further, Yoshikawa (1995) identified a combination of particular risk factors associated with delinquency and adult crime which increased the likelihood of delinquency:

- lone parenthood and low economic status
- insecure attachment to parent made worse by life stress and low social support
- parental criminality made worse by family conflicts
- poor or harsh parenting made worse by marital discord

All of these identified risk factors that are antecedents of antisocial and criminal behaviour will have been experienced by the children of a problem gambler in different combinations.

46 of the 72 residents who came into treatment in 2014/15 recorded that their relationship with a partner had ended because of their gambling. 21 of them had one or more children, 30 children in total.

12 residents had criminal convictions as a result of their gambling addiction, with a total of 17 children between them.

All of these children have been exposed to some or all of the risk factors that may adversely affect their life path and a combination of risk factors makes future problems more likely.

Applications over last 12 months

Application Process

We have continued to see an increase in applications within this year in the number of people applying for treatment.

We had 341 applications for treatment.

132 of these initial applications were not progressed further as contact was lost .

42 changed their mind and withdrew during preliminary assessment.

4 were sent to prison so were unable to continue.

1 (an ex-resident) was directed to outreach as a more appropriate service.

5 were declined

26 applications were still being assessed at the end of March 2015.

131 were offered a residential assessment and 72 people entered for a two week residential assessment and of those 72, 60 successfully completed the two week residential assessment and went on into treatment. 12 people chose or were asked to leave which remains comparable to previous years.

Although this year saw our highest recorded number of applications thus far it is of importance to note that a high number of people dropped out following their initial application. It is difficult to say exactly why that would be however we are able to speculate with some confidence that this highlights the process that many people go through when contemplating change. As it is so easy to apply to us this can be done in a moment when they are experiencing the consequences of their situation. The fact that they are in some discomfort forces action. When they have had time to calm down they may still be aware of the problem but less committed to take action. In many cases people will go through this process several times before they really come to terms with their situation and commit to recovery.

Referrals

Gordon Moody Association continues to welcome referrals from any source and figure 19a indicates sources during April 2011 to March 2015 (299 who entered residential assessment across four years).

Self-referrals continue to be the largest percentage for the year 14/15, which accounted for 51% of all applications. Figure 19b shows a comparison of referral source over the four year period.

Figure 19a

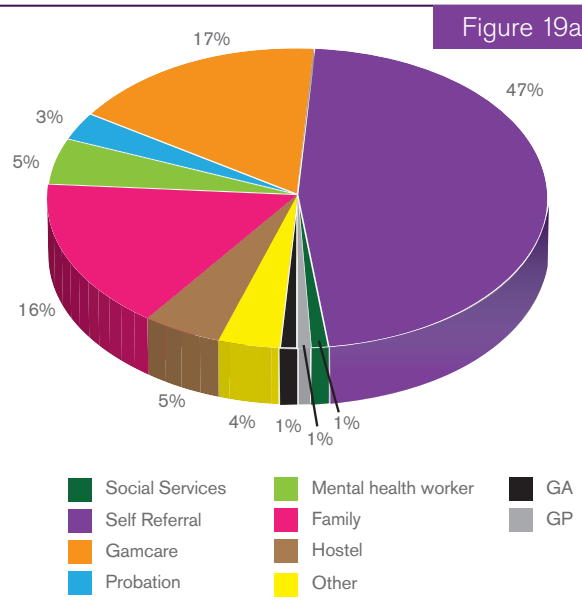
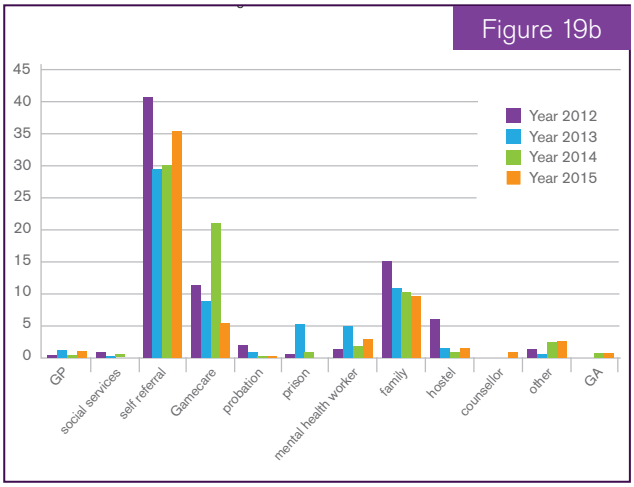


Figure 19b



Assessments Offered

When an application is processed and the person is considered suitable, he is offered a residential assessment in order for him to have the time to consider if he wishes to engage in the treatment programme, and for the therapeutic team to assess his willingness to engage. This takes the form of a two week residential assessment which if successful creates the platform for the beginning of the 12 week treatment programme.

Number of Residents

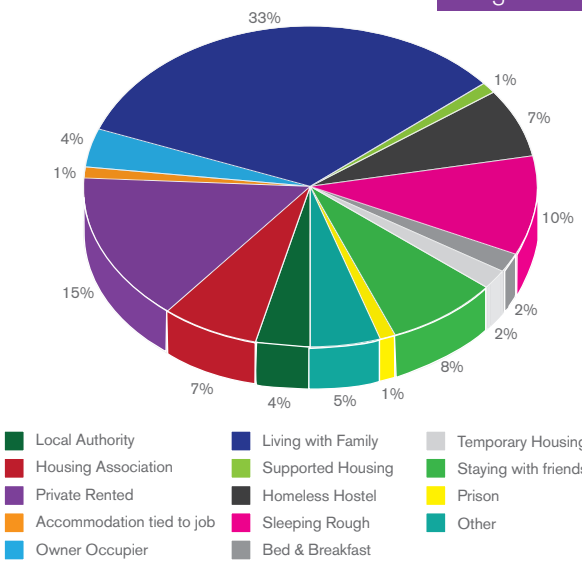
During April 2014 to March 2015, 87 people in total received residential treatment. At the beginning of this period 15 people were in residence already (as such are not included in this year's figures but in the cumulative) and 72 accepted the assessments offered, 12 people did not complete the assessment and 60 entered treatment. During treatment 11 people chose to leave and treatment was withdrawn for 4 people at the end of the period 17 people were still undergoing treatment. During this period 43 people completed treatment.

Accommodation status upon entry

People join the programme from many different types of accommodation. Some are still living with their families but for others this isn't an option as these significant relationships have broken down; they may be living with friends or in temporary accommodation such as bed and breakfast. Some have managed to retain their own homes but others are homeless, sleeping rough or living in hostels. Others will have committed crimes as a result of their addiction so will be in prison but do not wish to leave to the same lifestyle so apply for treatment following the end of their sentence.

Figure 20 shows the different accommodation types over the last 4 years of the 299 people who have come into our residential centres for treatment.

Figure 20



Outreach Service

Through the years of working with people in this environment it has been identified that quite often it is when people first leave the treatment programme that they are most vulnerable and need extra support.

The outreach service was developed in 2004 to provide half way accommodation and support for those residents who weren't ready to live completely independently and to provide outreach support to others who had completed the treatment programme and returned home or set up home elsewhere, but who needed some continued contact and support to prevent relapse. An outreach worker is attached to each residential centre and peer support groups are facilitated online through the Gambling Therapy website which also provides support for those who are not geographically able to access face to face outreach support.

Across the Dudley and Beckenham residential centres an estimated 80-90 ex-residents are supported in varying degrees at any one time, some of whom will contact the service less frequently than others dependent on need. There are also ex-residents who completed

their treatment some time ago who will make contact occasionally and 'drop in' for a top up session or just to touch base.

At the Dudley site there are 10 halfway house beds and at Beckenham there are four.

People in the halfway accommodation engage in the relapse prevention programme and are expected to do so as part of their stay there. This work enables them to further personalise the work they have done and cement what they have learnt about themselves during treatment. At the beginning of their stay they agree on a set of goals that they wish to pursue and are supported in doing so.

For example if during the programme they came to realise that the type of work they were doing was facilitating their gambling, or the lifestyle that enabled it, they may wish to retrain. They are offered employment support and helped to source training, voluntary work and so on.

Similarly, if they have identified that their previous location prior to treatment was too entrenched in their gambling, they will be offered relocation support.

The outreach service also supports individuals to access counselling if there are mental health or emotional issues that make moving on difficult for them. Additional support is given to them during this time; as experience shows that at times of emotional stress they are more vulnerable to gambling, as it has in many times in their life provided pain relief from the things they find problematic. Even if gambling is not a direct result the behaviours that become more prominent during times of stress can cause situations that lead to gambling. For example they may be less tolerant within interpersonal relationships, more impatient and so on, causing conflict with those around them. As a result they require more support to work through these issues so they don't spiral out of control and lead to gambling.

Through this continued support Gordon Moody Association is able to facilitate a more secure recovery for all those who choose to access it. Therefore it reduces the long term need for interventions and sets people up for a more independent life. In future evaluations it will be useful to compare post treatment outcomes for those who use outreach and those who don't.

Women's service

Introduction

From our previous experience of running a residential treatment programme for women we discovered some common obstacles that typically prevented them from getting the help they so desperately needed.

Many of them were so shameful of the predicament they found themselves in that they would not admit to the people around them what they were doing, or the extent of the mess they had got themselves into. As such going away from home for any length of time would mean that they had to tell people.

Generally we found that women really struggled with letting those around them know how desperate they were feeling, many of them describing the concept of letting the side down if they admitted they couldn't cope. They would be more worried about how those around them would cope if they couldn't see them as a rock for them anymore. There was a real perception with some of them that they were not entitled to acknowledge their own feelings and that everyone else's were far more important than their own. Many of them felt they were some kind of failure by admitting that there were some things that they just couldn't cope with. Further, that to go away and leave them to tend to their own needs would be a really selfish thing to do.

Generally we found that women tend to retain their sense of responsibility for those around them when they are struggling with an addiction; where they would still function to tend to everyone else's needs at their own expense. The knock on effect of which would be their own increasing need to gamble to deal with the mounting pressure they were feeling to keep everything together, despite the inner turmoil that would be going on within them.

A New Model For Treatment

With these factors in mind we wanted to create something that allowed women to have something that cut across these obstacles; whilst providing a programme that gave them the support and nurturing environment that people get form a residential setting.

We wanted to bridge the gap between the convenience of outpatient sessions and the intense level of supportive treatment that residential provides.

As such we came up with a new model of treatment that consists of:

An initial retreat style residential programme that lasts for 4 days and 3 nights.

- Set in a rural retreat within a therapeutic community facilitated by 3 therapists

Followed by 12 weeks of 1-1 outpatient style support sessions.

- A choice of face to face /telephone sessions
- Online/Skype sessions

Plus a 2 weekly exclusive group facilitated by one of the therapists

A second retreat style residential programme that lasts for 3 days and 2 nights.

- Returning to the therapeutic community in the same setting facilitated by the same therapists.

The women are then able to access our outreach service in which they have ex-resident online groups they can attend as well as full access to our online facility with the Gambling Therapy department of GMA.

Content of Programme

The existing GMA treatment programme is designed to make people examine themselves, their lives to date and really get to grips with the issues affecting them. It is a very emotionally intrusive and demanding process which is designed around the fact that individuals have a lot of support to help them through it.

In deciding what to include in the women's programme we were acutely aware that they would not have the same level of support outside the retreat, and that we needed to create a programme that would deal with the necessary issues whilst not pushing them too much thus creating more emotional pressure than they were already experiencing.

The pieces of work that we chose from the GMA residential treatment programme were the more practical solution-focussed pieces. They focus on the coping skills they need to acknowledge how they feel day to day without being fearful, to understand that how they are feeling is connected to the triggers around them, to know what those triggers are and ultimately to give them the tools to cope with them rather than gambling without understanding why they are doing it.

If they are able to work in this way they are then able to secure the here and now and get some gambling free time behind them. With the mental clarity that this brings they are then able to start dealing with the underlying reason for why they gamble without needing to gamble to deal with how that process makes them feel.

The weekly one to one support focuses on helping them continue this work, discussing what they have been experiencing and helping them retain perspective and their emotional equilibrium. The underlying issues for their gambling are explored at their own pace; so whilst this is difficult for them, the therapist is able to do this based on what they feel they are able to cope with at that time and within context of what going on for them generally.

In the final retreat the elements of the relapse prevention programme are delivered that are in context with the work they have already done. This focuses on helping them to redesign their lifestyles using the information they have learned about themselves over the 12 week period. They are helped to do this using a real perspective of how their gambling mind set can re-emerge if they continue with a lifestyle that does not support their needs, and takes into account the real pressures that life poses. Their own potential/ talents and qualities are used as a focus in order to increase their levels of self efficacy which is so important for them moving forward. They are then able to continue on their recovery journey knowing what they need to do and have set realistic goals to make it happen; giving them the all important sense of hope and control over their own lives.

The Pilot programme: January 2015

Being used to working with a rolling programme which harnesses the use of an established culture for change; we were initially aware of the potential problems that may occur with bringing in a cohort of people at the same stage in their recovery.

We had 7 women who came together in the cohort on day 1 of the retreat and initially, as one would expect, not knowing us or each other, they were very nervous. The group as a whole presented as very polite and quite guarded. However by the end of their first day they were starting to share their experiences and relaxing with each other.

On the second day you could see that a safe environment had been created and people were really starting to talk about their issues, allowing themselves to get emotional and to deal with the things that were really affecting them.

On the third day we could see real friendships forming which seemed to provide a platform that allowed them to delve into their deeper issues; the mutual trust and care of the people around them really appeared to help them move forward. Some were also making plans to catch up and be part of each others' lives after the programme.

On the fourth day there were some real anxieties coming up for them, as they were then dealing with the fact that they were back out on their own having to deal with the life they had left outside. However this appeared to be balanced in terms of the fact that they knew that they would be continuing to work together and would be meeting again in 12 weeks. So it seemed that they no longer felt as alone as they had before.

During the twelve weeks of support all of the women worked well with the two therapists; both of whom felt that the women engaged with them well and were benefitting from the treatment. They felt they were beginning to process their lives and all the stresses of them with a more balanced approach and reasoned, measured thinking process.

All of the 7 women came back for the second retreat and the friendships that had formed in the first retreat had cemented during the 12 weeks. Most of them had kept in touch at some level, some more so than others, and they had formed a real support network for each other which they felt had made them feel stronger and more able to deal with their day to day lives.

On the first day they seemed to pick up where they left off; the environment was again a secure and safe place where they could be open about the real issues they had been dealing with.

On the second day some real anxieties - and the behaviours that go with them - emerged, creating almost a sense of panic within the group. However this served as a very good platform to allow themselves to show their natural anxieties, whilst acknowledging their ability to deal with them. It served as a very good motivational tool that they were in actual fact far more in control than they were when they started the process with us.

On the third day they were naturally anxious about their future and the things they knew they still had to deal with, but far more determined and ready to put their plans for the future into action even looking forward to it.

Outcomes

At the end of the first retreat, despite their natural anxieties about going home, all of the women left with a stronger resolve and a sense of a better understanding of why they had been gambling. They all had a plan in terms of the things that they needed to put in place to move forward into a gambling free life and felt that they had the ability to carry out those plans. They were generally aware of any obstacles that would prevent them from doing so, and were of a mind-set that even if they could not be remedied immediately, their reaction to them could change.

Six weeks into the pilot programme all but one of the women were attending regularly to their sessions and one had been intermittent.

The weekly group was well attended and 4 of the 7 used it consistently, 2 of the others used it intermittently and 1 had no access to internet so did not use it at all.

One of the women was gambling regularly but had managed to confine it to once a week and was managing to work within a budget. She accepted at that point that what she was doing was a holding response and was working to reduce it further.

The other six have reported a couple of lapses in response to crises but were predominantly not gambling at that stage.

When they came to the second retreat all but one of the women discussed having had experienced some gambling during the 12 week period. But at the 12 week point were experiencing longer periods of gambling free time.

Two of the women discussed regular gambling at this point. The one unfortunately was also experiencing other co-morbid mental health issues, which was making reasoned and controlled thought difficult. She was still experiencing manic episodes of gambling with little success in controlling her own impulses.

The other was an older woman who had been struggling to create a different lifestyle that facilitated her recovery. However, she made great strides in doing that whilst at the final retreat, so it is hoped that this may have further enhanced her recovery and her need to gamble has been dealt with.

The women all showed improvements in terms of how they were able to rationalise what they were thinking and feeling. This better enabled them to mentally process what they were dealing with, with regards to their emotions and domestic/day to day problems. They discussed their experiences with a clearer understanding of how they think and feel and how they are connected to the behaviours that lead to gambling. The general sense of chaos also appeared abated and all women exhibited a better sense of being in control and being aware of the elements within themselves and their lives that they need to change and/or deal with differently.

Outcome Measures

We set out to provide some concrete outcome measures to demonstrate the overall effectiveness of the pilot.

At the beginning of the first residential retreat we asked all of the women to complete the GMA self assessment questionnaire and in order to get a comparative measure they also completed them at the end of the final retreat.

Core-10 forms were completed at the beginning and end of the residential retreats and were repeated weekly in their 1-1 sessions.

The GMA questionnaire includes the following screening tools:

PGSI - Problem Gambling Severity Index

This self report screening tool is designed to capture a snapshot of the individual's gambling behaviour over the last six weeks, and some of the consequences of it.

The score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "never," "sometimes," "most of the time," and "almost always," respectively, and adding together the scores for the nine questions.

The higher the score the greater the risk that the person's gambling is a problem.

0 = Non-problem gambling, 1-2 = Low level of problems with few or no identified negative consequences, 3-7 = Moderate level of problems leading to some negative consequences, 8 or more = Problem gambling with negative consequences and a possible loss of control

PHQ-9 - Patient Health Questionnaire

The Patient Health Questionnaire **(PHQ-9)** helps identify depressed individuals and was designed as a tool to determine the level of treatment required for patients in the primary care setting. It is a nine-item depression assessment which relies on the self report of the individual. In the context of the Gordon Moody Association assessments it asks the individual to report on the last two weeks. The score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively, and adding together the scores for the nine questions.

Scores of 5-9 indicate minimal symptoms, 10-14 minor depression to major depression with mild symptoms, 15-19 major depression with moderate/ severe symptoms, and > 20 major depression- severe.

GAD-7

This self-administered patient questionnaire is a screening tool and severity measure for generalised anxiety disorder. It consists of 7 questions which are designed to capture the level of anxiety that the individual has been experiencing over the last two weeks. The score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively, and adding together the scores for the seven questions.

Scores of 5, 10, and 15 are taken as the cut off points for mild, moderate, and severe anxiety respectively.

Subjective Health and Social Functioning

This is a screen that asks the individual to rate their overall psychological and physical health and their quality of life. In the context of the Gordon Moody Association programme the individual is asked to answer with regards to the last 28 days. It is a scale that was adapted from the TOP questionnaire (treatment outcomes profile) that was developed through working with people with substance abuse issues. The higher the score shows that the individual feels they are doing better in these areas.

SOGS -The South Oaks Gambling Screen

SOGS is a 23-item questionnaire based on DSM-III criteria for pathological gambling. It asks a series of questions to determine the severity of the gambling behaviour of the person completing it. The scores on the SOGS are determined by scoring one point for each question that shows the "at risk" response indicated and adding the total points. The maximum score being 20, 0 = no problem with gambling, 1-4 = some problems with gambling, 5 or more = probable pathological gambler.

Core 10

Is a short 10 item questionnaire that is used as a screening tool and outcome measure and it covers the following items:

Anxiety (2 items), depression (2 items), trauma (1 item), physical problems (1 item) functioning (3 items - day to day, close relationships, social relationships) and risk to self (1 item). The measure has 6 high intensity/severity and 4 low intensity/severity items.

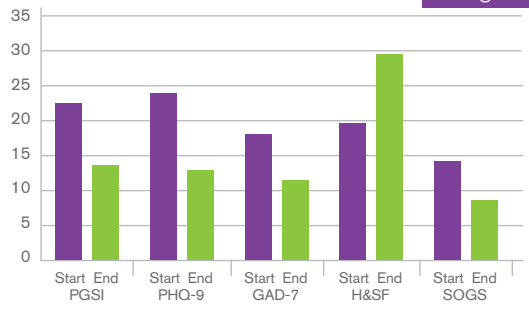
The CORE 10 allows us to verify/ gauge how residents are feeling at points where they may not necessarily verbalise it. It allows a view of how each individual is progressing on a timeline graph throughout his or her journey observing emotional patterns against life events which backs up the notion that they are connected.

Any score under 10 comes below clinical cut off and below 5 is classed as healthy and 3 comes under risk cut off. A score of 40 would be classed as severe, 25 = moderate severe, 20 = moderate and 15 = mild.

Results

The graph below indicates the average scores of the cohort on each measure in the questionnaire at the start and end of the programme.

Figure 21



PGSI

The scores from the group demonstrate an overall improvement on this measure, (22 – 14) and although they would still be categorised as a problem gambler based on this measure there is an indication of a possible better level of control.

PHQ-9

The scores on this measure indicate an overall improvement from the average of 23.7 on the first score to 13.3 on the second. This indicates a shift from major depression with severe symptoms to minor/major depression with mild symptoms.

GAD-7

The scores on this measure indicate an overall improvement from the average of 17.7 on the first score to 12.3 on the second. This indicates a shift from severe anxiety to moderate.

H&SF

The scores on this measure indicate an overall improvement from an average of 19.6 on the first measure to 29.4 on the second suggesting that the group were feeling that they were doing better in these areas and their quality of life was improved.

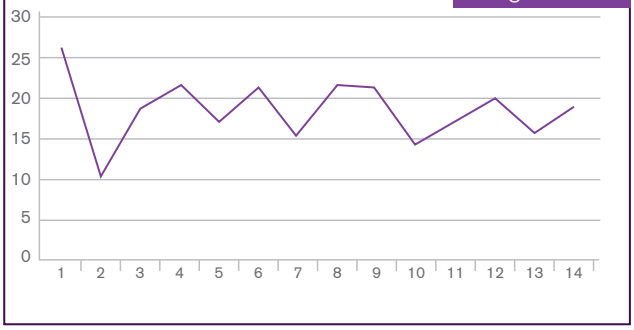
SOGS

The scores on this measure indicate an overall improvement from an average of 14.3 on the first measure to 8.6 on the second suggesting that although both scores are still in the pathological category there is a decreased level of gambling behaviour.

Core 10

The graph below indicates the average scores of the cohort on Core 10 at the start and end of the first retreat, during each week of the programme and start and end of the final retreat.

Figure 22



The graph demonstrates a gradual reduction in scores between peaks. This may suggest that despite the fact the women are still reacting to their life negatively there is a potential improvement in terms of how they are feeling and managing this. The dramatic dip on the second score indicates the initial value of the first residential retreat and how much better they were feeling at the end of it. There is also a dip prior to coming on the second retreat. There is an incline on the final score, however it is not as high as previous scores, again indicating that although they have natural anxieties potentially they are dealing with them better than they were.

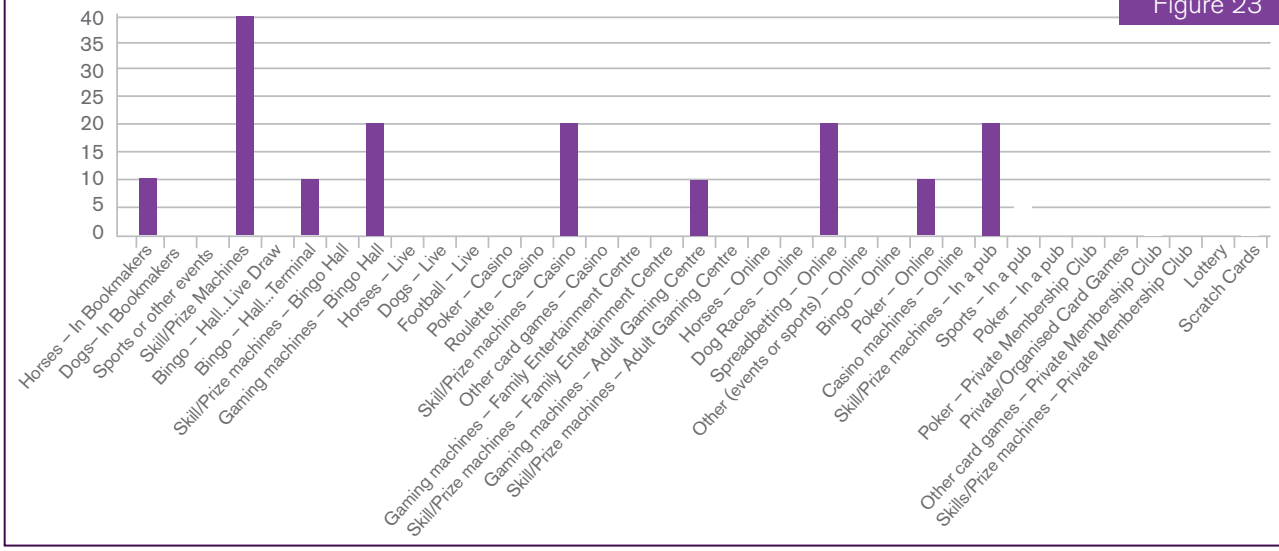
Profiles

Age range of the 7 women on admission:

24,34,37,44,50,56,73.

Their self reported Gambling styles are shown in figure 23

Figure 23



Employment Status and Income (Figure 24) against Average Amounts gambled per year (Figure 25).

Figure 24

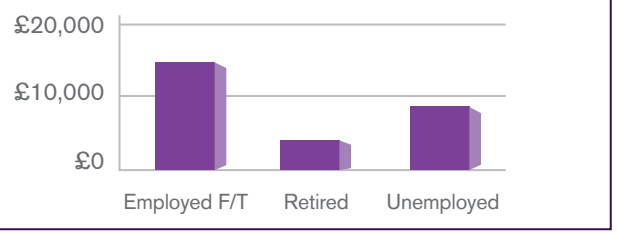
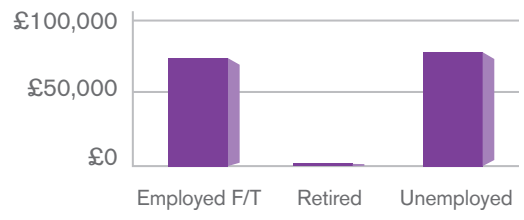


Figure 25



5 were unemployed, 1 retired and 1 worked full time

One woman was full time, had a debt of £81,000 with an annual income of £15,000.

5 were unemployed, had a total debt of £83,300 and an average income of £4,600.

The retired woman did not record any debt.

Age started gambling

1 was 16-18

5 were over 18

Conclusion

The cohort for this pilot study showed improvement on all measures used suggesting that the programme has demonstrated value. These improvements although in some cases not substantial are still encouraging that this treatment model provides women with a viable platform with which to address their problems. Given the extent of their gambling, and the complexities of the accompanying problems and behaviours they were exhibiting at the beginning of the pilot, we feel that the improvement they made will facilitate a long term recovery process for them.

The feedback we received from the women participating in the programme was that we have created a model they found incredibly helpful that the process was really creating a springboard for a successful recovery.

Evaluation

The benefits of this model

Poulstone court was an excellent choice in venue. It provided a protective environment away from the pressures of 'the real world' that allowed the group to focus on themselves. The peace and quiet (no tv's, radios or wifi) offered a no distraction environment, as such the group very quickly came together and started working therapeutically.

The healthy food provided by the staff was an excellent way of re enforcing the need for self care. The women were eating healthy food that they may have not tried otherwise and very quickly felt the benefits of eating well and looking after themselves and how this can improve their mental well being in a very short time.

Within the timeframe that we had the group bonded really well and created a very supportive environment that facilitated many emotional breakthroughs within the group. All of the women expressed a feeling of safety and security that allowed them to explore what they needed to. Being in a community of other women allowed them to see themselves through a different perspective; that there were other women there who they liked despite what they had done and the way they behaved on occasion. As such they were forced to see that they weren't that bad themselves. Further, all the things they had typically been saying to themselves were not actually true and how damaging that has been for them.

Having people around who understood them allowed them to accept that they are not intrinsically bad people; that their behaviour and how they feel about themselves is due to their gambling addiction and that there is commonality with other people. This gave them a sense of control, that they were able to do something about what they were experiencing and it's not something fundamentally wrong with them self.

They were able to see them self through other's eyes, they were accepted and were even able to find humour in some of the things they had done, hence take the power out of them. They were able to make friends and be part of a supportive group again giving them more a sense of control over their own lives. They no longer felt isolated.

Recommendations for future programmes

The number of women in this cohort worked with the environment and the three facilitators present. We were able to provide the intensive level of support that the women required whilst keeping the groups fluid and interactive.

In the first retreat, having a cohort of residents, some still in gambling mode, arriving together meant that the level of intervention needed initially was very intense and relentless. Also, in the second retreat the levels of anxiety within the group were heightened due to their feelings of vulnerability, knowing that the treatment was coming to an end. From a management perspective this made the delivery and maintenance of a therapeutically supportive environment quite draining. With the number of women to staff ratio we had this was managed well but raises the question of the optimum number in any one cohort.

We would not wish to increase the number by many as there is also the potential to lose the inclusive dynamic through sub group formation. As such we would only ever recommend for future programmes a maximum of 10 women in any one cohort. This will allow a few more places to allow for the demand but will hopefully retain the therapeutic process we experienced with this pilot.

Some of the women asked that we would provide them with additional information, with regards to external support in their respective areas. That this could help them widen their support and deal with the other issues they were experiencing, alongside of and because of their gambling - for example debt support agencies, bereavement counselling and so on. We will be including this in what we provide for future programmes.

We also found that whilst undergoing the 12 weeks between retreats there was a need for some kind of structure that would keep them working practically on the things that typically come with being in recovery. With this in mind we have constructed a 12 week workbook/diary that will keep them more focussed on the work they need to do. We are hoping this will also enhance the sense that they are still working with us and not on their own.

Conclusions

The outcomes described in this Impact report continue to demonstrate the effectiveness of our residential treatment and its ability to successfully rehabilitate compulsive gamblers, in addition to the new model created for women and again are a testament to the hard work, dedication and proven expertise of Gordon Moody Association and its staff.

The coping strategies that residents are embracing are facilitating long term change and the post treatment figures are beginning to give us a clearer picture of the longer term effect.

The 4 year cumulative figures are beginning to provide a more robust picture of the demographic profile of the problem gamblers who seek residential treatment. The intention is to build on this every year and to help identify and contribute to identifying trends and significant patterns within this client group.

Future Evaluation

This report is the fourth of a series which has begun to explore the information gathered about people who have been helped by the Gordon Moody Association residential treatment programme. External research initiatives have begun to answer some of the questions asked about the best ways of treating severely addicted problem gamblers. Questions such as:

- What are the factors which lead to people becoming problem gamblers?
- Are there certain styles of gambling which tend to be used by problem gamblers?
- How high is the relapse rate in ex-residents?
- What measures enable people to remain problem free?

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help for problem gamblers

gordon moody association

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PDF versions of this report and previous versions are available to download from www.gordonmoody.org.uk

How to access help

Should you know of someone who might benefit from our residential treatment please go to our website www.gordonmoody.org.uk and submit an online application form or email help@gordonmoody.org.uk or call us in confidence on 01384 241292 for an application pack or to discuss next steps.

How to support our work

As a charity we rely on the support of other interested parties and we are keen to engage and collaborate with people and organisations who share our concern. If you would like to discuss how you can get involved as a partner, donor, volunteer or trustee; or to help in any other way please contact **elaine.smethurst@gordonmoody.org.uk**

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