help for problem gamblers

gordon moody association

Impact Report 2013

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. Following on from last year's report there is an inclusion of post treatment outcomes which begins to demonstrate the impact of the residential programme and its effectiveness as a method of treatment that facilitates long term change and therefore its cost effectiveness as a treatment provision.

The outcome information included in this report covers the twelve month period, 1st April 2012-31st March 2013 and all 65 residents coming into the Gordon Moody Association for treatment during this time across both residential centres. In addition, this report includes cumulative profile figures which have been created by incorporating last year's findings therefore profiling 150 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 our standard application forms, all residents fill in a set of questionnaires, to include 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 repeated at the end of treatment and provide outcome measurements demonstrating the change achieved and the effects of engaging in residential treatment. The same questionnaires have been sent to those who have completed the treatment programme for completion, with a view to continuing this at regular intervals. This post treatment assessment will provide further evidence of the longer term effectiveness of the Gordon Moody Association residential programme and is reported on for the first time in this Impact report.

During this year the Psychlops measurement tool was also introduced, with the permission of Kings College London, as part of the evaluation of the Dramatherapy pilot with Roundabout Dramatherapy group at the Beckenham residential centre. The brief findings are included in this report. However a separate report is available which gives a more in-depth analysis. It was also felt appropriate to use the same measurement at the Dudley centre, not as a comparison, but because Psychlops as a tool provides a useful means of recording the issues identified by the client group to be important to them through their therapeutic journey, and enables them to see a difference in terms of how they feel about them throughout that journey.

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 40 years of working with this client group (men and women in previous years though currently men only). The treatment is specifically gambling focused and offers an intense level of support, addressing the extremes of associated behaviours, aiming to rehabilitate individuals by giving them the skills to integrate back 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. The cost to both the individual and to society can be extensive if one considers the wider implications. 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 looking at what it is within each resident that made him gamble and the associated behaviours that came with it. Then the therapist and client together look for ways of dealing with these issues and devise strategies that avoid a return to addicted gambling. Group living and group therapy act in further support and the programme takes twelve weeks to complete.

It can be a very emotionally intrusive and demanding process and, prior to embarking on the 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.

The 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 that where it is needed. All are able commonly to support, challenge and question the strength of each other's motivations, commitment to recovery and willingness to change.

As a result, 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 many 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 facilitates the element of 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. From this perspective they are then able to see a way out of the cycle they are stuck in which facilitates motivation for change.

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. These may be practical and/or social and can be a source of shame or embarrassment to them. Within this supportive environment they are helped to overcome these feelings, thus helping them to learn and 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 to record the resident's physical appearance, and their general level of mental and emotional wellbeing before the commencement of treatment. This process is repeated at the end of treatment with a view to capturing how the therapeutic process has improved their overall wellbeing.

The following information has been collected from the case notes of 65 residents treated during the period April 1st 2012 to 31st March 2013. 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 varying time intervals after they have left the residential programme.

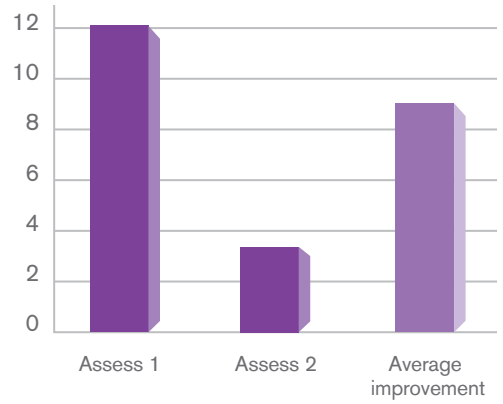
The Psychlops measurement was administered at the beginning of the therapeutic process (during assessment) mid way (at 6 weeks) and end of therapy (12 weeks).

Changes shown in outcome measures

Christo Inventory

When residents come into the treatment programmes 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



The graph above (Figure 1) shows that individuals who were resident between 1st April 2012 and 31st March 2013, scored on average 12.07 on the Christo scale upon entering the programme (assess 1) and 3.03 upon completion of the treatment programme (assess 2).

For the 41 residents that started and completed during this period the average improvement score on this assessment was 9.07

PGSI - Problem Gambling Severity Index

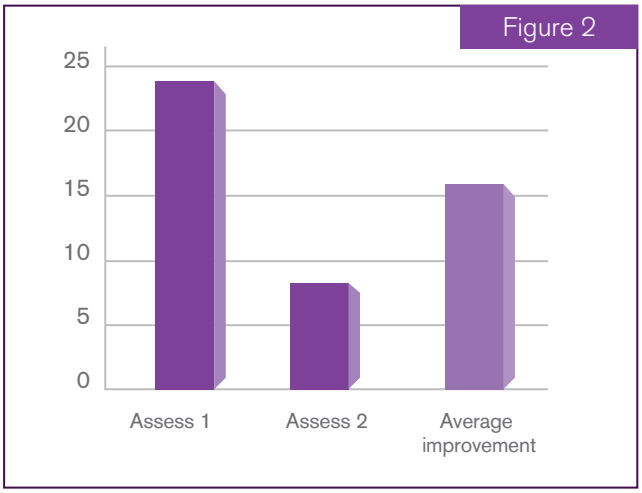
This self report screening tool is completed by the individual as part of his assessment on arrival for treatment, and again when he has completed the treatment programme. It is designed to capture a snapshot of the individual's gambling behaviour over the last six weeks, and some of the consequences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



The above graph (Figure 2) shows that individuals who were resident between 1st April 2012 and 31st March 2013, scored on average 23.74 on the PGSI score upon entering the programme and 8.02 on completion of the treatment programme.

For the 41 residents that started and completed during this period the average improvement score on this assessment was 16.30

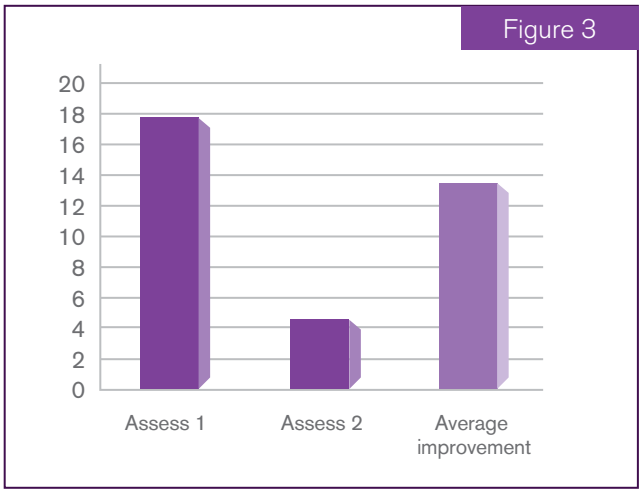
PHQ-9 - Patient Health Questionnaire

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



The above graph (Figure 3) shows that individuals who were resident between 1st April 2012 and 31st March 2013, scored on average 17.77 on the PHQ-9 scale upon entering the programme (assess 1) and 4.54 upon completion of the treatment programme (assess 2).

For the 41 residents that started and completed during this period the average improvement score on this assessment was 13.64

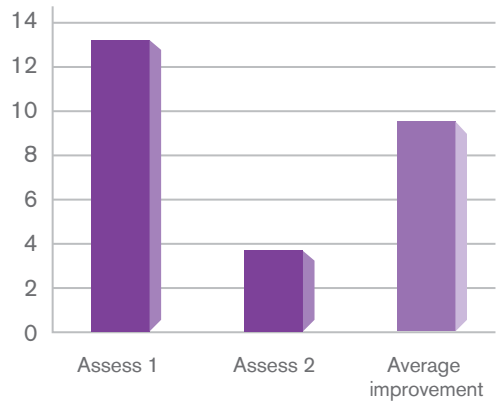
GAD-7

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



The above graph (Figure 4) shows that individuals who were resident between 1st April 2012 and 31st March 2013, scored on average 13.27 on the GAD-7 scale upon entering the programme (assess 1) and 3.68 upon completion of the treatment programme (assess 2).

For the 41 residents that started and completed during this period the average improvement score on this assessment was 9.65

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.

Figure 5

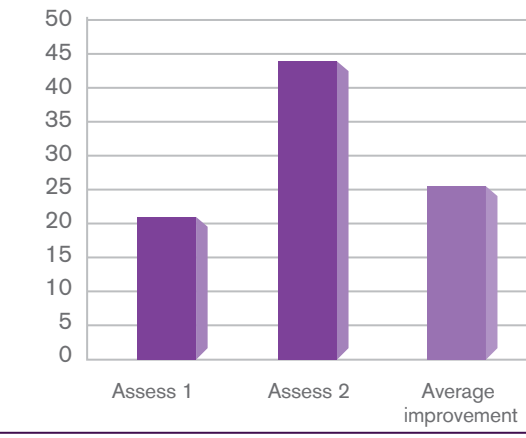


Figure 5 shows that individuals who were resident between 1st April 2012 and 31st March 2013, scored on average 21.14 on the Health and Social Functioning scale upon entering the programme (assess 1) and 43.65 upon completion of the treatment programme (assess 2).

For the 41 residents that started and completed during this period the average improvement score on this assessment was 25.43

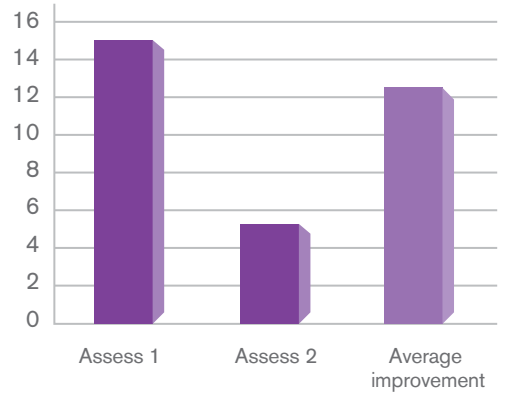
SOGS -The South Oaks Gambling Screen

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 (overleaf) shows that individuals who were resident between 1st April 2012 and 31st March 2013, scored on average 14.92 on the SOGS Scale upon entering the programme (assess 1) and 3.27 upon completion of the treatment programme (assess 2).

For the 41 residents that started and completed during this period the average improvement score on this assessment was 12.39

Figure 6



Longer Term Impact

It is evident that these outcomes demonstrate an improvement on measures for the duration 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. To begin this evaluation ex-residents were contacted and asked to complete the same outcome measures questionnaire. Initially 40 questionnaires were sent to ex-residents for whom contact details were available, and this report records the responses from those 19 people who responded (48%).

In addition 15 people who were using the outreach service also completed questionnaires at various intervals following treatment. Over time we are hoping that this will allow us to collate data that gives us more information about people's journeys in recovery by asking them to complete questionnaires at 3, 6, 9, 12 month intervals.

In this first stage 34 people in total have completed questionnaires. The graph below (Figure 7) illustrates their scores recorded at varying intervals following treatment.

Given that the average scores at the end of treatment on the same measures were:

PGSI = 8.02, PHQ9 = 4.54, GAD-7 = 3.68, H&SF = 43.65, SOGS = 3.27

These early indications suggest that the outcome measures achieved at the end of treatment are sustained.

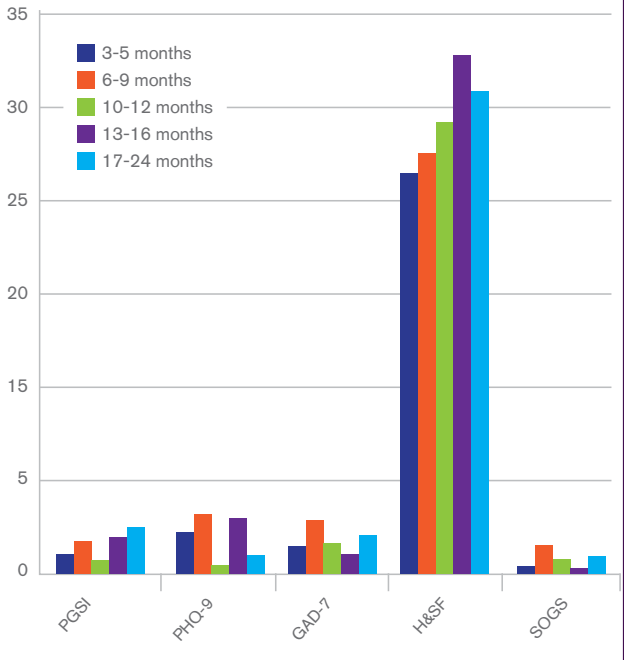
Of course it is more likely that those who are doing well in their recovery may be happier to complete the questionnaires and therefore the figures are representative of those people who have responded and not all those who have completed treatment.

Not all 34 responders completed questionnaires at every interval and the graph is representative of the following:

- 12 people who responded at 3-5 months post treatment.
- 7 people who responded at 6-9 months post treatment
- 4 people who responded at 10-12 months post treatment
- 5 people who responded at 13-16 months post treatment
- 6 people who responded at 17-24 months post treatment.

Since only 8 have completed more than one questionnaire these initial findings are very tentative. However they do indicate that people who engage in our treatment programme at the point they responded have learnt coping strategies that are impacting positively on their overall health and well being and standard of life in general.

Figure 7



Dramatherapy Pilot

During the year 2012/2013 Gordon Moody Association piloted a dramatherapy programme in conjunction with the Roundabout Dramatherapy group at the Beckenham residential centre with a view to evaluating the efficacy of such an approach within this client group.

The merits of using such a different approach to treatment especially within this client group is that many who enter treatment find it difficult to access their emotions and work on an emotional level; therefore certain memories or issues may take longer to be addressed with other more conventional methods. As such to be able to express themselves in a more creative way can facilitate the recovery process by revealing some of the fundamental struggles and conflicts affecting them without them having to verbalise them.

Psychlops Measurement

Alongside the outcome measures already reported the Psychlops measure was recorded in relation to the Dramatherapy group and participants showed significant improvements.

The Psychlops is a questionnaire that collects the person's specific issues they are dealing with; 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).

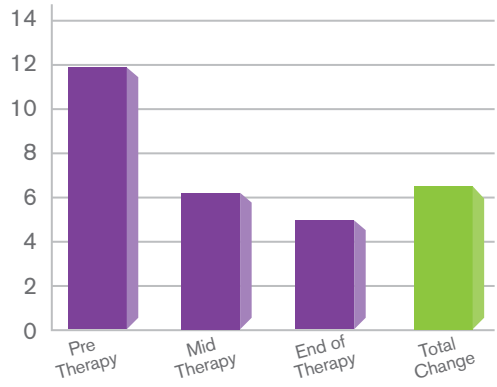
Scores on Psychlops Measures

Figure 8 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 between the pre and end of therapy.

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).

Figure 8



The average pre-therapy score for the group during this year was 11.86. Their average post-therapy score was 5.2. Indicating a total change of 6.67.

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.

The results of the Psychlops in conjunction with this pilot showed, with a standard deviation of 5.2, an effect size of 1.3 thus showing a significant improvement in scores across the therapeutic process.

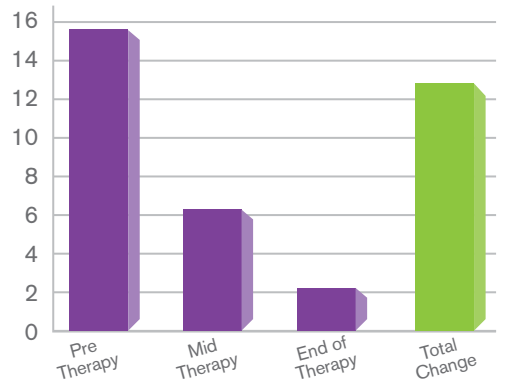
The findings of this pilot were presented at the 2013 BADth conference to members of the art and drama therapist community, where it created much interest in terms of the use of dramatherapy in the treatment of mental health issues and addiction.

For the year of the pilot, Roundabout were able to secure some funding that allowed this to go ahead, but whilst a positive outcome was achieved the results did not indicate that dramatherapy added sufficient value to support the continuation of the programme.

Psychlops Measurement outcome at Dudley

The Psychlops measurement was also introduced at the Dudley residential centre during this year as it was seen as a useful measurement in its own right. It 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. 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 (Figure 9) illustrates the average pre-, mid- and end scores together with the average total change score.

Figure 9



Psychlops change score

The scores were calculated in the same way demonstrating an average pre-therapy score of 15.57, an average post-therapy score of 2.44, giving a total change of 12.94.

Effect Size

The effect size was also calculated in exactly the same way. With a standard deviation of 3.53 the effect size was 3.71, demonstrating a hugely significant improvement in scores.

Gordon Moody Association are always looking for ways to evolve and adapt as we continue to learn more about how best to help this client group whose characteristics and behaviours continue to present new challenges in this changing world, and will be looking at ways to continue to incorporate more creative ways that facilitate our holistic approach. Whilst the Dramatherapy pilot at Beckenham has now ended the use of art in different formats and elements of drama and role play continue to be incorporated at both residential centres.

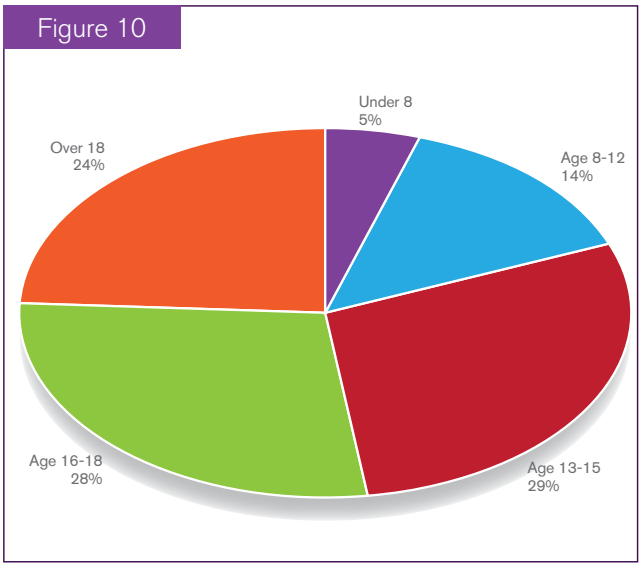
Profiles of Gamblers assessed April 2011 to March 2013

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 2012/13 and added to the figures from last year's report to create a cumulative figure of 150 people throughout 2011/13.

Age started Gambling

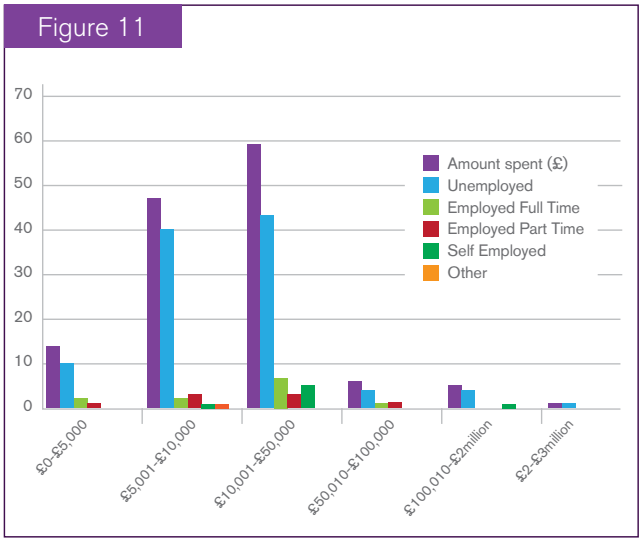
Residents were asked the age when they started gambling and the results are shown below. Most would have started gambling as a social pastime with friends and family which then progressed to them using gambling as a means to escape. For some this may have happened quite rapidly but for others this will 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; at which point gambling serves as a means to escape.

Figure 10



Employment Status and Amount Spent On Gambling Per Year April 2011 to March 2013

Figure 11



Last year we reported the recorded amounts that our residents claimed to have gambled per year. This year's residents have recorded comparable amounts. However what does appear to have shifted somewhat is the proportion of employed residents that have accessed the programme. Using the two highest recorded categories as examples, this year 70% (14) of those recording an amount of between £5-£10,000 were unemployed as opposed to 96% (26) the year before and of those recording an amount of £10-£50,000 65% (17) were unemployed as opposed to 78% (26) the year before.

Figure 12

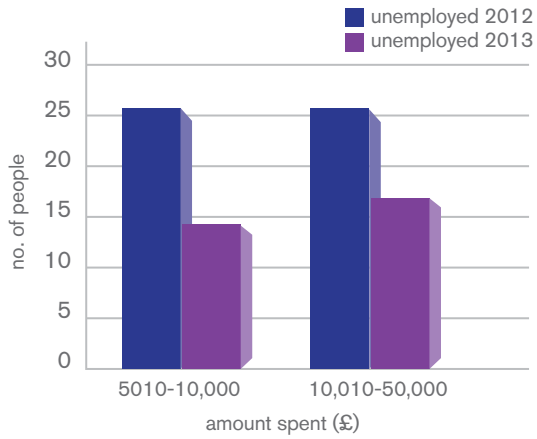
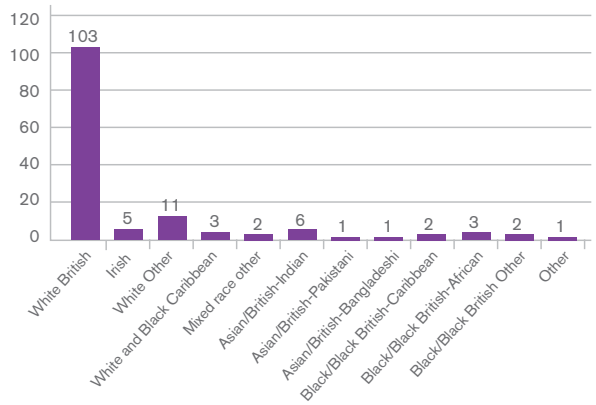


Figure 13



That said, the cumulative graph (Figure 12) is still showing 85% unemployment with those who are gambling between £5-£10,000 per year and 72% unemployment for those gambling between £10-£50,000 per year. This is still a worrying figure if considered that more often people minimise their losses when reporting them. We have no idea whether this is taking into account all they have spent and whether they have taken into account amounts they have borrowed/ acquired - as is often the case. There are also the amounts won and re-gambled to consider. At this point the figures identified here are an indication of the figures involved as it is impossible to gain a truly accurate amount.

Ethnic Origins

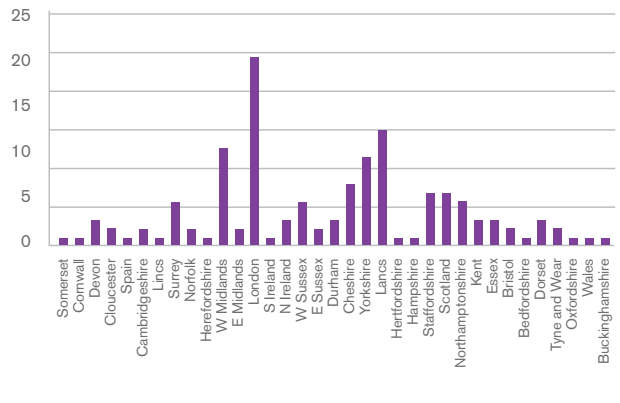
The self-reported ethnicities of the applicants are recorded and the ethnic mix of those people that have received help from the Gordon Moody Association residential treatment programme over the combined years 2011/2013 are shown in the chart below (Figure 13). Whilst the majority of the client group are White British this may be representative of the prevalence of problem gambling in Great Britain. Whilst the 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.

That said it is noted that there needs to be a concerted effort to identify why predominantly white British males enter into treatment and whether there are any blocks that prevent other ethnicities entering treatment and what can be done to address them.

2011/2013 Where our Residents were living prior to Treatment

The residential centres are located quite a distance apart from each other and wherever possible residents are placed in the centre located away from where they

Figure 14



normally live, with a view to allowing them distance to create a very different life for themselves. Being away from the environments and people who may be entrenched in their gambling lifestyles can be part of helping them to change their behaviour.

Figure 14 illustrates all the people coming into treatment 2011/2013 across both units in terms of the geographical area they were situated prior to coming into Gordon Moody Association.

Cost to Society

From the information in this report it is possible not only to estimate the financial cost of problem gambling for the individual and his family and the devastating impact on mental and physical health, family relationships, employment and quality of life but also to begin to assess the wider social impact of problem gambling.

Financial cost

The amounts gambled by those in residential treatment during the last two years have varied between £5,000 and £3m. In the largest category of £10,000 to £50,000, 59 people claimed to have gambled away a total amount of £1,225,194 with an average amount of £20,766 gambled per person. Even for those in employment this is a sizeable amount to have to find on top of living expenses and, since 65% were unemployed this last year and 78% the year before, all their gambling money had to be funded from other sources - borrowing 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.

Many get into huge debt and often 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.

Those who are unable to cope with their debts 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.

Those who are unemployed and unable to work due to their addiction are surviving on state benefits which at the very minimum amount to £56.80 per week (Jobseekers Allowance) and may amount to a great deal more. Assuming six months unemployment and at the basic rate of benefit this is an additional cost of £1477 per person.

Criminality

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 2010/11 to be £26,798.

Health services

Whilst problem gambling has not until recently been identified officially as a health issue and little or 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 and anxiety and the effects of other risk taking behaviours.

The effects on children

Sadly many family relationships breakdown as a result of problem gambling and children are the innocent victims not only because of the emotional distress created within the home but also often the loss of contact with their parent who leaves and the poverty which can result because of the behaviour of the problem gambler.

With this in mind 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.

Applications over last 12 months

Application Process

Within this twelve month period, following requests for treatment, 236 application forms were sent out to people who were either in trouble themselves or for someone they were trying to help. Out of those 236, 97 application forms were returned.

Of those 97 returned 56 were offered an assessment during this time frame, 65 people entered for an assessment (figure includes those who had already been offered prior to 1st April) and of those 65, 61 went on into treatment. Of the remaining 41 returned applications during this period, 4 people were declined as they were considered too high risk, 2 changed their mind following the return of their forms, and 3 decided to go back to work for the time being. The rest of the potential 32 applicants dropped out of the process and contact was lost. However, some of these will potentially be included in next year's report as they re-established contact following the cut-off date.

Considering the number of people who were dropping out at the initial application stages it was decided to review the application process, to see if measures could be taken to reduce the early dropout rate.

From this review it was noted that a great deal of information which is used to determine suitability for assessment was being gathered from forms being sent out to the potential applicant upon first contact. Given the general state of mind of most people applying for help it was identified that this could be quite off-putting at this initial stage, hence one reason for such a low return and follow up. The decision was therefore taken to simplify and personalise the application process and since April 2013 applicants are now only required to complete the gambling audit at the first point of contact - a form which is less intrusive and purely gambling related.

On receipt of the gambling audit a telephone interview is arranged during which the additional forms are discussed and completed. These changes have resulted in an improvement of 34% in the dropout rate at the initial stage of application. The definitive figures at the end of the full year will be included in next year's report.

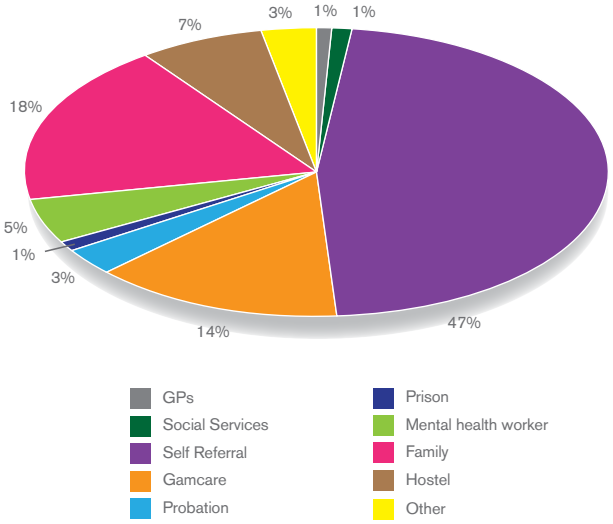
Referrals

Gordon Moody Association continue to welcome referrals from any source and the following illustrations indicate where they have been typically coming from over the 24 months from April 2011 to March 2013

Referral sources for 12/13 changed slightly, notably in 11/12 there were only 1% of residents referred from mental health services which during the year 12/13 went up to 9% and referrals from hostels went down from 9% to 5%. Due to the small numbers involved these would not be indicative of any national trends but perhaps over time may support what is happening nationally. The cumulative illustration however offers a slightly more robust figure for the 2 year period as it represents the journey of 150 people into treatment.

Sources of referrals years 11/13

Figure 15



Assessments Offered

When an application is processed and the person is considered suitable, he is offered an 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 in the therapeutic programme. 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.

During April 2012 to March 2013 82 people in total received residential treatment. At the beginning of this period 17 people were in residence already (as such are not included in this year's figures but in the cumulative) and 65 accepted the assessments offered and entered treatment.

Applications Declined

Gordon Moody Association specialises in treating gambling addiction and its associated behaviours and some people who apply for treatment may not be deemed suitable for the residential environment or for what the therapeutic programmes are able to provide. Due to the nature of the environment and the level of staffing/supervision during out of hours anyone who needs extensive care or who may be a danger to himself or others may be declined a space.

If applicants have mental health issues that are assessed to be too acute to be managed or if they have a history of violence and/or arson then it is likely they will be declined. This can create a difficult situation since there is a lack of available alternatives for such people who are in obvious need of help. On some occasions referrals can be made to other services and individuals sometimes re-apply at a later stage when their situation has changed and are then admitted and treated successfully.

During April 2012 to March 2013 4 people were declined.

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.

The graph below (Figure 16) shows the different accommodation types over the last 2 years of the 150 people who have come into our residential centres for treatment.

Figure 16

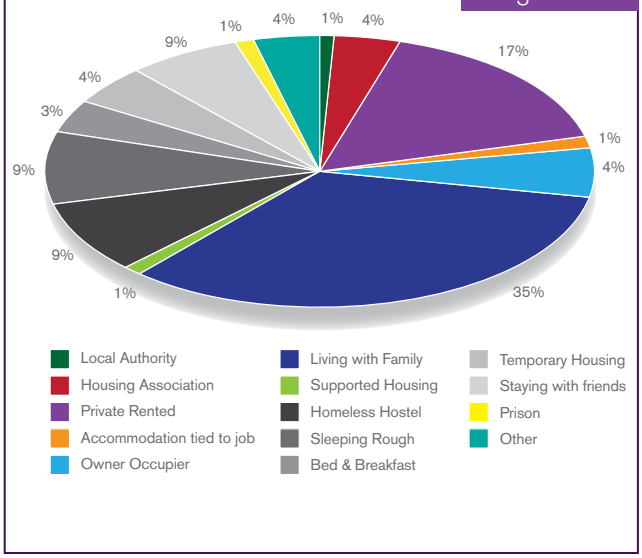
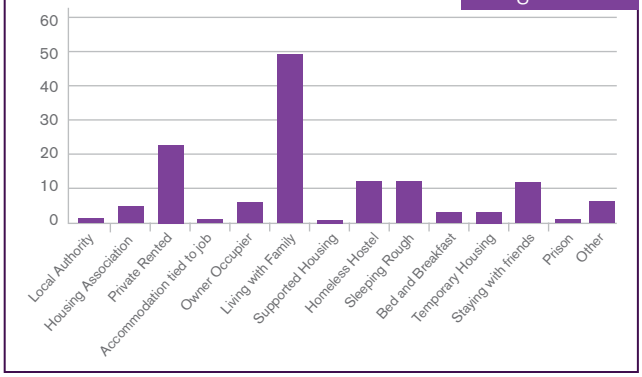


Figure 17



Gambling Styles

As was mentioned in last year's report the self reported gambling styles of all individuals who come into treatment are collected. However, there are still discrepancies with respect to some of the terminology used by different individuals to describe to their chosen forms of gambling and efforts are being made to agree some unambiguous descriptors to enable this information to be included in next year's report.

Outreach Service

During the years of working with people in this environment it was identified that quite often it was when people first left the treatment programme that they were most vulnerable and needed extra support. As a result it was decided to set up an outreach service.

The outreach service was developed in 2004 to provide half way accommodation for those who weren't ready to live completely independently and to provide outreach support to others who had left the treatment programme 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.

At the Dudley site there are 10 halfway house beds and at Beckenham there are four where the same type of support is offered.

At both sites people in the halfway can engage in the relapse prevention programme and are expected to 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 in halfway 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 want to look at retraining. They are supported in looking at what they would like to do and helped to pursue that in sourcing training, voluntary work and so on.

On the other hand, if they have uncovered that where they were living prior to treatment was too entrenched in their gambling, they may want to look at relocating. With this in mind alternative areas are looked at in terms of working on better environments that will support their needs in recovery.

They are also supported to access counselling if they have uncovered or touched on issues from their life that makes moving on difficult for them. If this is the case additional support is given to them during this time; as we know from experience 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 the 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 such 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.

Conclusions

The outcomes described in this report are comparable to those published last year across all measures. They demonstrate the effectiveness of the residential

treatment programme and are testament to the hard work and dedication of Gordon Moody Association and its staff. The knowledge and expertise that exists within the organisation have resulted in proven success in rehabilitating severe problem gamblers, by providing them with coping strategies that facilitate long term change.

Thus far 2 years cumulative figures have been collated which starts 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 identify trends and significant patterns.

The availability of post treatment data is in its infancy and more data will be gathered during the coming years to provide evidence that the residential programme not only works in the short term but continues to have a positive and long lasting effect over many years.

Future evaluation

This report is the second 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. During 2013 two 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?
- What age does problem gambling begin?
- How high is the relapse rate in ex-residents?
- What measures enable people to remain problem free?
- Are longer programmes more or less effective than shorter?
- What is a successful outcome e.g. never gambling again, or managing the gambling habit and keeping it under control?

CORE IMS have been commissioned by the Responsible Gambling Trust and are working with the therapeutic team and residents to provide an external view on the outcome measures used and the effectiveness of the programme. CORE will also be advising on a common data collection framework which all support providers can use to enable comparable measures to be used to assess the effectiveness of different types of treatment.

In addition Gordon Moody Association holds a rich store of archival data that has been collated over several years from which a retrospective picture can be compiled. 2013 saw the start of a collaborative research initiative with the University of East London to analyse existing records. The aim is to publish academic papers which increase understanding about this client group and add to the sum of knowledge in this field to ensure successful treatment interventions.

help for problem gamblers

gordon moody association

Report author: Ruth Champion, Director of Therapeutic Services

PDF versions of this report and the 2012 report 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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