# Our Annual Residential Services Impact Report for 2016/17

help for problem gamblers

gordon moody association

# Gordon Moody Association Impact Report 2017

## Introduction

The purpose of the analysis contained in this Impact report is to provide a continuing measurement of the effectiveness of the Gordon Moody Association residential treatment programmes for both Men and Women.

The outcome information on the residential treatment programme covers the twelve month period 1st April 2016 - 31st March 2017 and the 88 male and 28 female residents who entered for treatment during this time. In addition, this report also includes cumulative profile figures which have been created by incorporating the previous six years' findings for men profiling 469 individuals who went through the male treatment programme. For women the findings cover 54 individuals over 2 years.

Information gathered from the standard application forms provides a profile of all residents, 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.

As we believe that the cost to both the individual and society is great if left untreated, within this report we have also attempted to give an insight into this based on the information we collect.

In addition to the information gathered from the initial application forms, all residents complete a set of questionnaires, including the Christo inventory (residential only), 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. The questionnaires 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 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 46 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.

## Residential Centres

**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 others 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 individuals to identify and explore their own communication and behaviour. They may be in denial of some of their actions but in a supportive environment and without feeling judged they are able to reflect on other relationships they 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. Residents 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**

The following information has been collected from the 88 residents treated during the period April 1st 2016 to 31st March 2017. It captures the recorded levels of functioning and the emotional states 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

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.

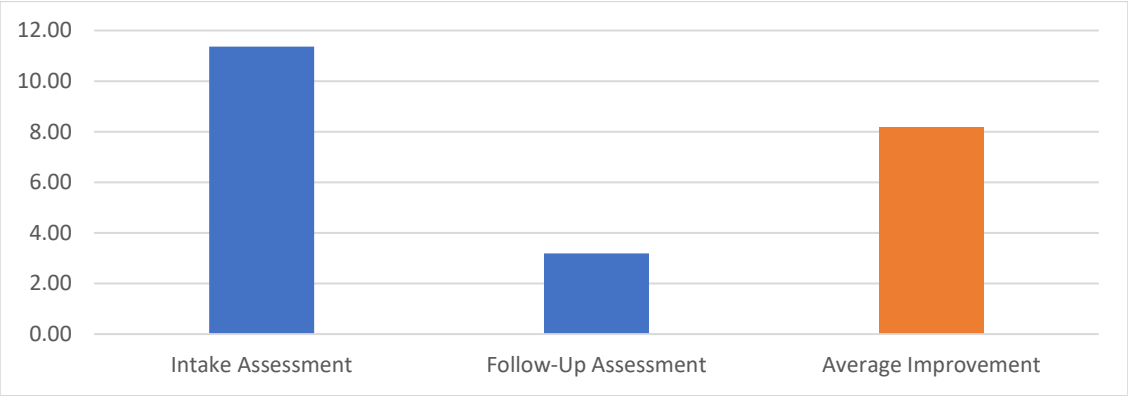



Figure 1 shows that individuals who were resident between 1st April 2016 and 31st March 2017, scored on average 11.37 on the Christo scale upon entering the programme (assess 1) and 3.18 upon completion of the treatment programme (assess 2). For the 41 residents who completed during this period the average improvement score on this assessment was 8.18.

### 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 provide 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.

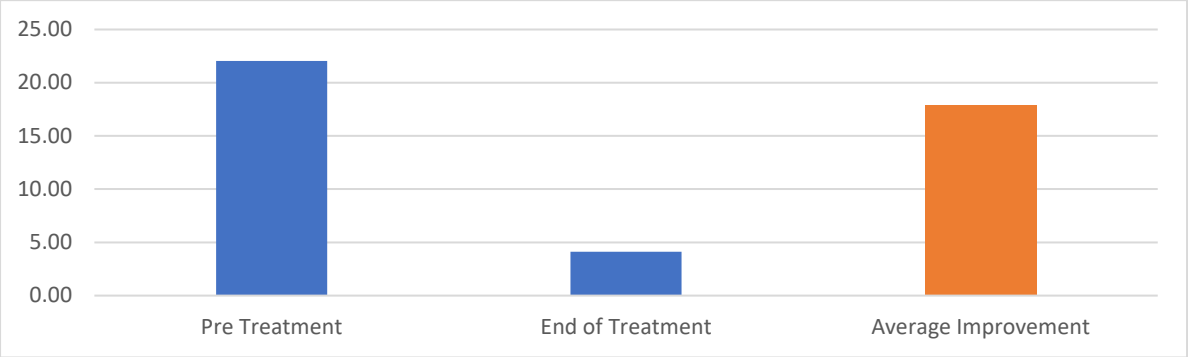



Figure 2 shows that individuals who were resident between 1st April 2016 and 31st March 2017, scored on average 22.04 on the PGSI score upon entering the programme and 4.13 on completion of the treatment programme. For the 41 residents that completed during this period the average improvement score on this assessment was 17.91

**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

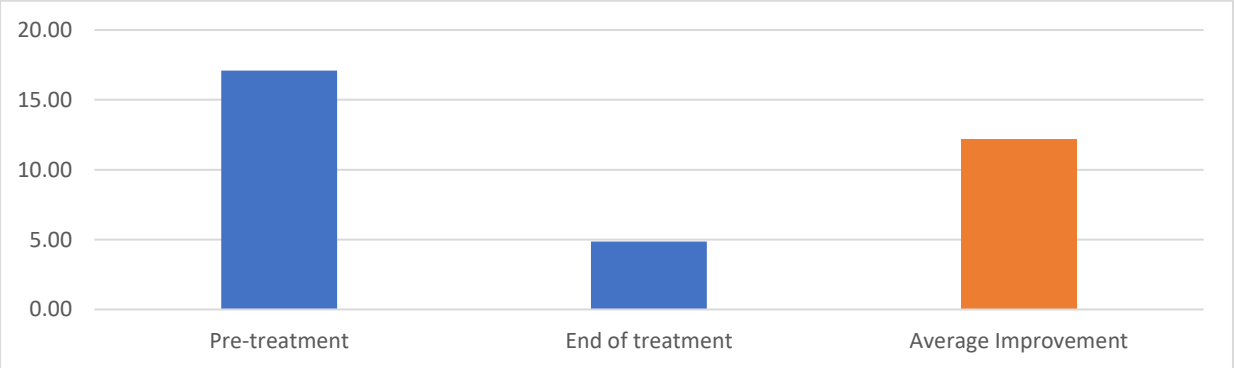


Figure 3 shows that individuals who were resident between 1st April 2016 and 31st March 2017, scored on average 17.09 on the PHQ-9 scale upon entering the programme (assess 1) and 4.87 upon completion of the treatment programme (assess 2). For the 41 residents that completed during this period the average improvement score on this assessment was 12.22

**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.

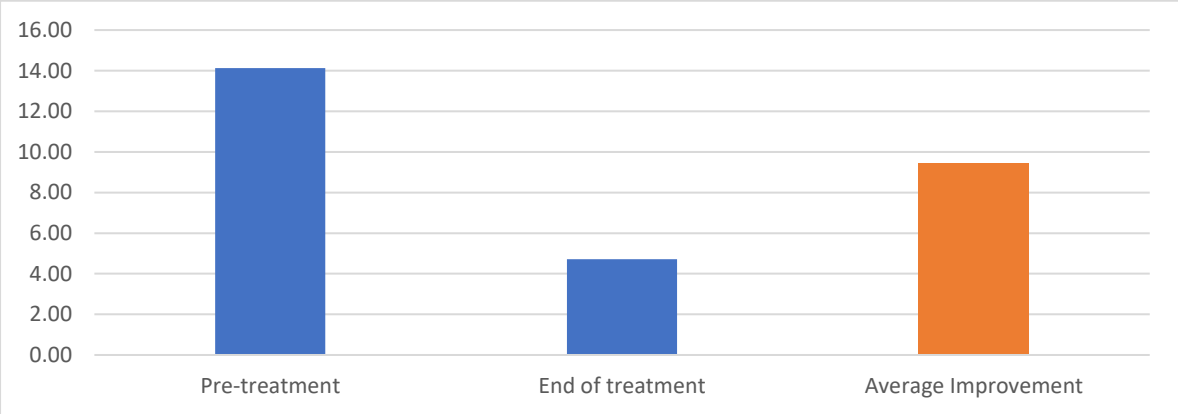



Figure 4 shows that individuals who were resident between 1st April 2016 and 31st March 2017, scored on average 14.13 on the GAD-7 scale upon entering the programme (assess 1) and 4.71 upon completion of the treatment programme (assess 2). For the 41 residents that completed during this period the average improvement score on this assessment was 9.42

**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.

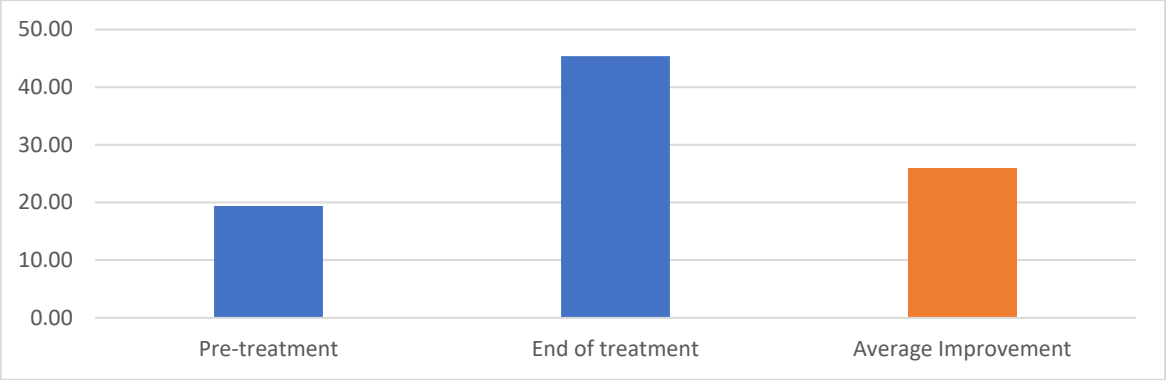



Figure 5 shows that individuals who were resident between 1st April 2016 and 31st March 2017, scored on average 19.39 on the Health and Social functioning Scale upon entering the programme (assess 1) and 45.39 upon completion of the treatment programme (assess 2). For the 41 residents that completed during this period the average improvement score on this assessment was 26.00

**SOGS -The South Oaks Gambling Screen**

SOGS is a 23-item questionnaire based on DSM-III (Diagnostic Statistics Manual) 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.

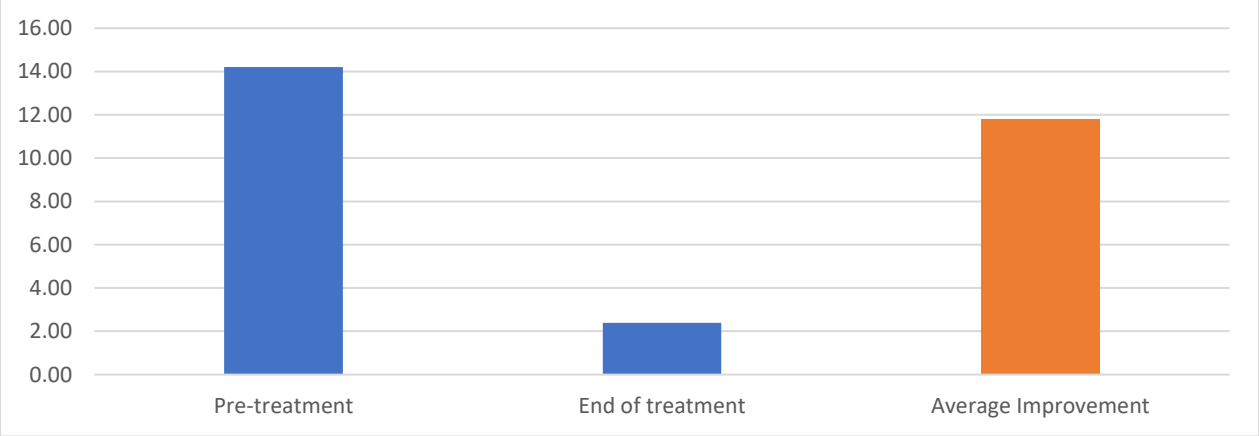


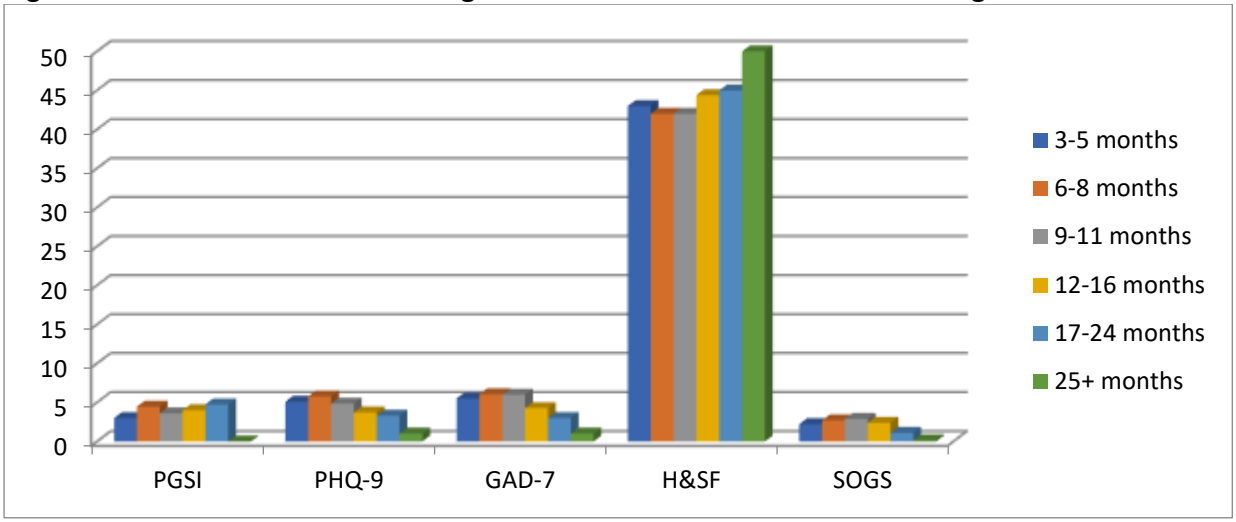

Figure 6 shows that individuals who were resident between 1st April 2016 and 31st March 2017, scored on average 14.21 on the SOGS Scale upon entering the programme (assess 1) and 2.39 upon completion of the treatment programme (assess 2). For the 41 residents that completed during this period the average improvement score on this assessment was 11.82

Longer Term Impact

It is evident that our outcomes demonstrate an improvement on measures during and immediately after 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.

203 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.




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 203 responders completed questionnaires at every interval and the graph is representative of the following:

- 114 responses at 3-5 months post treatment.
- 66 responses at 6-8 months post treatment
- 52 responses at 9-11 months post treatment
- 43 responses at 12-16 months post treatment
- 21 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 this data does appear to show 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 their quality of life in general.

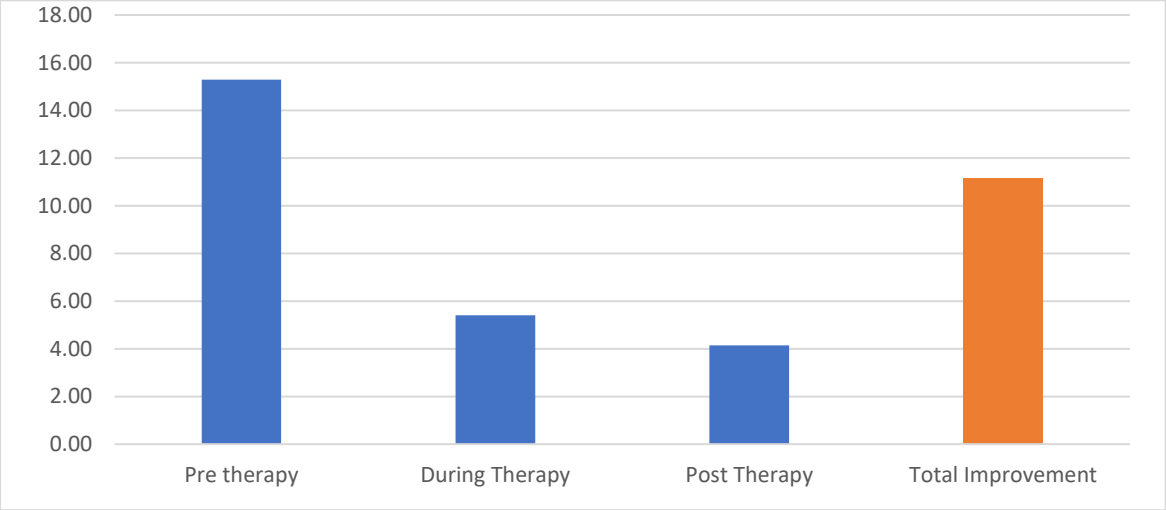
**Psychlops Measurement outcome**

The Psychlops questionnaire collects information on each individual's specific issues; then throughout the therapeutic journey it measures how the individual changes in relation to his 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.

**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.




**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 15.29. The average post-therapy score was 4.14 indicating an average total change of 11.15.**

**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 3.69 an effect size of 3.02 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.

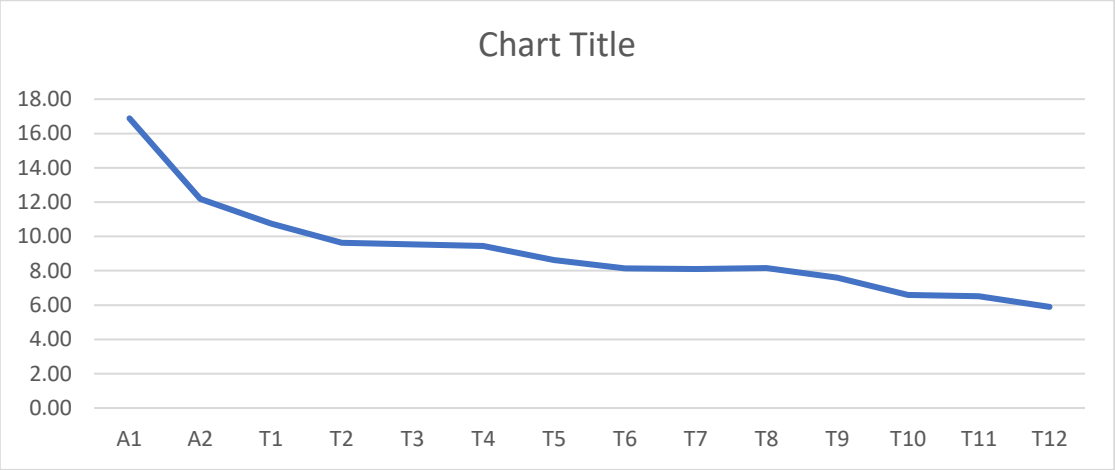
It is a short 10 item questionnaire that is used as a screening tool and outcome measure and it covers the following items:

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.

Figure 9.

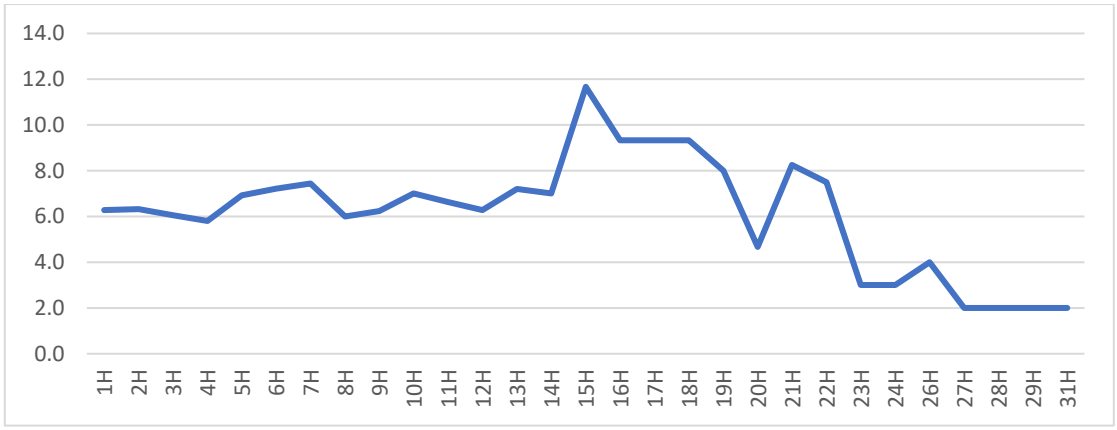


It is noted that our residents are scoring just under moderate within their first week in residential assessment. This potentially could represent the fact that they are in treatment and feeling more supported. However as we do not have any data prior to entry we could not confirm this.

By week 12 the average score of our residents in this period is 5.89, showing a definite reduction in score across all items to below clinical cut off and just above healthy.

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 15, remain under the clinical cut off score. Potentially the spike could represent a crisis point in which one of the residents has been affected adversely by life events. However, the fact that the scores come back down would suggest that their coping responses are effective and they are maintaining an emotional equilibrium.

Figure 10.



## Profiles of Gamblers in Residential Centres assessed April 2011 to March 2017

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 the 88 people who entered both residential centres during 2016/17 and added to the figures from previous reports to create a cumulative figure of 469 people throughout 2011/17.

### Age started Gambling

During the time period involved in this report (April 16-March 17) the age range of the residents was from 20 to 68 with the average age being 36.

Upon entry the age when they report they started gambling is recorded 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

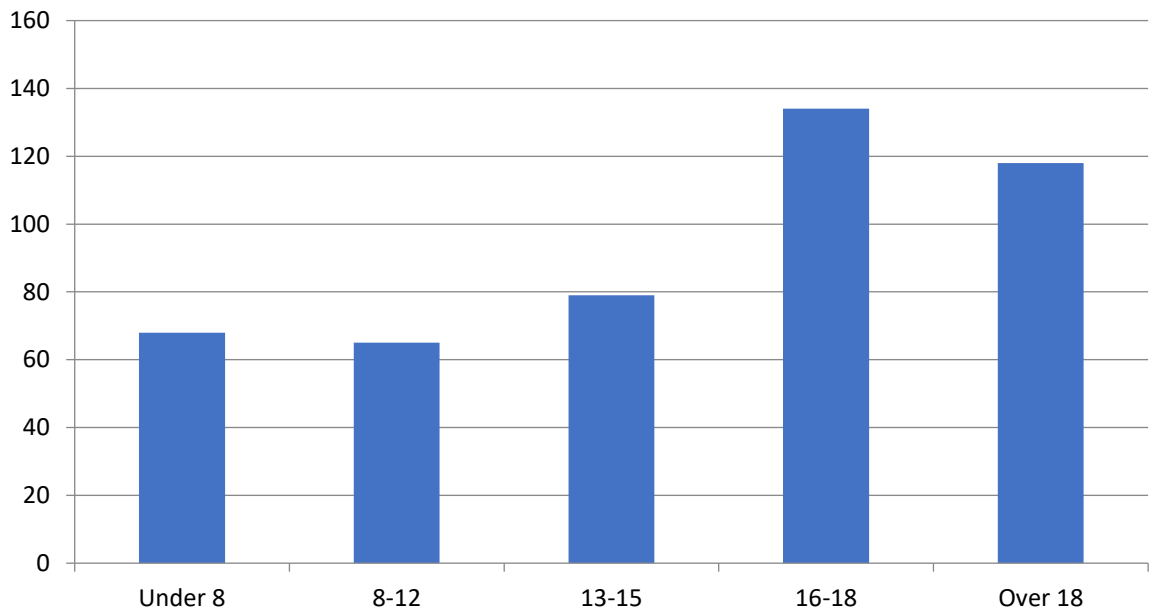
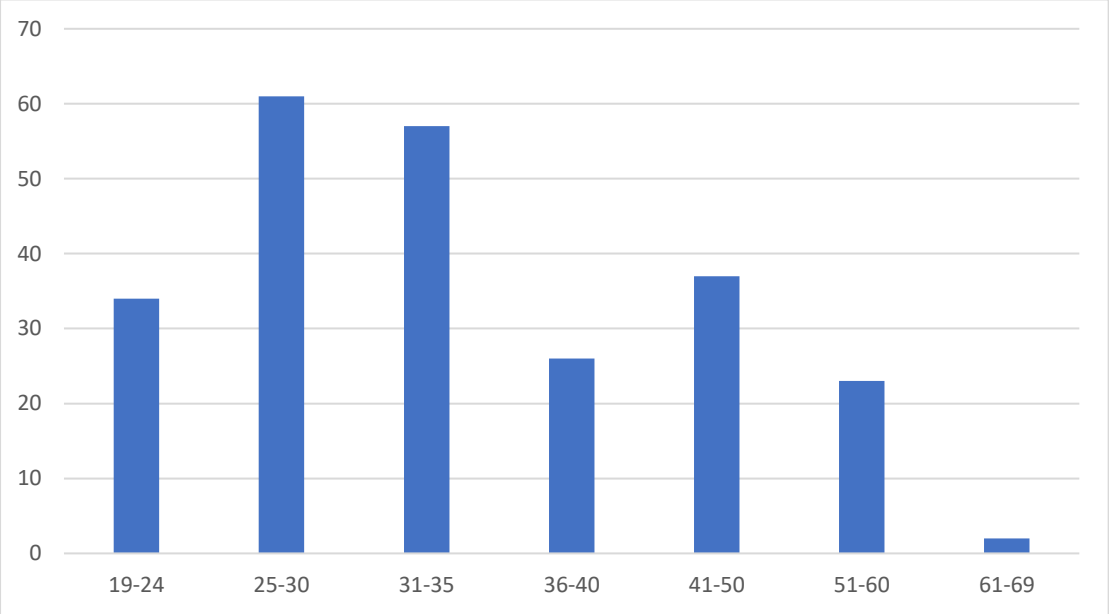
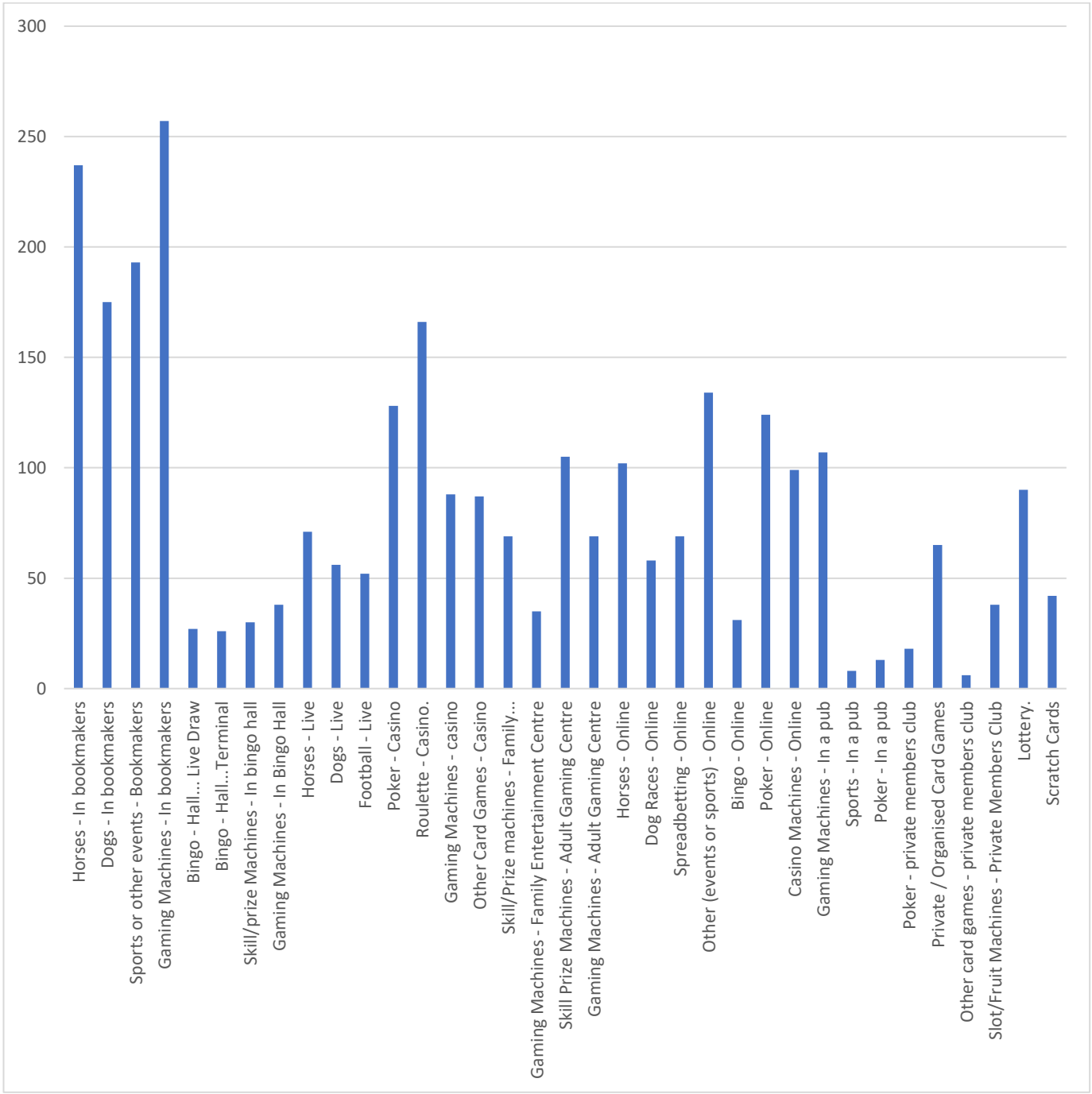


Figure 12 shows the age of people, year 2014-17 (242 people) when they entered treatment.



## Gambling Styles

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 (Figure13) below represents the styles recorded upon entry for treatment for 2014 - 2017 (242 people).



## Employment Status and Amount Spent On Gambling Per Year 2016/2017

Figure 14

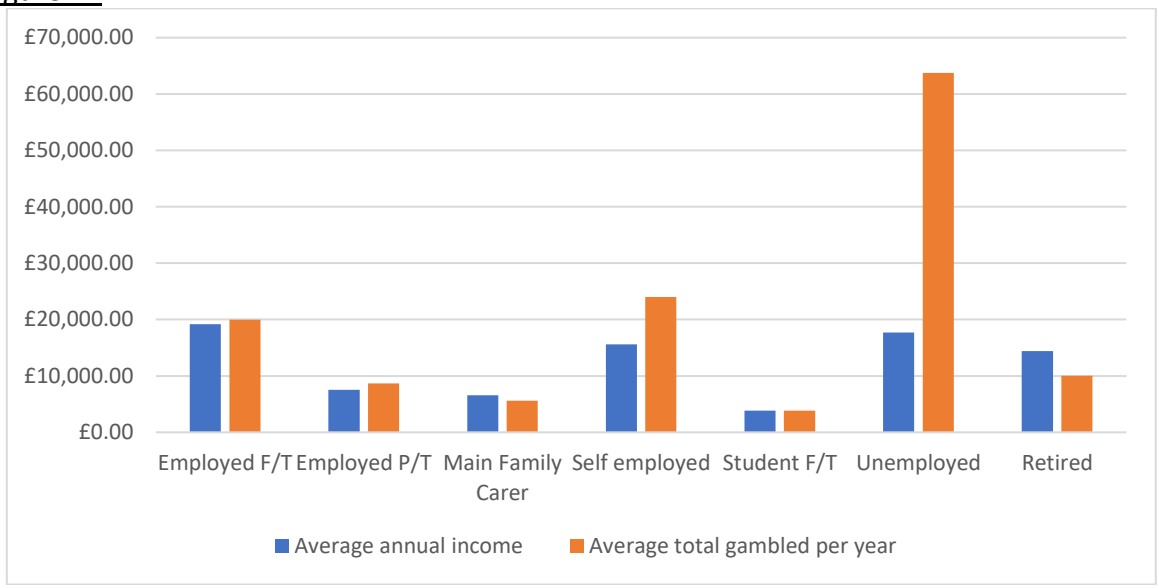



Figure 14 illustrates the recorded amounts gambled per year against employment status of all residents in 2016/17; a total of 88 people.

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.

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 74 people who stated their income and gambling amount for this period the average amount gambled was just under 1.5 times their average income prior to coming into treatment.

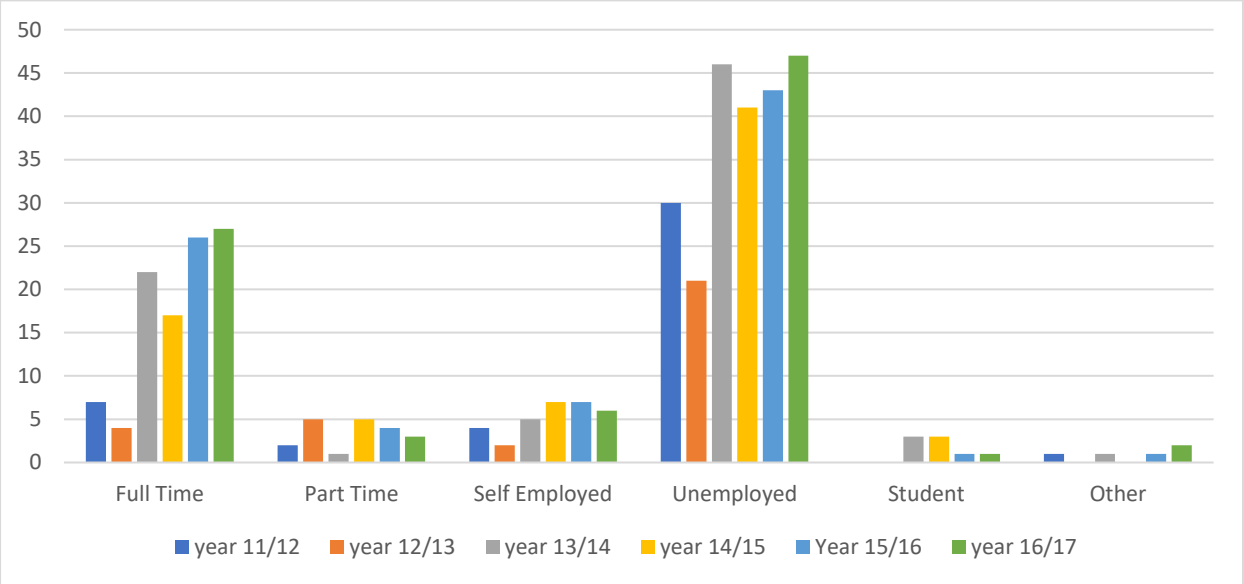
For the year April 16 to March 17 the actual reported total amount gambled by the 74 people who answered was £3,616,180 with a total recorded debt amongst them of £1,230,718

To include the figures from the people involved in previous years, the total reported amount gambled between 2011--2017, by the 319 people who disclosed the information included in these reports is £12,208,379.

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 5 years there has been a steady incline in those in employment. During this period this trend appears to have continued in that there are more full time employed. It is reasonable to

suggest that people may be seeking treatment sooner and before they have reached the point where they are unable to keep a job.

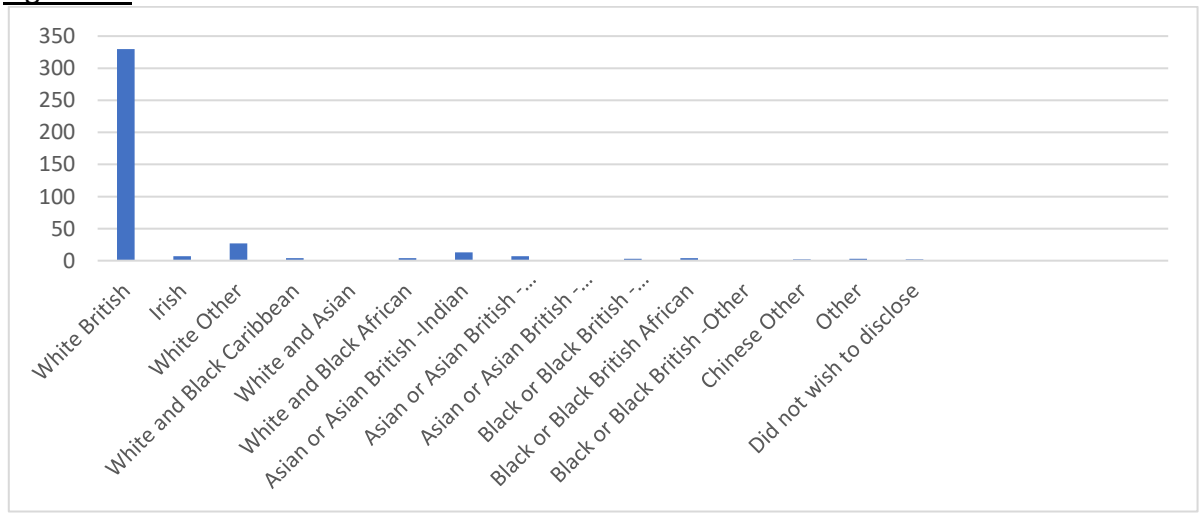
Figure 15




**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 2011/2017 are shown in Figure 16. The majority of our client group report as 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.

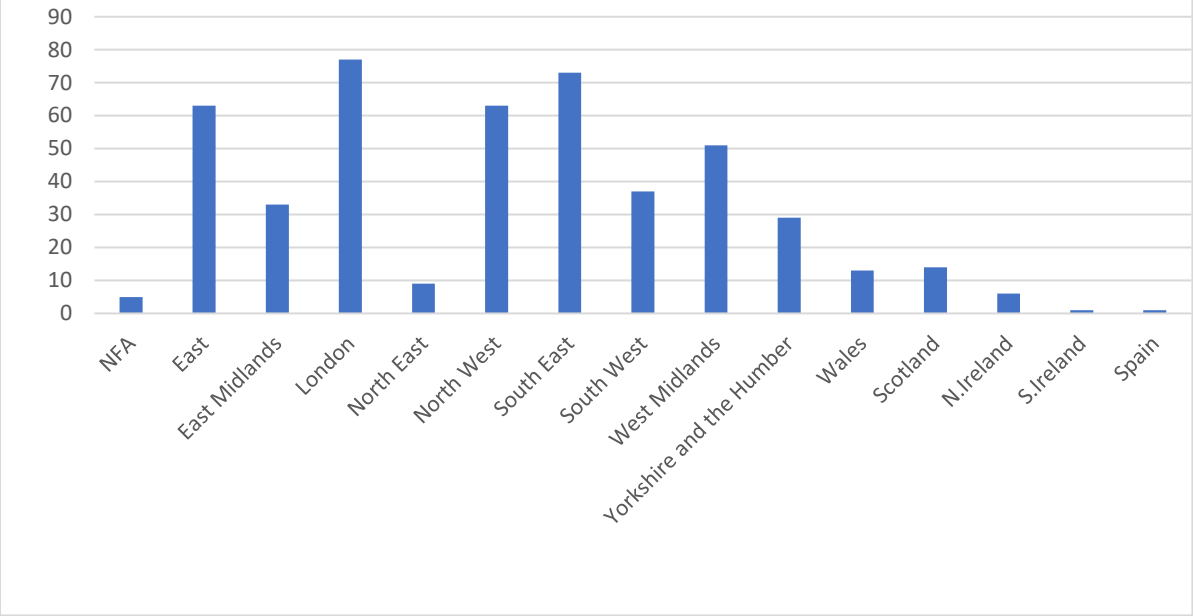
Figure 16.



**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 reinforcing their gambling lifestyles can be part of helping them to change their behaviour.
Figure 17 illustrates all the people coming into treatment 2011/2017 and their geographical location prior to coming into Gordon Moody Association.

Figure 17.

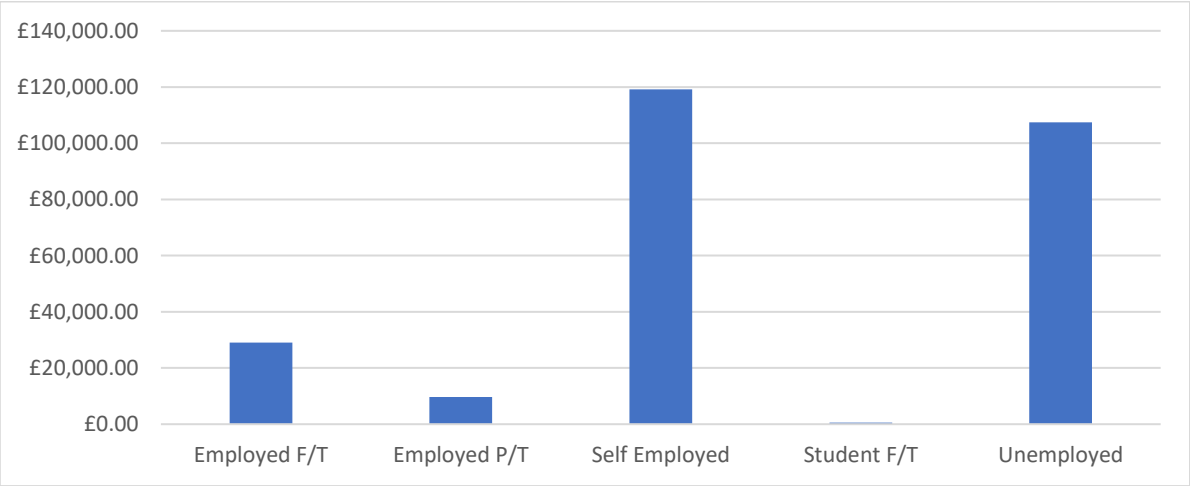


## Cost to Society

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 74 people recorded this year is just over £5.5m

Figure 18 illustrates the total amount of debt for each category in this period (2016/17).




Forty of the people recorded in this year's report were unemployed and had a combined debt of £107,432. This is an average of £2,685 debt per person with an average annual income of £8,736.

In comparison to their income these are sizeable amounts to have to find on top of living expenses, particularly with those in the unemployed category and will have been borrowed from family and friends, high street money lenders, pawnshops and loan sharks.

Some Gordon Moody Association residents report that their families re-mortgage 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 in which case society then carries the rest of the debt. If court costs are involved this adds to the total financial cost.

## Other Societal Impacts

*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. During the last year of the 88 residents who came into treatment who had committed a crime in order to fund their gambling, 28 of them received a criminal conviction.

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 2015/16 to be £35,182. The cost of treatment is a good investment when compared with the adverse effects of gambling addiction in the community.

10 of the 28 residents reported they had received custodial sentences. This would have been a cost to society of £351,820.

*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.

A key tool in recognising the impact of gambling addiction would be the collection of data. It is hoped that health and social services will begin to collect information about gambling behaviour alongside questions on alcohol use, exercise and other lifestyle factors which affect health outcomes.

The incidence of gambling addiction amongst those diagnosed with anxiety and depression and other mental health issues should also be monitored as a matter of urgency.

*Affected Others*
In last year's report we discussed how, in addition to the financial problems created by problem gamblers, other people in their lives are affected too. Significant others and their families are the people who have probably suffered the most, as well as their friends.

People with gambling addictions tend to be very self -focussed and often do not have the capacity to consider the impact they are having on the people around them. This lack of awareness of how their behaviour affects those close to them can result in relationship

breakdown and trauma. For the most part the family and friends of problem gamblers will have been lied to, manipulated and been at the receiving end of some very erratic and, in a lot of cases, hostile and abusive behaviour.

Apart from the emotional distress experienced by the children of problem gamblers the effects of poverty caused by the gambling can be devastating. 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. Farrington, Barnes and Lambert (1996) found that 53% of juvenile offenders 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. And 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 to offending behaviour in adolescents (Turner et al, 2009).

The combination of particular risk factors associated with the likelihood of delinquency and adult crime (Yoshikawa, 1995) were also identified in relation to the behaviours and life patterns that are present with a problem gambler.

- 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.

During this year:

- 69 of the 88 residents who came into treatment in 2016/17 recorded that their relationship with a partner had ended because of their gambling; added to the 99 from last year's report this equals a total of 168 relationship breakdowns.

- 37 of them from this year had 1 or more children with a total of 69 children between them; added to last year's total this equals 160 children affected.

- 12 of them had criminal convictions with a total of 13 children between them; added to the 34 children from last year equals a total of 47 children affected.

- 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

There has been a further increase in applications for treatment this year (last year's figures are shown in brackets):

- 483 applications for treatment received (479 last year).
- 228 of those initial applications were not progressed further as contact was lost (214 last year)
- 49 applicants withdrew prior to coming in for assessment (57 last year)
- 2 people were declined (5 last year)
- 82 applications were still being assessed at the end of March 2016 (22 last year)
- 176 were offered a residential assessment (181 last year) and 88 people entered for a two-week residential assessment (82 last year); of those 88, 64 successfully completed the two week residential assessment and went on into treatment (67 last year)
- 30 people chose or were asked to leave once in treatment which is higher than the previous year (20 last year)

Although this year has seen yet again a higher number of applications thus far it is of importance to note that nearly half of them dropped out.

It is difficult to say exactly why this is; and each year we speculate that this highlights the process that many people go through when contemplating change.

One possibility is that 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 may 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, however self-referrals continue to be the largest percentage for the year 2016/17, which accounted for 64% of all applications.

Figure 19a indicates sources during April 2011 to March 2017 (469 who entered residential assessment across five years) and Figure 19b shows a comparison of referral source over the four year period.

**Figure 19a**

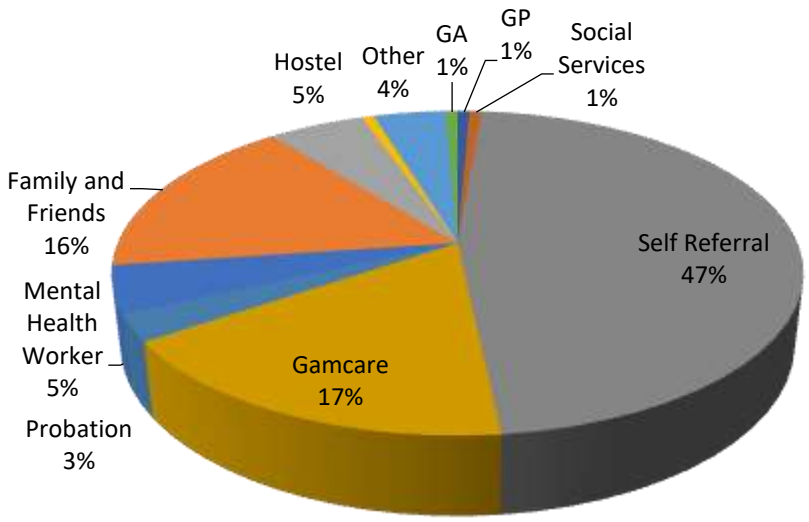
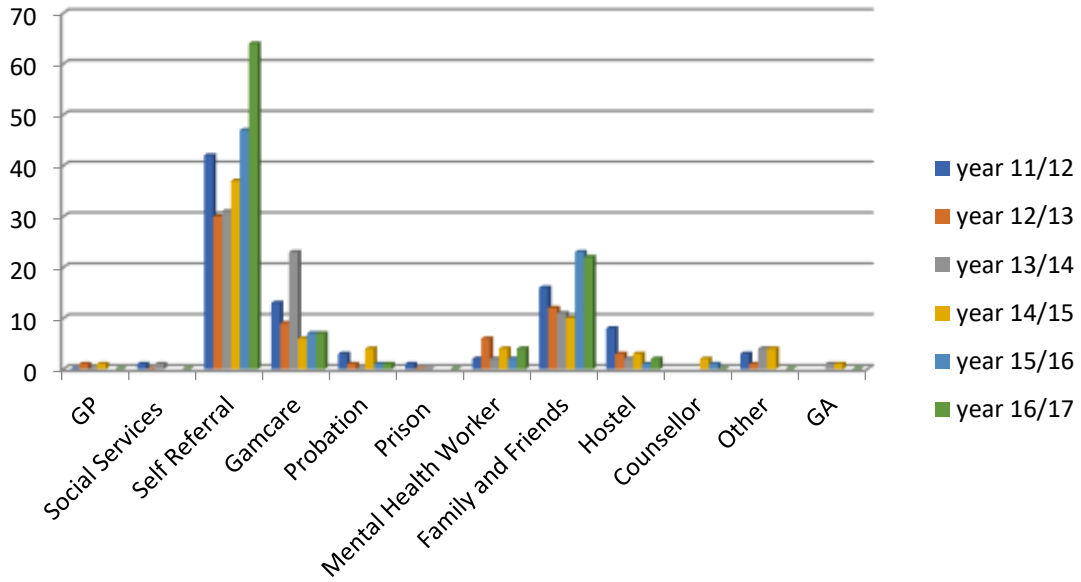


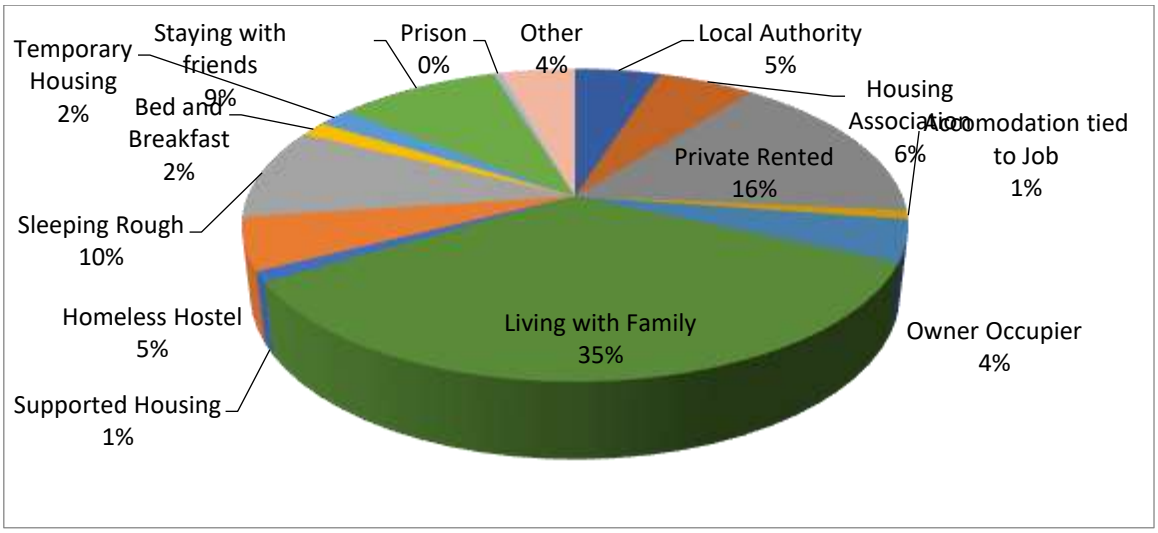

**Figure 19b**



## 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 6 years of the 469 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 the outreach workers are actively working with 30 people on average each month in addition to those 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. At the beginning of this period 2016/17 there were 7 people already resident and another 31 people who entered.

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.

We are currently evaluating the post treatment outcomes measures to determine any differences between those who chose to stay in the halfway accommodation and those who left at the end of treatment. This will be part of a separate report that we will make available in 2018/19.

**Women's service**

During this year the previous pilot women's service has gone from strength to strength. It is now a fully contracted 3 year programme of services. Within this period a total of 85 applications were received of whom 54 lost contact prior to interview.

- 37 were offered a place.
- 28 entered treatment.
- 9 changed their mind prior to arriving.
- 3 people were declined.

As the programme does not run continuously applications are not processed in the same way as for the residential programme. For example an application in September will be acknowledged on receipt but the applicant would be informed that processing will take place in December for the January programme. All applications are assessed at the same time and shortlisted for the places available.

This enables all applications to be considered in parallel and offers an opportunity for recent applicants to join the programme. Since there are only a few places available for each course to offer places as the applications come in could be quite damaging for the process of change for those who apply after the spaces have been filled. There is also an ever-present possibility that someone who applied early and was offered a place could still change their mind. By adopting this method the risk of drop-out prior to treatment is reduced. It should be noted however that the current gap between programmes contributes to drop-out as women seek alternative coping strategies when help is not immediately available. The longer term aim will be to offer more frequent programmes during each year.

**The Treatment Programme**

We have created a programme that cuts across the many obstacles we know exist for women in treatment. We are providing a programme that gives them the intense level of supportive treatment in a nurturing environment that residential treatment provides; together with the convenience of outpatient sessions.

The initial retreat style residential programme lasts for 4 days and 3 nights and is set in a rural retreat within a therapeutic community; it is facilitated by three therapists.

The first retreat is followed by 12 weeks of one-to-one outpatient style support sessions plus a fortnightly exclusive online group facilitated by one of the therapists.
Then there is 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 service of GMA.

**Content of Programme**

The current Gordon Moody Association residential 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 works because the residents have a lot of support to help them through it.

The same levels of support are not available to the problem gamblers on the women's programme throughout the 12 week period. The women have to go about their daily lives and deal with the day to day problems/issues/demands that exist in the real world. We have therefore created a programme that deals with the necessary issues, whilst not pushing them too much emotionally.

The pieces of work chosen from the GMA residential treatment programme are the more practical solution-focussed pieces. The focus is on building the coping skills the women 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 can learn 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 reasons for their gambling 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 the context of what is going on for them generally. A 12 week work book has now been introduced which provides structure and consists of pieces of work and exercises that help the women to take a work focussed approach to many of the day to day issues that are experienced during recovery. The workbook also offers resources to support reflection and goal setting.

In the second 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.

## 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 the women completed the GMA self-assessment questionnaires and in order to get a comparative measure these were also completed 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 is 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.

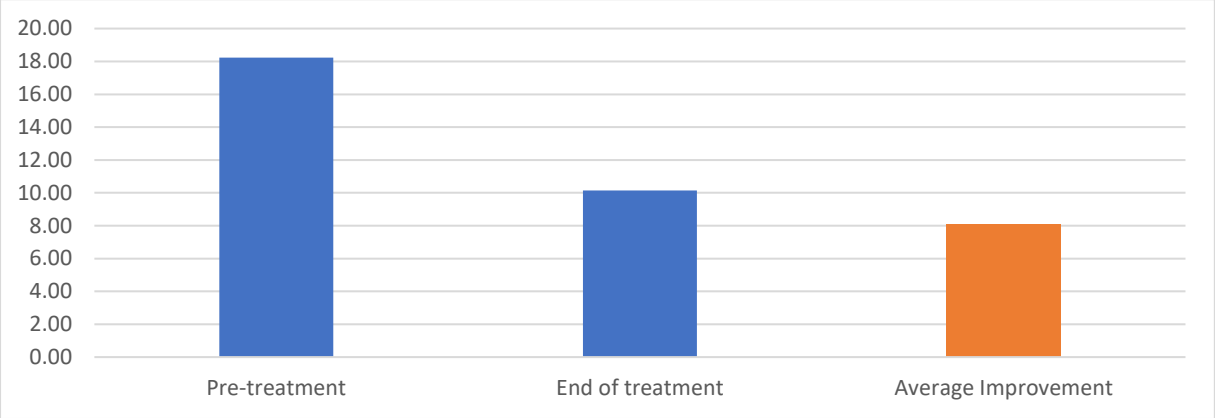
Any score under 10 comes below clinical cut off and below 5 is classed as healthy and 3 comes under risk cut off. A score of 40 would be classed as severe, 25 = moderate severe, 20 = moderate and 15 = mild.

**Results**

The graphs below indicate the average scores on each measure in the questionnaire at the start and end of the programme.

**PGSI**

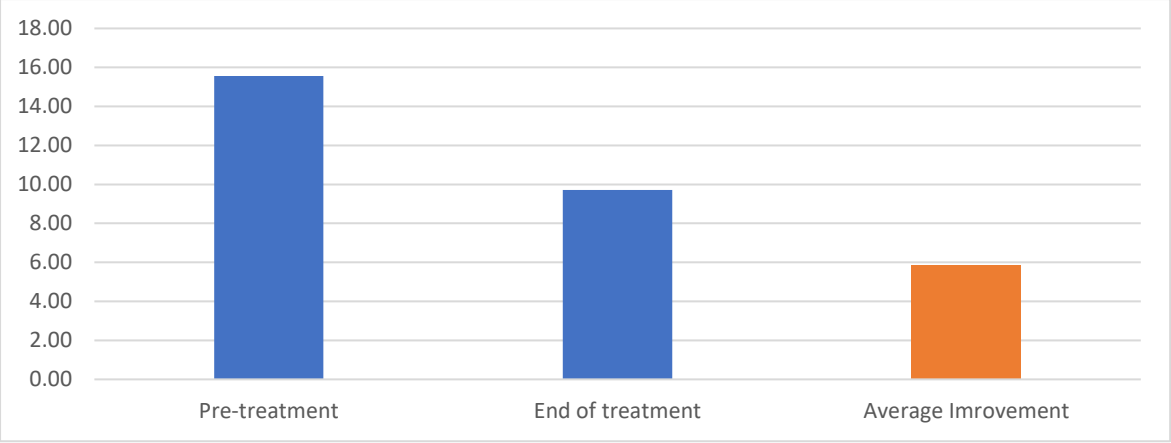
Figure 21




The scores from the group demonstrate the average of 18.22 on the first score to 10.14 on the second. 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 with an overall average improvement of 8.08

**PHQ-9**

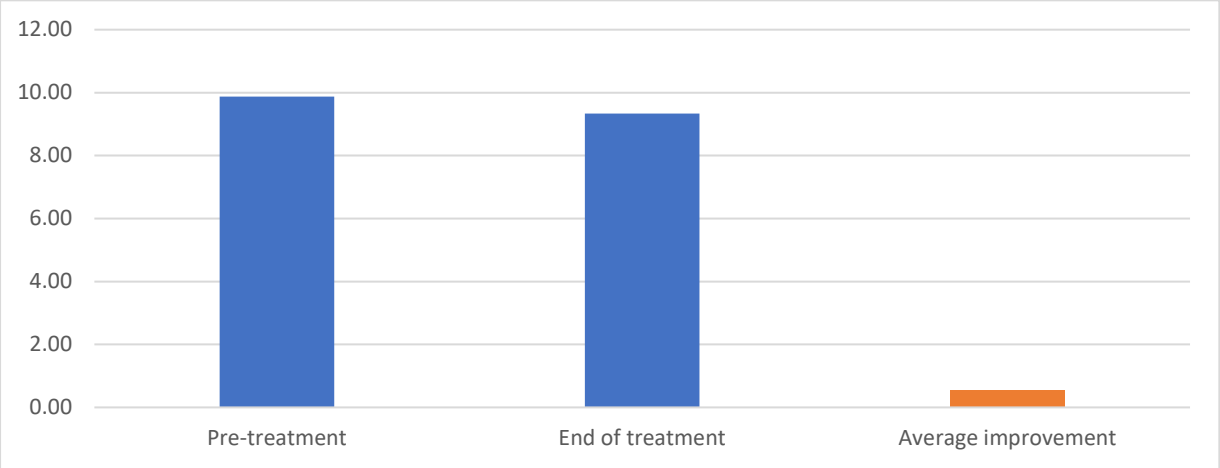
Figure 22




The scores on this measure indicate an overall improvement from the average of 15.56 on the first score to 9.71 on the second. This indicates a shift from major depression with severe symptoms to minor/major depression with mild symptoms. With an overall average improvement of 5.85

**GAD-7**

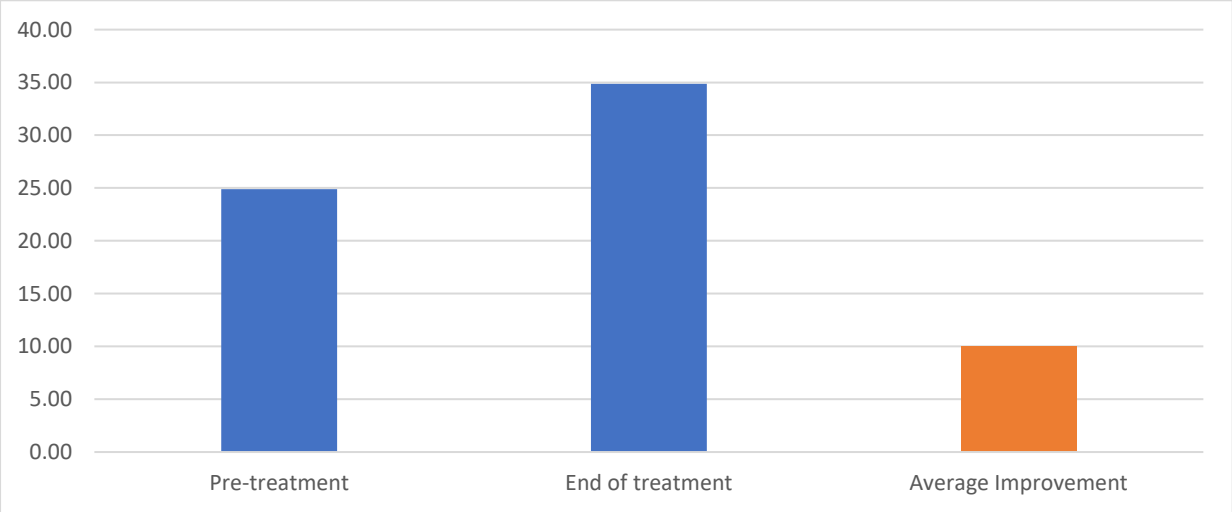
Figure 23




The scores on this measure indicate an overall improvement from the average of 9.88 on the first score to 9.33 on the second. This indicates a shift from moderate anxiety to mild. With an overall average improvement of 0.5.

**H&SF**

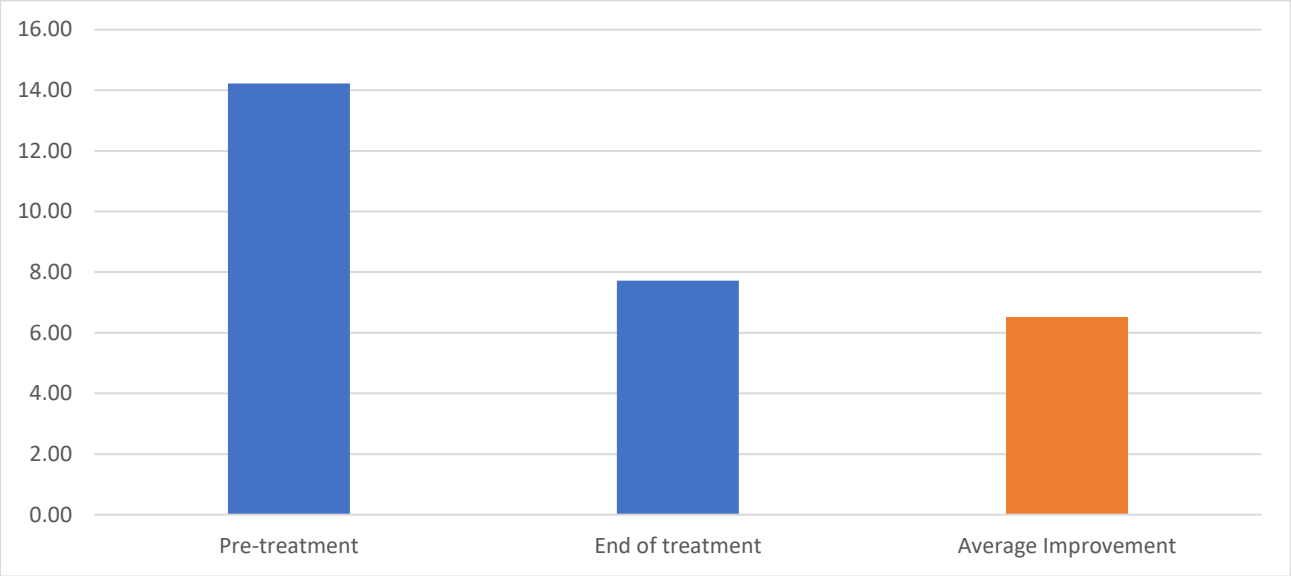
Figure 24




The scores on this measure indicate an overall improvement from an average of 24.89 on the first measure to 34.86 on the second suggesting that the group were feeling that they were doing better in these areas and their quality of life was improved. With an overall average improvement of 9.97

**SOGS**

Figure 25

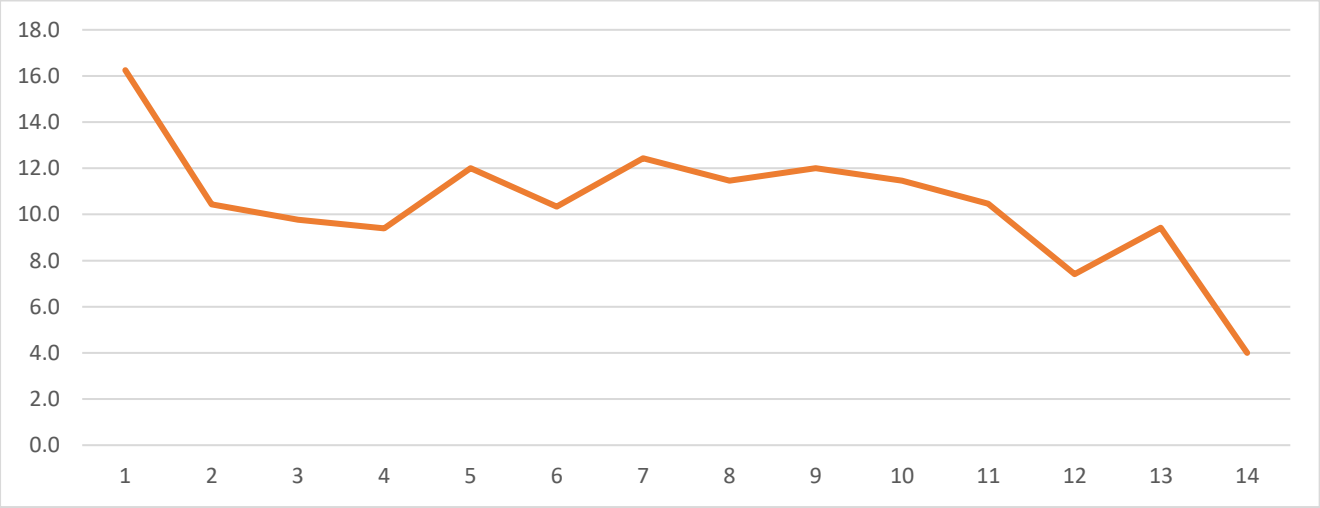



The scores on this measure indicate an overall improvement from an average of 14.22 on the first measure to 7.71 on the second suggesting that although both scores are still in the pathological category there is a decreased level of gambling behaviour. With an overall average improvement of 6.51

**Core 10**

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

Figure 26




The graph demonstrates a high score of 16 on entry to the retreats which could represent the anxieties of travelling to and entering the residential programme. However, there is an

average reduction to 11 in scores during the initial retreat demonstrating a reduction in symptoms by the time they went home.

The scores were generally maintained, despite some ups and downs throughout the treatment programme with an overall reduction to 4 at the end of the programme.

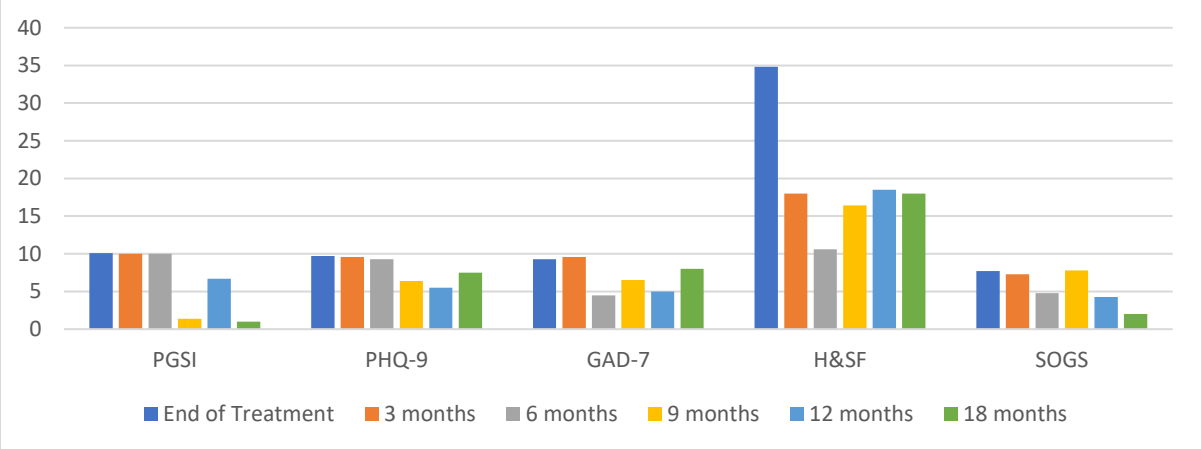
The overall picture would indicate that over the duration of treatment individuals are generally improving on the items measured in this scale.

Post treatment Outcomes

The outcome measures recorded from the women in this report suggest that the programme is giving them the tools to deal better with their day to day lives and ultimately take control of their gambling. However it is important to evaluate, wherever possible, whether the model of treatment is facilitating a longer term change.

Using Survey Monkey as a tool we have begun to collect some post treatment measures to evaluate how the women are coping post treatment and whether they have been able to sustain any lasting change. What we have recorded so far is as follows:

Figure 27




The post treatment scores collected so far appear to indicate that the women are sustaining the end of treatment scores in the short term, apart from health and social functioning and gradually improving on them.

We will continue to encourage clients to complete the questionnaires post treatment at regular intervals and will report the findings which over time should start to give a more reliable indication of the longer term effectiveness of this model of treatment.

**Profiles**

The age range of the women who entered treatment in 2016-17 was 24 to 67 with the average age being 43.

The profiles shown in Figure 27 are in relation to the 54 women in the 6 cohorts since the pilot began in January 2015. Future reports will continue to show cumulative figures in relation to all those attending across the years.

Figure 28 shows the current accommodation status of the women. The chart would suggest that predominantly the women, unlike their male counterparts, are retaining a form of stability in their living arrangements.

Figure 28

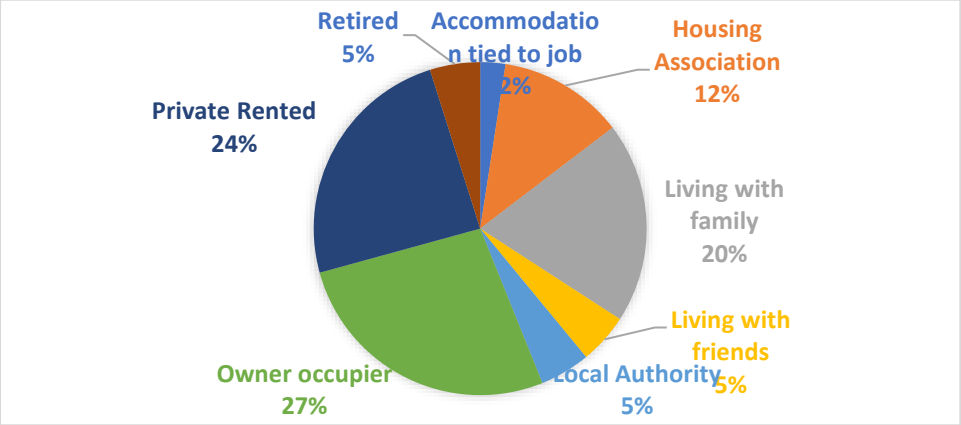



Figure 29 shows the ethnic origins of the women which appears to be a similar representation as the men in terms of who is coming forward for treatment.

Figure 29

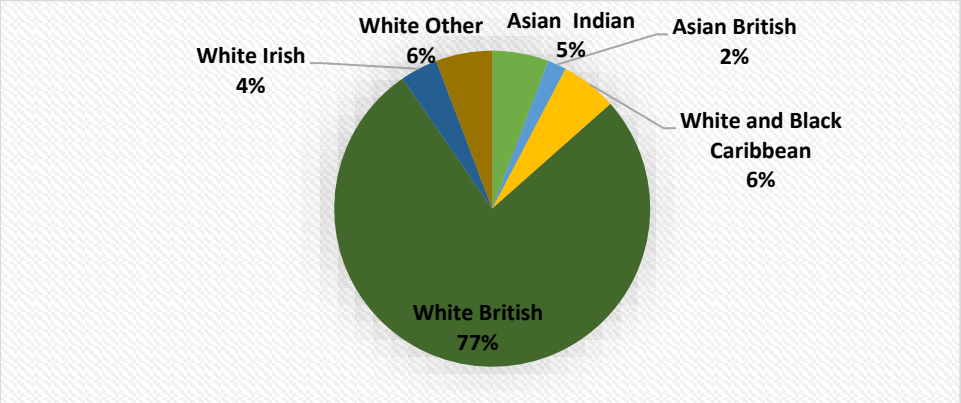


Figure 30 shows the age they started gambling and that for the most part they are over 18 when they start gambling. Many of them report later onset gambling than the men.

Figure 30

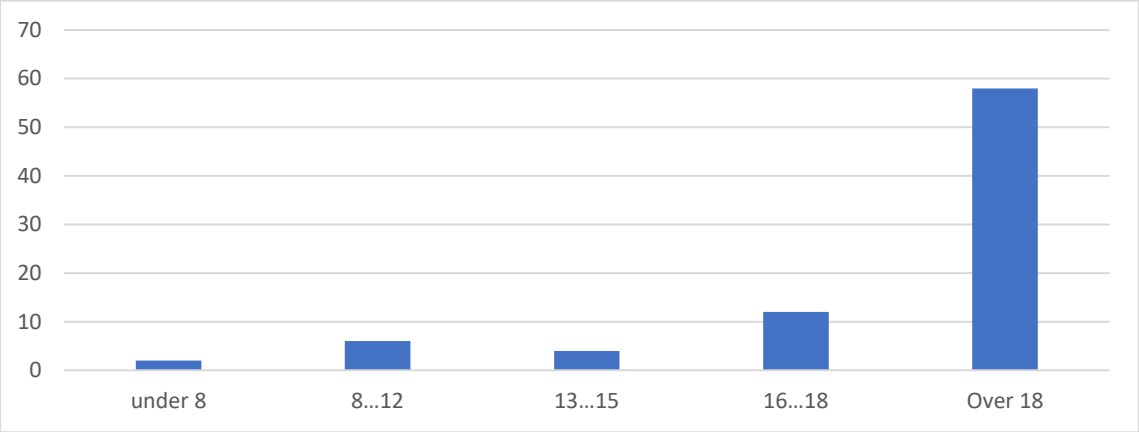



Figure 31 shows the numbers in each age group upon admission

Figure 31

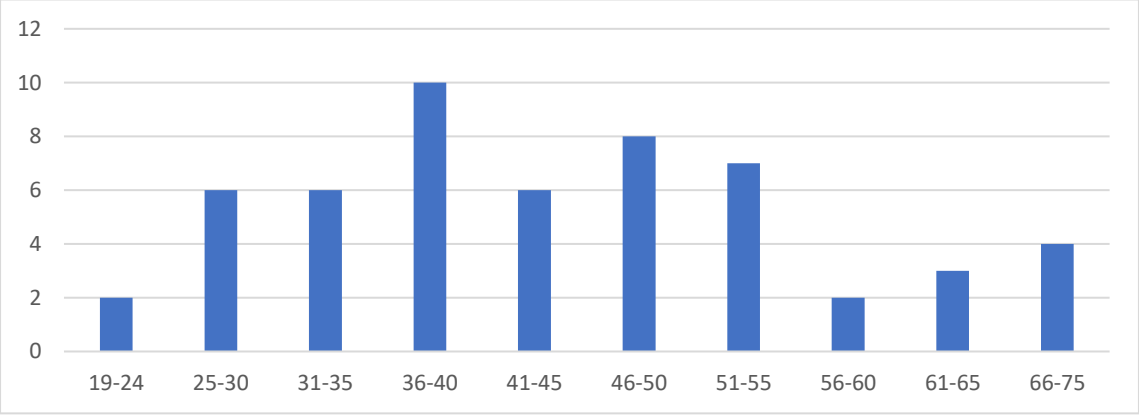


Figure 32 shows the Self-reported Gambling styles

Figure 32

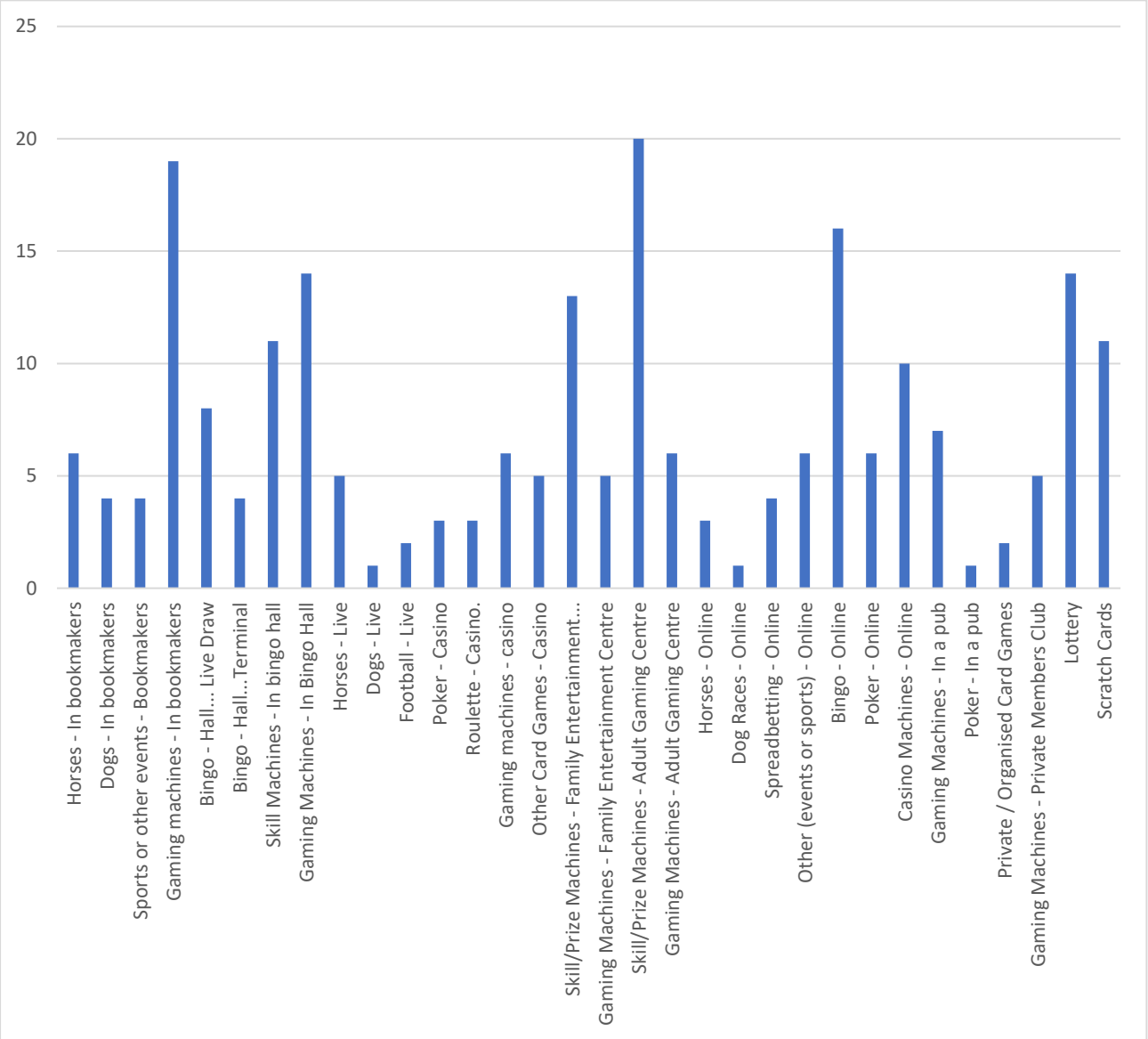
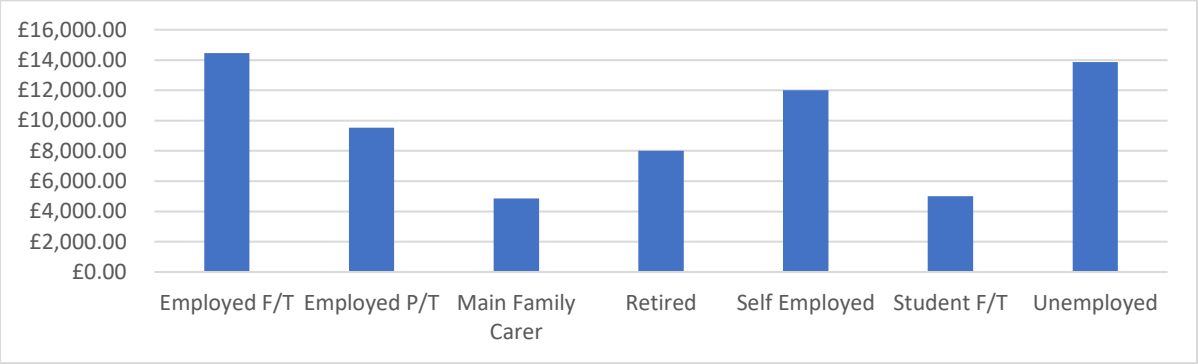


Figure 33 shows the average amounts gambled per year against their employment status for year 2015/17

Figure 33




Full time employed...amounts gambled shown are in relation to 23 of the women.
Main family carer....amount shown in relation to 6 of the women
Unemployed....amounts gambled shown are in relation to 15 of the women
Full time student...amount shown in relation to 1 woman
Self-employed ...amount shown in relation to 1 woman

The collective debt reported by 33 of the women treated at GMA in 2 years is just under £933,00 and Figure 34 shows average debts against the average Income for the years 2015/17

Figure 34


Again as already seen with their male counterparts, in comparison to their income these are sizeable amounts to have to find on top of living expenses.

**Evaluation**

We continue to get really positive feedback from the women who take part in our treatment programme, all of whom state that they feel they have a chance at a normal life because they have taken part in it. As we now have secure funding for this programme we will be able to continue delivering to more women. In turn, this will allow us to continue collecting data; to not only examine the longer term results and therefore the efficacy of this model of treatment, but contribute to the broader picture of women in gambling in the UK.

**Overall Conclusions for Residential Centres and Women's Programme**

The outcomes described in this Impact report continue to demonstrate the effectiveness of our treatment programmes and their ability to successfully rehabilitate compulsive gamblers.

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

The 6 year cumulative figures are providing 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.

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