CHAPTER SIX

Residential Treatment for Harmful Gambling

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A residential treatment approach involves interventions delivered in a 'live in' setting away from an individual's regular home. The nature and scope of these interventions can vary widely. Longer term residential placements for rehabilitation and recovery are often distinguished from shorter 'inpatient' stays in hospital or other treatment settings, for detox or short-term urgent treatment.

Ealy Years of Residential Rehabilitation Facilities

The history of residential spaces for addiction recovery goes back to the early 19th century. The first “sober houses” were opened in 1810 and the first “inebriate asylum” in 1830 by Dr. Samuel Woodward. By the end of the century, Dr. Leslie Keeley’s 31-day residential treatment stay became famous, offering healthy food, exercise, and fresh air in almost 120 institutes that opened in a span of 30 years. This was very influential in fashioning the approaches of modern-day rehabilitation facilities: providing a secure, comfortable, and healthy place for recovering addicts to learn how to live without their chemical crutches. But it wasn’t until the 1940’s when the founding of Alcoholics Anonymous (AA) and the development of the “Minnesota Model” of

chemical dependency combining the 12 steps with residential therapeutic communities, really set the landscape of residential rehabilitation facilities in USA.

Since the 1970s residential treatment facilities have expanded to cover a wide variety of emotional and behavioural health conditions from substance misuse and process addictions (such as gambling, sex and love addiction, shopping addiction) to eating disorders, trauma and PTSD.

In 1972, the Brecksville Unit of the Cleveland Veterans Administration Medical Center began the first inpatient treatment programme for pathological gambling in the United States. The 30-day, highly structured gambling treatment programme aimed for abstinence from gambling, a reduction in gambling urges, and restoration of social functioning.

To our knowledge, there are less than ten residential treatment programmes specifically dedicated to gambling related harm. Most of these are in Australia, Canada, or the USA.

The UK's First Residential Rehabilitation Facilities

In 1968, UK psychiatrist Ian Christie converted a ward in St. James' Hospital, Portsmouth, into Europe's first concept-based therapeutic community, later re-named from the Pink Huts to Alpha House. Meanwhile, psychiatrist Griffith Edwards at the Maudsley Hospital was involved in advising the Ministry of Health about the establishment of another residential project in South London called Featherstone Lodge, later re-named as Phoenix House (Winship, 2014).

A wide range of approaches emerged in the early days of these residential programmes, . This included approached led by lived experience used in some of the US settings, to those overseen by

psychiatry but based on democratic group led programmes in therapeutic communities in the UK. The first NHS residential unit for drug treatment was set up at the Bethlem and Maudsley hospitals in London in 1968 (Winship, 2014). Just three later in 1971, Gordon Moody established his hostel in London to offer residential based support for those with severe gambling problems.

Residential Programmes Interventions

Residential rehab facilities are the best option for those who have completed medically assisted detox, especially if they have a history of relapse or know their home environment is addiction-friendly and it will be difficult for them to maintain their recovery there. Residential facilities provide a supportive environment for those who are dually diagnosed with a mental health co-morbidity and need more care and support provided by health professionals.

Furthermore, residential treatment offers a way to stabilize a person and can help develop skills and patterns of thinking that can help them stay well once they complete treatment. Rehab offers a recovery community and safe space, with a structured schedule and the benefits and responsibilities that come with it.

The content of therapeutic interventions in most residential programmes has been broadly dominated by twelve step approaches based on the AA model, though more so in the USA than in other countries (Gray & Argaez, 2019). In the case of Gordon Moody, the twelve step Gamblers Anonymous (GA) approach was central to the initial programme because Reverend Moody was influential in establishing GA in the UK in 1964. However, this has changed in recent years towards a more holistic and integrative approach.

Although differences in approach remain, the components and delivery of interventions are more standardised in contemporary residential treatment. Guidelines and evidence have emerged for treatment providers that focus on validated behavioural interventions, including cognitive behavioural therapy (CBT), motivational interviewing (MI), and individual, family and group counselling approaches. In the UK, for example, National Institute for Clinical Excellence (NICE) guidelines state residential programmes should include psychosocial interventions including contingency management, behavioural couples therapy and CBT (NICE, 2007). The most recent review of evidence suggested that programmes typically include individual and group psychological support, self-help, peer support, help with reintegration into the community, and support for withdrawal or with maintenance on substitute drugs in a hospital or supervised residential facility (Andrade et al., 2019). Twelve step programmes remain a significant element of many programmes. For example, a recent national audit of US residential treatment programmes for opioid dependence found almost all offered twelve step interventions (Beetham et al., 2020).

In several countries, a period of residential treatment is now recommended for those with more severe addiction problems in stepped care guidelines. As a benchmark for addiction treatment, UK guidelines suggest four tiers of service specialization, with tier 4 interventions including specialised residential drug treatment that is planned and coordinated to ensure continuity of care and aftercare (Department of Health and Social Care, 2017).

Evidence of Effectiveness of Residential Programmes Interventions

The most recent evidence shows clear benefits of residential treatments that are maintained over time. This section summarises and assesses this research and assesses some of the more limited evidence.

In the 1990s, the UK government was concerned about the effectiveness of treatments for substance misuse and commissioned a significant evaluation called the National Treatment Outcomes Research Study (NTORS). This prospective cohort study monitored patients in treatments for drug abuse in a range of settings and evaluated outcomes over a five-year period. Substantial reductions across a range of problem behaviours were found 4 to 5 years after service users were admitted to national treatment programmes, and abstinence rates increased to 38% after 5 years for the whole cohort. This finding led to a newfound confidence in residential treatment among policy makers and treatment providers and influenced similar efforts in a number of countries (Gossop, 2015). Evidence from a large-scale, longitudinal, national, multisite treatment study conducted by Andrade and colleagues (2019) showed residential addiction treatment to significantly improve addiction problems and also reduce crime, reduce unemployment and help those in recovery be active members of the society again.

Additionally, a 2019 international review of the clinical effectiveness of residential treatment found good evidence from two existing systematic reviews and new individual RCTs that residential treatment is at least as effective as less intensive treatment, with length of stay ranging from 14 days to 6 months (Gray & Arguez, 2019). While the length of stay has become shorter in the last two decades, research and guidance consistently suggest longer time periods

lead to greater gains and that at least three months should be offered (National Institute on Drug Abuse, undated). The reasons for shorter length of stay are varied, but often included cost pressures from health insurers or other funders. In the UK, funding is often provided by local authorities who have faced average overall budget reductions of 30% over the past decade (Institute for Government, 2021), resulting in shortened periods of care and the closure of a number of facilities.

The review by Gray and Arguez (2019) noted that while the evidence favoured residential treatment, it had low methodological quality, with little detail provided regarding the specific interventions. In one RCT, participants were randomised to outpatient treatment, a residential placement featuring a" therapeutic community" or one featuring an "Oxford House." The latter refers to a rented house for a group of at least six people responsible for maintaining the home, paying bills and following Oxford house rules, which include abstinence. The philosophy focuses on ownership of one's own recovery, with the goal to build self-help, self-efficacy, and a sense of responsibility through a democratic system. (Jason et al., 2015)

Emergence of Research into Effectiveness of Gambling Treatment Interventions

The existing body of literature is much greater for substance related disorders than for harmful gambling, as is the number of residential facilities. Hence, the available data on any aspect of such programme, including their effectiveness, is also quite limited. Nevertheless, when the issue has been investigated, both gamblers and therapists suggest a firm need for more residential treatment. Ledgerwood and Arkfen (2017) found 42% of problem gambling outpatients in the US were willing to attend residential treatment if it were offered, while therapists thought about a third of their clients required it. Notably, a study exploring the issue in 13 residential treatment

programmes for substance misuse found a 20% lifetime prevalence of a co-occurring gambling disorder, and a third of the cohort identified gambling as an issue that could hinder their recovery (Leavens et al., 2014), yet few of these had addressed the issue in their substance misuse treatment.

Unsurprisingly, studies show differing characteristics between outpatient and inpatient problem gamblers, with more severe gambling related problems and higher comorbidities for the latter (Ladouceur et al., 2006). The needs driving individuals towards inpatient or residential treatment and the thresholds for entry mean this is always likely to be the case. Perhaps because of the severity of their problems and the mental demands of participation in intense therapeutic programmes away from home, dropout rates are also unfortunately high. A recent study of admissions to the Gordon Moody programme found half of participants did not complete treatment (Roberts et al., 2019) Several factors were correlated with dropping out including debt, depression, adverse childhood experiences, older age, and the type of gambling being online or poker.

A review of Australian gambling treatment services during 2000-2002 concluded there was no need or demand for residential treatment and that the gambling and comorbidities could best be managed in other ways (Macallum & Blaszcynski, 2002). An evaluation in the USA found no differences in outcomes between one residential and ten non-residential treatment programmes in Minnesota (Stinchfield, 2011). However, more recent research has shown more promise. One review of a programme in Germany found evidence of good outcomes, with 35 of 49 patients abstinent after one year and 31 were still abstinent after two years of treatment (Muller et al., 2017). And in a pilot study of a two week programme in Australia found inpatient gambling

treatment predicted significant improvement in gambling indicators over the following year (Morefield et al., 2014).

As noted above, residential treatment for other addictions has demonstrated successful outcomes and cost effectiveness. Problem gambling shares many features with other addictions but also has some differences that could potentially impact on the outcomes. Further research is required to determine whether this is the case. The remainder of this chapter provides a detailed insight into the approach that has evolved and adapted at Gordon Moody in the UK, based on decades of experience.

The Gordon Moody Way: Combining Evidence and Lived Experience to Develop a State-of-the-Art Model of Care

"One agency … stands out within the UK and, I believe, in Europe, as the only specialised, long-term residential facility for problems gamblers – the Gordon Moody Association" (Bellringer, 1999).

The history of Gordon Moody dates back to the 1950s. The Reverend Gordon E. Moody, MBE, a Methodist minister and Secretary of the British Churches' Council on Gambling from 1958 to 1978, was a prominent figure in the implementation of the first Gambling Act and the establishment of GA in the UK during this time. With time, Reverend Moody realised that despite attending weekly GA meetings, many were struggling with their addiction between meetings due to alack of support from others and no place to live safe from gambling triggers. In response, he opened a hostel offering a helping hand to those struggling with gambling addiction in 1971 in

South London and called it Gordon House—the first residential facility in the world devoted solely to treating harmful gambling. Over the next 50 years, the experience of working in a residential setting with this service users group helped develop the unique therapeutic residential programme offered today. Gordon House at Gordon Moody provided a safe haven where people with gambling problems can leave them behind and begin to rebuild their lives.

From the outset, the organisation was established as a registered charity that under the UK constitution required Gordon Moody to "make provision to relieve the suffering and distress caused by compulsive gambling." That remains the case today: "Gordon Moody is a place where the gambler can stop running and can, with help, develop the courage to face the mess that he has created. It enables him to take responsibility for himself and for others, thereby helping to restore self-esteem" (Bellringer, 1999).

In its first years, Gordon House's twelve-bed residence became a refuge for harmful gamblers released or diverted from prison to help break the cycle of gambling, crime and imprisonment.

Further accommodation was opened in Dudley, West Midlands in the 1990s to reach people outside London. This provided a 22-bed facility surrounding a landscaped garden with external spaces for counselling, support, and communal areas for both therapy and socialising within the therapeutic community. In 2022, the treatment facilities in London and West Midlands were able to offer more than 200 residential treatment places per year for both men and women.

Theoretical Underpinning of Gordon Moody's Model of Care

In line with the official classification of both the DSM-5 and the official International Classification of Diseases (ICD-11), Harmful Gambling is defined as a complex and multi-faceted behavioural addiction characterized by "persistent and recurrent maladaptive gambling behaviour that disrupts personal, family, and/or vocational pursuits" (American Psychological Association, 2013).

At Gordon Moody, gambling is conceptualized along a continuum, ranging from no gambling to occasional gambling, "at-risk" gambling, mild harmful gambling, and finally severely harmful gambling. Gambling harms are also placed along a severity continuum ranging from no harm through mild, substantial, and severe harm. Thus, through all interventions offered, harms experienced at any level of gambling involvement is carefully considered. Gordon Moody has a multi-dimensional conceptualization of recovery and measure the effectiveness of their interventions incorporating broader outcome domains beyond disorder-specific symptoms and behaviours. Prevention and treatment interventions are constantly optimised by acknowledging the importance of the current gambling environment, particularly given the rapid growth of internet-based gambling and changes in regulations and guidelines, such as the revision of the Gambling Act 2005 or the development of NICE guidelines for treating gambling related harm.

The current theoretical framework is in line with the regulations and guidelines recommended by Public Heath England and NICE The model of care embraces a trans-theoretical approach to change and is supported by the latest empirical evidence demonstrating what works in assessing and addressing gambling related harm (Rizeanu, 2013; Barker et al., 2016; Nower &

Blaszczynski, 2017; Rodda et al., 2018). The clinical team use leading approaches for treating gambling disorders such as brief interventions, financial education, self-help tools, motivational interviewing, CBT, as well as a number of integrative therapeutic techniques.

Underpinning all of this is a compassionate approach that offers understanding and support. The purpose is to create safe and caring environments that empower the service users to make positive lasting changes toward more fulfilled lives, with. interventions tailored to their needs and a recovery focus that builds on their strengths and capacity to flourish.

The Profile of Service Users Accessing Gordon Moody Residential Treatment

In most cases, applicants for treatment at Gordon Moody are extremely vulnerable. A robust and supporting service user journey is therefore imperative so that anyone reaching out for help has access to the right level of support to prevent cases of service users disengaging and becoming lost in the system.

As many as 80% of applicants have already sought help elsewhere for their gambling issues. This does not mean these other forms of help have not worked, but it does mean Gordon Moody is often their last hope.

Other prevalent characteristics in the population seeking help at Gordon Moody are the presence of highly complex social or family dynamics such as homelessness, lack of job, loss of family, domestic violence, a criminal history, a history of adverse or traumatic childhood

experiences, isolation, lack of social support, and/or living in a highly stressful or risky environment.

While 65% of applicants were male in 2021, applications from women are growing at a faster rate, increasing by 132% between 2020 and 2021. The average age of applicants remained consistent between 2016 and 2021 for both men and women, with most between 25 and 34 years of age.

Gambling harm severity is assessed using DSM-5 criteria for pathological gambling as well as readiness and commitment to treatment. Typically, a Gordon Moody applicant will have a DSM score of 18 (out of 20) or higher and may also be experiencing other issues such as substance misuse cross-addiction or co-morbidity.

Historically, the vast majority of Gordon Moody's applicants are of white British heritage (over 90% between 2011 and 2019). However, between 2019 and 2021 applications have been more diverse with service users of Asian or Asian British heritage seeing the largest growth (from 2% in 2019 to 8% in 2021).

The two other psychometric tools Gordon Moody uses in early assessment are the Problem Gambling Severity Index (PGSI; Ferris & Wynne, 2001), and the Clinical Outcomes in Routine Evaluation (CORE-10), a generic, short, and easy-to-use measure for common presentations of psychological distress in UK mental health care settings (Barkham et al., 2013; Lewis, 2016). The average PGSI score at start of treatment 21 out of 27 and the average CORE-10 score is 21 out of 40. Both are considerably higher than the average scores of service users accessing any other

gambling treatment services in UK, with the national average scores at the point of accessing treatment of 12 for PGSI and 8 for CORE-10 (Gamble Aware, 2021).

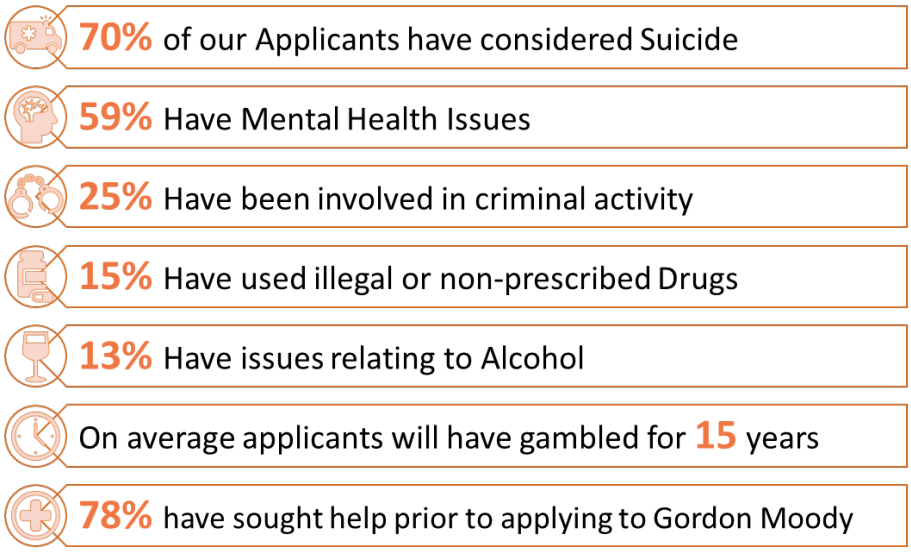
Service users often present with various mental health challenges including poor emotional regulation skills. In 2020, 70% of applicants had considered suicide in the year prior to applying (Sharman et al., 2019). In 2021, 76% of applicants had presented with a mental health diagnosis (most commonly depression, anxiety and emotionally unstable personality disorrder), a sharp rise from 25% in 2011 and 50% in 2015(Sharman et al., 2019), while 59% presented with a mental health issue other than depression or anxiety. Research has indicated a growing proportion presenting for treatment that are on prescription medications, the most commonly anti-depressants (Sharman et al., 2019).

In 2020, 28% of applicants presented with an alcohol or drug addiction. Mean prevalence of substance use appears to be significantly higher for Gordon Moody service users than in national level prevalence. Recreational drug use was reported by 23.8% of service users in 2017 compared to 8.4% for the general population (NHS, 2017), while alcohol use was reported by 74.4% of service users compared to 56.9% for the general population (Office for National Statistics, 2018).

Furthermore, 25% of applicants had some involvement with the criminal justice system in 2021, a sharp increase from 17% in 2020 and 18% in 2019.

Figure 1

Profile of Gordon Moody Service Users



We have learned in recent years that gambling harms can affect certain groups in society in unequal ways, which links to the much wider issue of inequality particularly in health care. Historically, the vast majority of Gordon Moody's users were white British men between the ages of 25 and 35. However, research shows the prevalence of gambling related harm is far wider than this, impacting a vast range of ethnic and demographic communities that now have limited access to treatment and support (PHE, 2021). Gap analysis conducted by Gamble Aware (2021) evidenced a need for treatment provision for various underserved groups in the UK, with women, LBGTQ+ and BAME groups all found to be underrepresented in treatment programmes.

The variety of needs, risks and presentations calls for a wide range of holistic and bespoke treatment approaches that account for all aspects of service users' lives. The next section will introduce Gordon Moody's approaches to treating gambling related harm.

A Tale of Two Approaches: Residential Treatment and Retreat & Counselling

Central to all Gordon Moody's programmes is the group living experience where residents share the same resolve. They support each other through the changes each must make by understanding that through their own experience they can recognize and provide for each other's needs. The programmes are primarily and purposely focused on addressing harmful gambling and its impact on lifestyle and behaviour. There is also a partial focus on supporting wider needs relating to debt, budgeting and safer banking, legal issues, physical and mental health, living skills, safer internet use, healthy relationships, employment/education/training (ETE), and housing and resettlement. This is achieved through discussions within core sessions, practical support from support workers, referral to external agencies and signposting.

Gordon Moody's programmes and interventions are delivered through evidence-based therapeutic and clinical approaches for addressing gambling related harm including CBT, motivational interviewing, psycho-dynamic and analytic therapy, interpersonal group therapy, art and creative therapies, one to one counselling and individual assignments such as reflective worksheets with pre-established questions (Fig. 2), self-awareness exercises and creative exercises.

The programmes also incorporate 'node-linking mapping' techniques (Routes to Recovery, 2007), which see the service users and their therapists collaborating in building visual representation maps to inform their assessment, recovery planning, goal setting, building social support, skills development and exit planning processes.

Figure 2

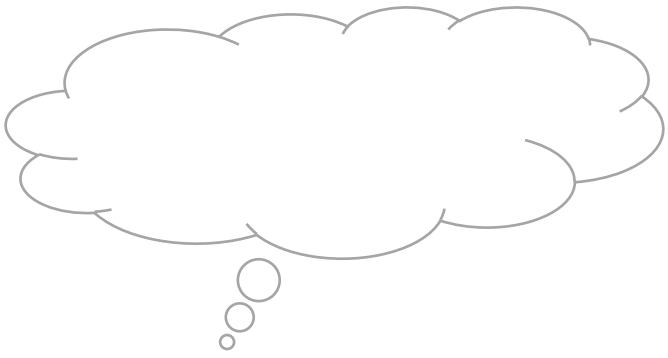
Example of Worksheet Accompanying the Foundation Group

What Needs to Change?

The fact that you're here with us indicates that you've reached a point where you want to do something about your gambling. Recovery isn't rocket science, but in order to stop gambling you need to be prepared to make changes in *every* area of your life. The aim of this session is to identify what needs to be changed, explore how to do this and consider what the benefits of making these changes will be.

Making changes can be scary, you'll need to be motivated and **hold on tight** to the reasons *why* you wanted to make those changes in the first place. So, let's look at that, what is it that your current level of gambling has done to you, your life and those around you that has made you want to stop?

What have you lost due to gambling?



It's a pretty big list, isn't it? Your losses are your **ammunition** when it comes to your fight to become, and remain, gambling free. When it comes to **motivation** it can be really helpful to visualise your gambling free future. Start now by picturing what that future will be like, who will be in it? What will you be doing?

What do you need to change about **YOU** to obtain this future?

What might you need to change about your surroundings, relationships and life in general?

When you applied for treatment, you may have felt that your gambling behaviour was the only thing that needed to change. How do you feel about it now and how do you feel about making the required changes?

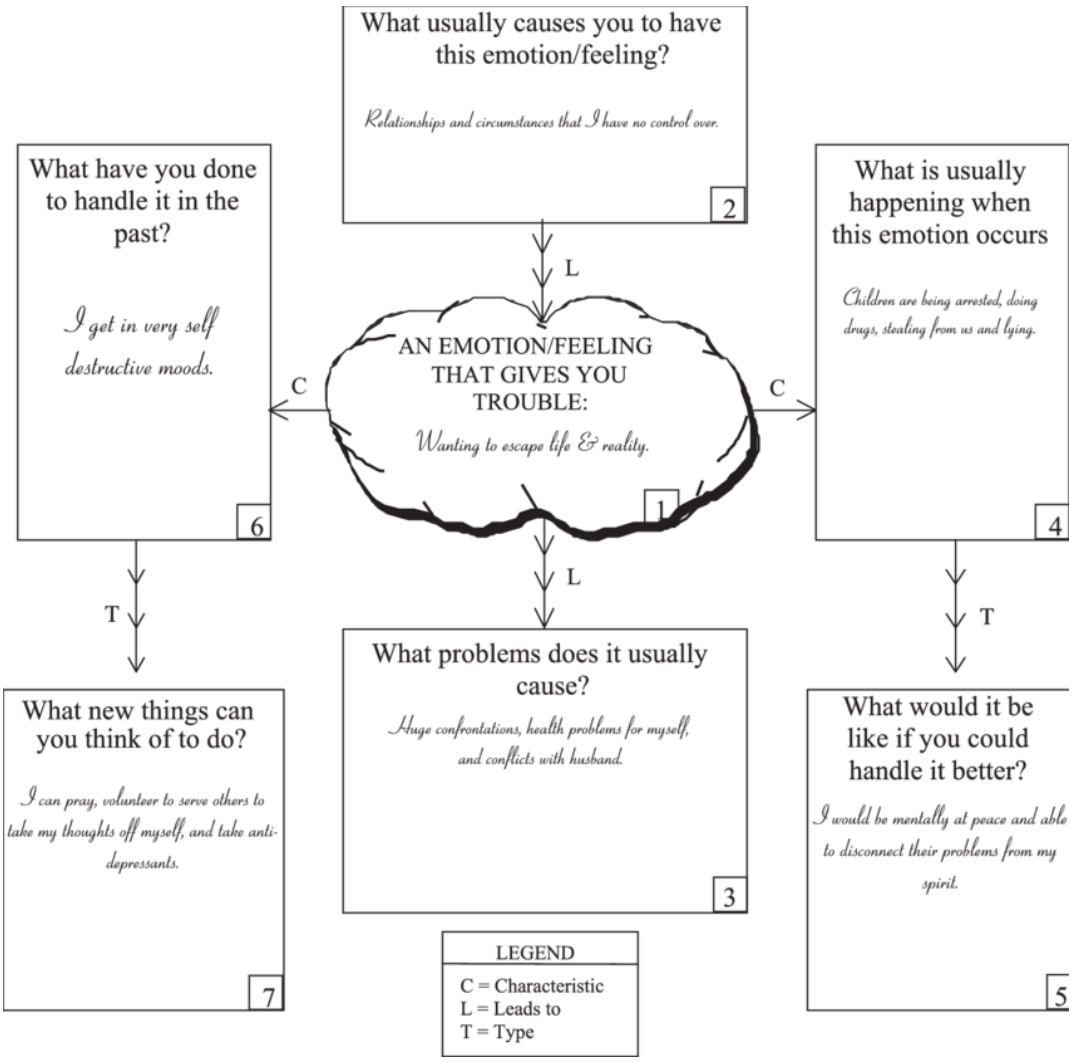
What scares you?

What excites you?

Who benefits?

Figure 3

Example of a Node-Linking Map



Residential Treatment

Gordon Moody currently offers a 14 week residential treatment programme at all its men's residential treatment facilities. This programme was designed in early 2000s by clinical staff and lived experienced alumni, and is reviewed and updated by staff and alumni every two years.

New residents need to be helped to establish a supportive relationship with the other residents, as this support provides the core of the Gordon Moody experience. Residents do not all have the same problems but they do share similar experiences and can recognise the signs of someone who is tempted to gamble or is struggling. Living with others who have 'been there' but have moved through the stabilisation process is particularly valuable to new residents trying to come to terms with their situation.

Residents also play a full part in the running and maintenance of their residential home, responsible for their own cooking and cleaning and do much of the decorating and basic maintenance of the properties with the help of staff. Because they come to the centre with a gambling disorder, care is taken to avoid creating new dependencies or further de-skilling. Active participation in running the residence also helps fill the time once might have been filled with gambling.

Assessment and Admission

A comprehensive clinical assessment is carried out by trained and experienced staff for all applicants to Gordon Moody. The assessment is comprised of several sections: (1) introductory conversation and needs assessment, (2) social functioning, (3) health and wellbeing, (4) alcohol and drug use, (5) relationships with family and friends, (6) safety, and (7) next steps towards recovery. The purpose is to ascertain the level of risk to the service user in terms of mental health, suicidality, and other issues such as substance abuse and safeguarding risks to those around them,

such as dependents, parents, or siblings. The assessment also explores their level of readiness and commitment to treatment.

Following the assessment, each case is presented to a multi-disciplinary referral panel populated by representatives from the senior team, service managers, and the clinical and assessment teams. Successful candidates are forwarded onto a bespoke pre-support programme to facilitate a smooth transition into treatment.

Gordon Moody has worked extensively with other treatment providers such as GamCare, the NHS London Gambling clinic, the NHS Northern Gambling service, NHS primary care, as well as other treatment providers for other mental health or addiction issues such as Changes UK and Adferiad to provide robust referral pathways for those that need it, further reducing the risk of people becoming "lost" in the system.

Two-Week Assessment

In the first fortnight after acceptance into the programme, staff and fellow residents help newcomers settle in, slow down and to make them feel part of the therapeutic community at the heart of the facility. The knowledge that they are not alone and are part of a team working to tackle and ultimately overcome their gambling disorder is compelling and motivating. The first two weeks gives service users and staff the opportunity to see whether the residential treatment programme is appropriate for them.

During this first week of the programme, each resident completes a detailed personalised life audit relating to their gambling disorder. The Life Audit is a unique 99-item tool covering every aspect of the individual's life (not just gambling history) developed early in the history of Gordon Moody, and is the basis for the bespoke care plans built by the service users together with their allocated focal therapist.

It begins by asking about their earliest gambling memories, the age when they can first remember gambling or being exposed to gambling, when gambling became a problem and what else was happening in their life at the time. This can often be a key to unlocking the reasons their gambling became destructive. The audit also investigates past efforts they have made to stop gambling and how successful they were. The remainder asks questions about their life outside of gambling, their physical health and their emotional health. Their beliefs and values are also discussed to help them see how their moral compass became skewed as gambling took hold.

The audit then looks at the social life of the service users, and how relationships with family and friends may have broken down or ended. It finishes with legal and financial consequences and whether there are outstanding matters to be dealt with.

At the conclusion of the session, individuals are asked if there's anything else they want to say, which they often do as it might be the first time they have opened up about their problems. They work together with their therapist to use what has come from the audit to formulate an action plan setting goals for treatment and how to achieve them. Some goals will be long-term, looking towards completion of the programme, while others will be focused on the first few weeks (e.g.,

addressing their physical wellbeing by joining the gym). These are then reviewed every four weeks throughout the programme and beyond into aftercare support.

Twelve-Week Treatment Programme

After the initial two weeks have been completed, service users work closely with the whole staff team to build an individual action plan as a "road map" into recovery (Fig. 4).

The core programme consists of a set 'foundation group' built on CBT and relapse prevention model foundations, delivered in two sessions per week for 12 weeks (Table 1).

Alongside the Foundation Group, a weekly Honesty Group is facilitated during the first six weeks of treatment and a weekly Relapse Prevention Programme is facilitated during the last six weeks.

Figure 4

A "Road Map" to Recovery – a Template for Developing Care Plans

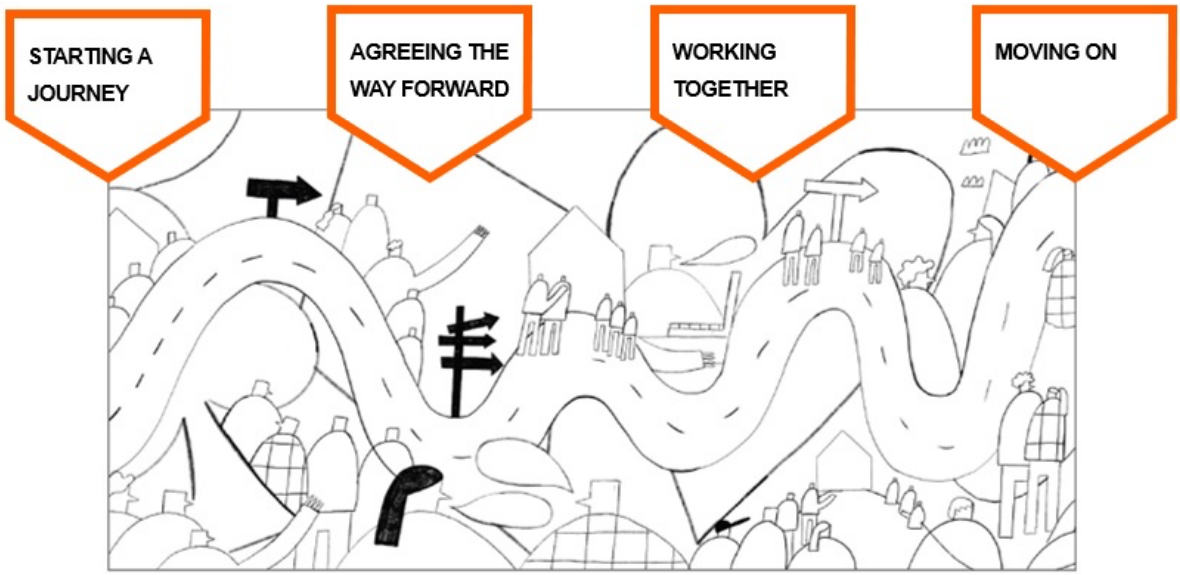


Table 1

The Foundation Group Sessions

1. Who Gambles?	7. Solving conflicts
2. What needs to change?	8. Testing personal control
3. Remaining open to change	9. Cycle of problem gambling
4. Reducing the risk	10. Managing external triggers
5. Personal Shield	11. Managing your feelings
6. Assertiveness	12. Distorted thinking and lies

Table 2

The Honesty Group and The Relapse Prevention Sessions

Honesty Group Sessions	Relapse Prevention Sessions
1. Hostility	1. Emotional Triggers and Coping Strategies
2. Rationalisation	2. Seemingly Irrelevant Decisions and High-Risk Situations
3. Denial	3. Moving into Independence
4. Diversion	4. Old and New Lifestyles
5. Minimising	5. Personal Financial Management
6. Blaming	6. Moving on and Building Recovery

Both residents and staff regard these as the key groups in their treatment as it elicits crucial information and allows an opportunity for reflection and changes in thinking and attitudes. Therapists use a standardised Treatment Facilitator Manual and Gambling Therapy Handbook along with standard facilitator sheets for each of the individual programme sessions.

In addition to the core groups, two weekly support meetings take place where residents reflect on the past week through a peer/semi-facilitated model. Residents at both sites value these sessions the most because it offers a safe space for them to identify and process emotions in a healthy way. Residents also engage in weekly art therapy and creative groups that encourage them to explore their relationship with gambling, themselves, and with people around them through a psychodynamic and expressive approach. Weekly one-to-one sessions are also undertaken with each resident and their individually allocated therapist to address individual needs based on a personalised support plan delivered through counselling.

The programme runs weekly from Monday to Saturday. Saturday afternoons are reserved for activities off-site and an opportunity to explore the local area and try new or past experiences, all undertaken together with a member of staff. Sunday is a day to relax but also prepare for the week ahead. Gordon Moody believes having free time allows service users to reflect on the work they have engaged with over the week and to engage in stimulating gambling free activities to re-discover possibilities for connection and entertainment when they stop gambling.

A New Residential Service for Women

Characterised a "feminization" of gambling (Volberg, 2003), more women than ever before are gambling and consequently developing gambling-related problems and seeking help (Holdsworth et al., 2012). Affected women are in urgent need of better quality and more extensive support and treatment. Gordon Moody has been addressing this challenge for several years through

its Retreat and Counselling programme (see below), but much more women-focussed treatment and more expert therapists are clearly needed.

In response, a new residential treatment centre was opened by Gordon Moody in November 2021 offering a unique safe environment specifically to treat women severely affected by gambling. With a large proportion of women also seeking support as an affected other, Gordon Moody created an evidence-based and service user led centre that provides not only a residential treatment programme for those severely affected by gambling disorders, but also respite, counselling and support for their families. The programme is not only effective but recognises the wider issues surrounding gambling disorder in women. It is also inclusive of LGBTQ+, BAME, and other ethnic and minority communities, among which research has shown a higher prevalence of gambling related harm (Levi & Diaz, 2020; Gunstone & Gosschalk, 2020).

The women's residential programme spans six weeks: one for assessment, four for treatment, and one wind-down week. The length of the programme was determined after a series of focus groups conducted with prospective service users and other professionals providing women-specific mental health and addiction support. The programme is followed by a robust virtual aftercare programme with continuous support for up to a year through wrap-around services. For the recovery journey to be successful, Gordon Moody offers specialised therapeutic support focusing on addressing issues such as trauma, adverse childhood experiences, domestic abuse, dealing with guilt and shame, parenting, personality disorders and substance misuse—issues that have been shown to be related to harmful gambling and women (Farstad et al,. 2020; Riley et al., 2021). Experiential therapy interventions such a yoga, somatic therapy or eye

movement desensitization and reprocessing (EMDR; a therapeutic technique supporting people to process traumatic events) is provided based on a bespoke assessment of care needs. Friends and families of the affected gambler will also benefit through counselling and Gordon Moody aims to provide support for over 100 women a year affected by another's gambling.

Table 3

Group Sessions for the Women's Programme

Week 1	Week 2	Week 3	Week 4
The Cycle of Change	Negative core beliefs	Stories and Heroes	Mindful Communication in relationships
What needs to change?	Behaviour chains and reducing risk	Living your Values	
The Cycle of Gambling	Triggers and High-Risk Situations	Budgeting Skills	Women roles
Barriers to Change	Guilt & Shame	Distorted thinking	Warning Signs and Trap Doors
Change and Resistance	Surviving Trauma	Slips and near misses	Developing support
Safer Internet Use	TA Ego states	Visualising Recovery	Letter to future friends
Letter to Self	Identity: The story of Rita	Confidence Building	Continuous Recovery
Assertiveness	Unhelpful thinking habits		

Recovery House Programme

Following the completion of the programme, those requiring additional support can also engage in residential relapse prevention and an aftercare programme.

The therapeutic core of the Recovery House Programme is made of 12 Beyond Recovery group sessions addressing the issues of wellbeing and recovery beyond the material covered by the main recovery and relapse prevention programmes. The group supports the residents to create a clear picture of how they want their life to look and to understand the field of possibilities they are now presented with.

Table 4

The Beyond Recovery Group Sessions

Your Physical Realm	Your Emotional Realm
1. When the body says no	7. Emotional regulation
2. The physiology of recovery	8. Building blocks of stress resilience
3. The return to self-care	9. The power of vulnerability
Your Mental Realm	**Your Spiritual Realm**
4. The reconstruction of self	10. Meaning and motivation
5. Healing states of mind	11. Introduction to mindfulness
6. Dealing with boredom	12. Connecting with others and giving back

The residents are also offered an additional support group and a one-to-one session per week and are encouraged to attend the virtual aftercare group delivered twice a week to all residents who have completed treatment.

In addition to the therapeutic input, residents in the Recovery House are supported to move into independence and achieve self-sustaining recovery. They are offered support around a range of issues including employment, housing, budgeting, finance, healthy eating, and other living

skills. Residents are also encouraged to engage in off-site voluntary or educational activities for a minimum of 16 hours per week.

Gordon Moody also has a peer-mentorship programme for alumni to take an active role in supporting other people affected by gambling related harm. Likewise, there is a strong emphasis on supporting residents to relocate in the local area, and practical support is provided to prepare them to move into new homes and furnish them, including home visits.

Retreat and Counselling Programmes

Gordon Moody's Retreat and Counselling Programme is an intensive treatment programme for both men and women struggling to overcome gambling harm but cannot commit to residential treatment. The service combines two three-day residential retreats with 12 weekly therapy sessions delivered online and/or by phone.

In its standard form, the first three-night residential session includes a series of therapeutic group workshops in a retreat style setting, during which service users can step back from their daily lives and focus on their needs and issues. They are supported to develop an understanding of why their gambling has become problematic, within a positive network of people struggling with similar problems. Remote counselling support is also provided between retreats and afterwards for a total of 12 weeks/sessions. This 'at home' stage is supported by a detailed self-completion handbook, and participants are also expected to attend fortnightly online group sessions facilitated by the retreat and counseling therapists.

After eight weeks, participants are invited back to stay at the retreat for another two nights to look at what they learned during their time back at home, discuss any insights gained from treatment and create a personal plan to lead a healthier, gambling-free lifestyle. The programme concludes after four additional four one-to-one weekly sessions, with the option of up to one year of aftercare support.

Post-Treatment Support (Aftercare)

Service users leaving the residential or Retreat and Counselling programmes are offered aftercare support provided by an outreach recovery worker, to carry forward the goals and priorities ascertained during treatment and the transition plan. This involves maintaining contact with service users, providing continued recovery support, motivational support, signposting to other support agencies, relapse prevention, crisis support and practical advice (e.g., regarding benefits or housing). Support is primarily provided by phone, text or email but also includes two weekly online therapist-facilitated peer-support groups with members who have successfully developed a self-sustaining, independent recovery community. In addition, the service users going back home are actively encouraged to use the support network of family, friends, or any other local community support.

The level of work is more intense within the first months of finishing the programme, with contact reducing thereafter, and is generally divided into three different stages, with progress, goals and action plans being reviewed every three months. After the successful completion of one

recovery year, service users are encouraged to engage in the peer-mentoring programme if they wish.

The aim is to create an aftercare programme that sits in synergy with the recovery model and to deliver highly service-centred and user-empowering post-treatment support. If relapse occurs at any stages, service users are supported depending on individual circumstances, strengths, needs and time since leaving treatment. Such support may include brief interventions to return them to abstinence, referral into other service providers that offer a low to medium intensity support, referral into Gordon Moody's Respite Provision (up to one week of residential relapse management support) or referral back into the Retreat and Counselling or residential programme.

The Whole Self: Addressing Comorbidity and Cross-Addiction in a Residential Setting

The last few years have seen a trend of increasing complexity in gambling treatment and significant gaps in the capacity for residential care to address co-occurring mental health issues and cross-addiction needs.

Excessive gambling problems may not be recognised as a priority issue due to co-occurring conditions the person may already be seeking help for. If the focus is on gambling issues to the exclusion of other conditions, the degree to which gambling is causing or exacerbating co-occurring conditions may be missed.

Other Addictions

Gordon Moody's assessment found that people with both harmful gambling and substance abuse problems were more likely to have attempted suicide at some point in their lives and to have reported problems with sexual compulsivity. People living with both these issues tend to engage in risky sexual behaviour. Gambling also proved to be a potential reinforcer of drug use and substitute for drug use, which made it an obstacle to success in drug abuse treatment programs.

Both excessive alcohol and drug use remain consistently prevalent in applicants to Gordon Moody, presenting a significant risk for them. Introducing a service user who has a dependency to alcohol or illicit substances can hamper their treatment and that of those around them. Comprehensive assessment tools and bespoke care package are therefore used to provide the right level of support for those struggling with substance abuse whilst in Gordon Moody's care.

Co-occurring Mental Health Disorders

The number of applicants who have been diagnosed with mental health issues has steadily increased from 23% to 44% between 2016 and 2021. The most prevalent mental health challenges that the service users faced in the last 3 years are depression (37.9%), anxiety (37.4%), EUPD/BPD (27.7%), PTSD (19.7%), and anti-social personality disorder (17%).

Similarities were observed between pathological gambling and EUPD/BPD in areas such as impulsivity, emotional dysregulation, volatile interpersonal relationships, anxious attachment styles, tendency for dissociation, rapid mood swings, and high suicidality risk.

A Partnership Approach

To address these issues and gaps in treatment provision, Gordon Moody joined forces with the Welsh addiction support program Adferiad to provide the first residential rehabilitation for adults presenting with gambling disorder and complexities, specifically co-morbid mental health disorders and substance misuse addictions.

As a partnership, we have co-produced a model that allows us to share our clinical and industry knowledge and build on our reputations as trusted treatment providers. We have developed a unified approach to clinical governance, risk assessment and management, safeguarding, and aftercare.

The model allows each organisation to apply its own expertise in the most relevant and meaningful way for the individual, avoiding duplication of provision and ensuring a cost efficient and highly effective approach to the treatment of gambling and co-occurring complex needs for those most in need of our support.

Service users can be either self-referred or referred by another health or social care professional into this treatment pathway. Throughout this pathway, users have access to medically managed detox services, mental health treatment stabilisations and rehabilitation, and residential gambling rehabilitation services.

A Changing Landscape

The video gaming and gambling industries are converging, with gambling products including gaming themes, gambling themes being integrated into games and social media apps, and operators encouraging customers to engage in both types of activity. Gordon Moody is seeing the rise of a new era of interactive entertainment in which the boundaries between gaming and gambling are blurred. The development of "Web 3.0" with potentially groundbreaking new technologies like the "metaverse" and decentralized networking could completely change the landscape of possibilities in gambling, making it more accessible than ever. Cryptocurrency and blockchain technology especially may represent the third revolution for video gaming, after the internet and smartphone. Real economic in-game markets, play to earn business models, the possibility to live and earn in gaming could bring higher risk of financial harm in gaming. As the gambling industry is stepping in the gaming arena, so should the gambling prevention and treatment services, to curve the spike into the range of gambling related harm and its co-morbidities this cultural and behavioural shift might bring.

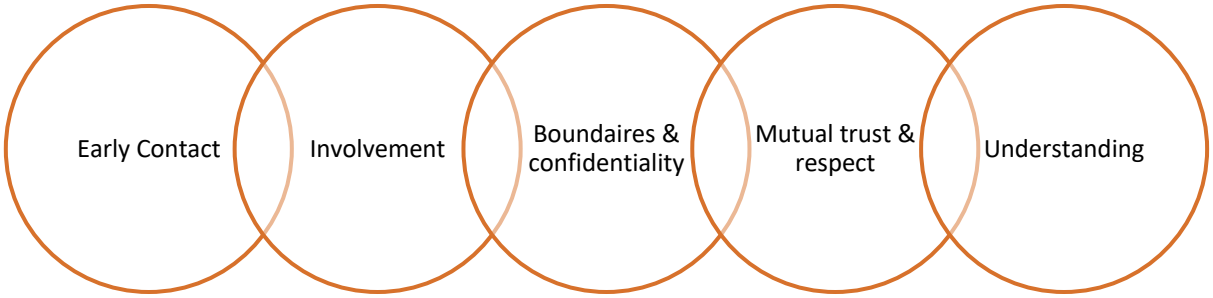
You Are Not Alone: The Role of Family in Recovery

The impact of living with addiction can be devastating both for the addict and those they live with. In 2003 the UK Government paper "Hidden Harm" highlighted the needs of families living with addiction and the responsibility of service providers to reduce intergenerational harm.

Partners, family and friends also need support and education regarding the intricacies of living with someone with harmful gambling. There is often pressure from family or significant others for residents to quickly return home, presuming the gambling problems have been resolved. Consequently, Gordon Moody works with family and friends every stage of the way, including them in treatment plans whenever possible and aiding the process of restitution and reconciliation.

Figure 5

Critical Phases of Family Engagement



Family relationships make an important contribution to recovery but can also be a contributory factor in addictive behaviour. It is therefore essential that patients consent to family involvement in their care, within the parameters of strict confidentiality and trust on all sides.

Where individuals wish to have their families involved, and the family also consents, Gordon Moody's family therapy sessions explore how the family can best help them when they are discharged. Together with therapists, family members work through questions or concerns they may have about their loved one returning to the family unit and co-produce coping strategies for

family members to help them demonstrate support, while recognising that breakdowns in trust have inevitably occurred in the past due to the addiction.

Families may have experienced stigma or shame because of their loved ones' addictions. At Gordon Moody they receive support to understand addiction and the impact it has had on their loved one to help them see the illness behind the often-distressing actions they have witnessed.

Gordon Moody's Friends and Family Support and Advice Service for affected others was developed in 2019 to encourage family members, partners, and friends to share problem gambling related concerns. Friends and family support groups were initially introduced as an additional resource to build on the therapeutic process identified when applicants sought help. The feedback received from service users informed the decision to provide further support for affected others suffering from gambling related harms.

Initial meetings were welcomed by affected others, whose attendance was regular and increased steadily. Gordon Moody initially started with two groups per week which was initiated as part of a consultation process with family members to facilitate work life balance. This was eventually reduced to one evening meeting, which became a manageable time for family and friends to attend. The meetings provide a safe space to discuss the emotional, financial, and physical impact of having a relationship with someone affected by gambling related harm. Having a supportive friend or family member alongside the service user often helps them to engage in the treatment and work though their difficulties.

Group members are keen to tell their stories and share their experiences. Financial struggles feature high on the list of concerns discussed, ranging from loss of homes, property, jobs, rental

deposits, and income, including direct theft from family members. Financial issues also lead to breakdowns in a range of interpersonal relationships, especially marriages. Group members also discuss feelings of isolation, shame, guilt and other emotional burdens around their gambling. Concerns around stress and anxiety together with uncertainty and raising a young family with additional responsibilities are also discussed.

Periodically, ex-residents or family members of ex-residents are invited as a feature of the service provision to share their perspectives and their stories of how they have navigated life after treatment with the group members.

Helping People Reclaim their Lives Free from Gambling: Outcomes of the Gordon Moody Programmes

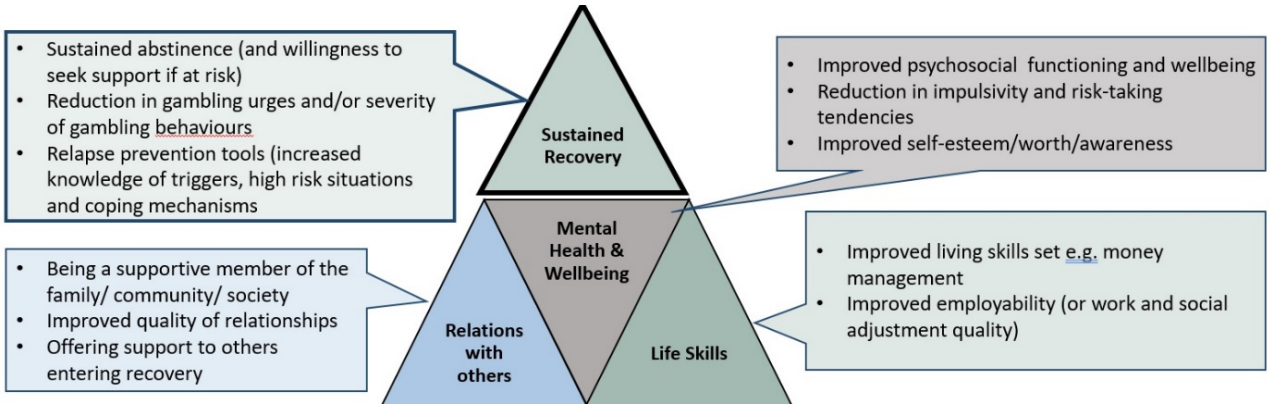
The benefits for users of Gordon Moody's programmes are what ultimately counts above all. Qualitative feedback from users indicates some of these benefits:

- Gives hope that they can be free from gambling.
- Helps them through the next day and encourages immediate focus on recovery.
- Builds self-awareness, understanding the possible triggers and risk situations, and how to identify and use their strengths-based recovery capital.
- Supports them to rebuild relationships, re-learn how to interact with others, and re-integrate into their communities.
- Encourages them to engage in life choices that will enhance their mental, physical and spiritual wellbeing.

- Expands their life skills and teaches what they need to embrace and enhance to be able to positively interact with outside world.
- Provides a path to recovery for their families and all affected community members.

Figure 6

Gordon Moody Theory of Change



Treatment at Gordon Moody is highly effective in improving mental health and wellbeing and maintaining abstinence.

In line with the UK National Gambling Treatment Service (NGTS), Gordon Moody uses two assessment tools during and after treatment, the PGSI and the CORE-10, to monitor progress and evaluate the impact of treatment. Service users are also invited to complete a follow-up assessment at 3, 6, 9, 12, 18 and 24 months after leaving treatment.

users make significant improvements on these measures during treatment, and in the case of the PGSI, sustained improvement into recovery. The average reduction of CORE-10 scores

from the beginning to the end of treatment in 2019/20 was 11 points (Figure 8), and the average reduction in PGSI scores from assessment to post-treatment was 17.5 (Figure 8).

Figure 7

CORE-10 Scores

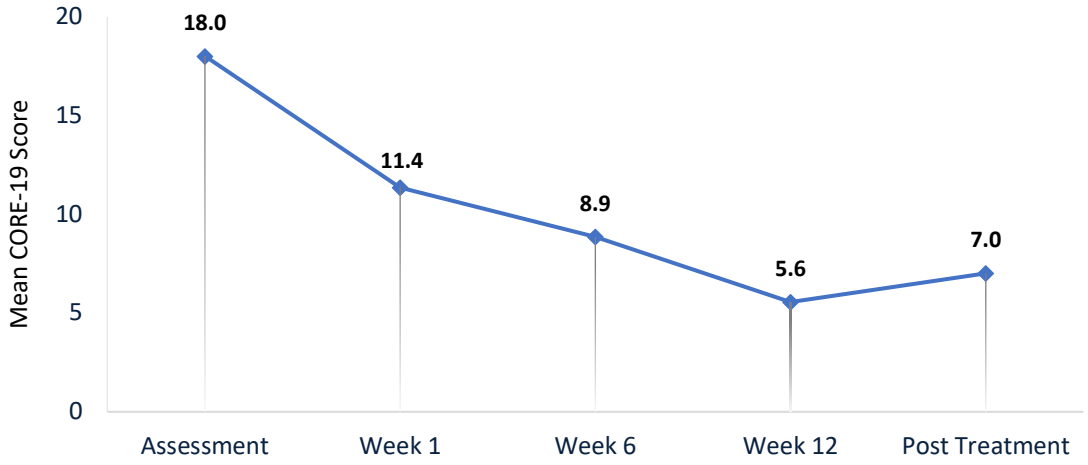


Figure 8

PPGSI Scores

Alongside the PGSI and CORE-10 tools, Gordon Moody also asks users to complete two other assessments of emotional wellbeing at the start and the end of their treatment: the Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) and the Generalized Anxiety Disorder (GAD-7) scale (Spitzer et al., 2006).

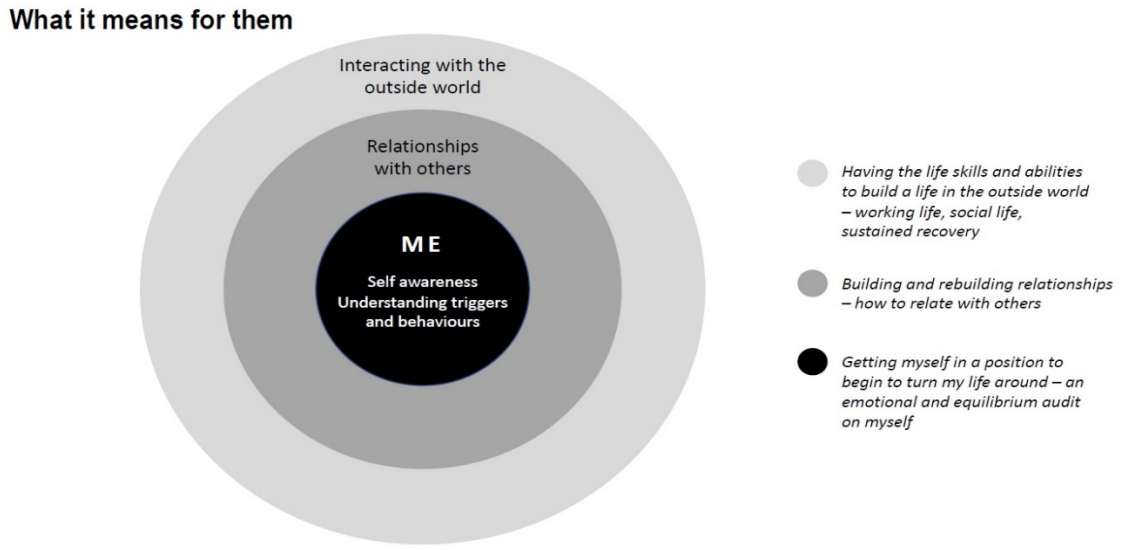
The nine item PHQ-9 is one of the most efficient instruments for screening the presence and severity of depression (Sun et al., 2020). With scores ranging from 0 to 27, 10 or above is suggestive of presence depression symptoms of depression, and scores over 20 indicate severe symptoms. Service users at Gordon Moody present an average score of 17 at the start of treatment and 4 at the end of treatment, a 76% improvement in the severity index.

The GAD-7 is one of the most efficient tools to screen for general anxiety disorder and assessing its severity in clinical practice and research (Rutter & Brown, 2016). With scores ranging from 0 to 21, a score of 10 or greater represents the cut point for identifying symptoms of anxiety, while scores over 15 indicate severe anxiety. Service users at Gordon Moody present an average score of 13 at the start of treatment and 3 at the end of treatment, a 77% improvement in the severity index.

However, Gordon Moody believes recovery to be much more than mere abstinence and low emotional distress scores. Ultimately, engaging with Gordon Moody services will improve people's quality of life of and empower them to live meaningful and fulfilled lives.

Figure 9

Gordon Moody Recovery Circles



Summary

Gambling addiction can escalate quickly, often while going unnoticed, and is therefore sometimes thought of as a 'hidden addiction.' Unlike substance use, it is not accompanied by visible signs of intoxication or impairment, but it can be equally destructive to one's life (if not their physical health), and sometimes more so, continuing for years without being noticed by family or friends. To help people affected by harmful gambling, the Reverend Gordon Moody set up a hostel in South London, in 1971, as the first residential facility in the world solely focusing on harmful gambling. Over the next 50 years, experience of working in a residential setting with this service users group helped develop the unique therapeutic residential programme offered today.

Throughout this chapter we have outlined the services currently offered by Gordon Moody, including residential treatment centres with intensive evidence-based recovery programmes, support for families, recovery housing for relapse prevention, an after-care programme, and retreat and counselling programmes. The range of support available offers wrap-around support for those considering engaging with the treatment programme, and post treatment support to maintain recovery, and family and friends support to help those who are affected by a loved one's gambling addiction.

Gordon Moody's approach is driven by evidence, and we strive to evolve our services in line with the ever-developing innovations in the gambling industry and the subsequent evolving needs of our service users. Perhaps more importantly, our service is based on compassion and understanding. We aim to help people create a clear picture of how they want their life to be like in recovery, and to engage in and understand the opportunities they will have. Ultimately, at Gordon Moody we identify the changes necessary to help individuals struggling with gambling harm to get themselves to where they want to be.

Note: NICE is a non-departmental public body of the Department of Health and Social Care in England, responsible with publishing healthcare and clinical excellence guidelines.

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