

Residential Rehabilitation Services for Gambling Disorder with Complex and Co-morbid Presentation: Evaluation Report

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Acknowledgments

GambleAware is an independent charity that commissions evidence-informed prevention and treatment services in partnership with the NHS, public health agencies, local authorities, the voluntary sector, and other expert organisations and agencies across Great Britain.

<https://www.begambleaware.org/about-us>

The views expressed in this report are those of the Tavistock Institute and IFF Research and do not necessarily reflect the opinions of GambleAware.

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Glossary

Term/phrase	Definition
Acceptance and commitment therapy (ACT)	ACT is a representative treatment in the third wave of behaviour therapy. ACT aims to improve psychological flexibility by helping individuals to accept their thoughts and feelings and be present in the moment.
Adferiad Recovery (Adferiad)	Adferiad Recovery is a member-led charity providing treatment and support to people with mental health, addiction, and co-occurring and complex needs in Wales. Adferiad Recovery is a partner in the delivery of the pathway.
Betsi Cadwaladr University Health Board (BCUHB)	BCUHB is the largest health organisation in Wales and is responsible for the delivery of health care services to more than 700,000 people across the six counties of north Wales.
British Association for Counselling and Psychotherapy (BACP)	BACP is the professional association for members of the counselling professions in the UK. It sets standards for therapeutic practice and provides information for therapists, clients of therapy, and the general public.
Cognitive behavioural therapy (CBT)	CBT is a form of psychotherapy that aims to change individuals' negative thought patterns and behaviours. CBT comprises several techniques and approaches that address thoughts, emotions, and behaviours.
Comorbidity	Comorbidity refers to two or more distinct medical or psychological conditions or disorders in an individual at the same time. Comorbid conditions can complicate diagnosis and treatment.
CORE-10	CORE-10 is a short outcome measure containing 10 statements about how a person has been feeling psychologically in the last week.
Data Reporting Framework (DRF)	The Data Reporting Framework (DRF) is a set of reporting guidelines PGSI by GambleAware that their funded treatment providers need to follow. GambleAware commissioned View It UK to independently collect and analyse this DRF treatment output and outcome data. The data is intended to support a range of activities including statistics and analysis of national data, policy development, commissioning, performance management, service planning and improvement.
Dialectical behavioural therapy (DBT)	DBT is based on CBT and was originally developed for borderline personality disorder, but it has since been adapted for various other conditions.
GambleAware	GambleAware is an independent, grant-making charity commissioning prevention and treatment services across England, Scotland and Wales in partnership with expert organisations and agencies, including the NHS.
Gordon Moody	Gordon Moody is a charity in the UK that provides support and treatment for gambling addiction. They offer residential treatment centres, recovery housing and a retreat counselling programme for

	those needing support. Gordon Moody is a partner in the delivery of the pathway.
Management Information (MI)	All data collected about the Residential Rehabilitation Service by Adferiad Recovery and Gordon Moody.
Multidisciplinary team (MDT)	Group of professionals from both Gordon Moody and Adferiad Recovery.
National Gambling Support Network (NGSN)	The National Gambling Support Network (formerly known as 'The National Gambling Treatment Service') is a group of organisations working together to provide confidential treatment and support to those experiencing gambling-related harms. Both Adferiad Recovery and Gordon Moody are part of the network.
Pathway	The term pathway refers to the new Residential Rehabilitation Service combining treatment at Adferiad Recovery and Gordon Moody.
Problem Gambling Severity Index (PGSI)	The Problem Gambling Severity Index is the standardised measure for people struggling with gambling over the last 12 months. It is a tool based on research on the common signs and consequences of "problematic gambling".

Executive Summary

Introduction

This evaluation explores the pilot implementation of the Residential Rehabilitation Service for Gambling Disorder with Complex and Co-morbid Presentation. It provides early evidence about establishing and delivering this new service, and of the outcomes of the service for the people it supports. The service was commissioned by GambleAware over a three-year period and is delivered by Adferiad Recovery, a Welsh charity supporting those living with mental health, substance misuse and complex needs, in partnership with Gordon Moody, a GB charity supporting those experiencing gambling harms. It is delivered in residential settings and encompasses medically managed detoxification, intensive treatment for gambling harm and acute mental health support. The implementation of the pathway was piloted from January 2022 onwards after an initial setting up period.

The general structure of the pathway includes a pre-assessment, detoxification (if required), residential treatment at Adferiad to focus on substance addiction and mental health issues, transfer to a Gordon Moody residential treatment centre to focus on gambling harms, and aftercare provision in the community delivered by Adferiad and Gordon Moody. However, there is flexibility for the pathway to be tailored to clients' needs on a case-by-case basis. The residential centres are staffed 24 hours per day, seven days per week by a combination of managerial staff, support workers, therapists, counsellors, lived experience mentors, session facilitators and night staff.

GambleAware commissioned a consortium led by the Tavistock Institute of Human Relations working with IFF Research and Magenta to carry out an evaluation of the pilot implementation of the Residential Rehabilitation Service. The evaluation was conducted between December 2022 and October 2023 using a theory-based, mixed methods approach, and involved qualitative interviews with clients, as well as with GambleAware and service staff, friends and family and residential support staff, and analysis of performance and management information from the two delivery organisations.

Key Findings

The client journey through the pathway and the key enablers and barriers for the different parts of the service are presented below. Please note this is a high-resolution graphic, details can be viewed more clearly by zooming in.

Residential Rehabilitation Service Evaluation Client Journey Map

1 Referral to Residential Rehabilitation Service

REFERRAL PATHWAYS		Time between referral and assessment Mean: 8 days	
Most common	Referral from the National Gambling Support Network (NGSN)		80%
Least common	Other (unspecified)		12%
	Self-referrals	8%	

2 Assessment

Clients have a comprehensive clinical assessment at Adferiad if they are first referred there or, more commonly, at Gordon Moody with a short follow-up assessment at Adferiad. Following assessment, there is a discussion with the MDT panel about whether the client is to be accepted onto the pathway based on their inclusion and exclusion criteria.

3 Detoxification

Over half of clients (55%) referred to the Service required detox before commencing treatment. Most commonly this was for:

Cannabis	Alcohol	Cocaine
Almost half (43%) of the clients who required detox needed detox from multiple substances.		

Length of stay
Mean: 6-10 nights

Clients go through detox if they have a substance addiction, and they are believed to have taken said substance recently.

- ENABLERS & SUCCESSES
 - CHALLENGES & BARRIERS
- 1
 - Weekly pre-treatment calls engage clients and helps to allay anxieties
 - Screening process identifies other comorbidities
 - Data sharing delays from external services, such as GPs, hospitals and mental health teams, impacts speed to treatment
 - 2
 - Assessment conducted by friendly staff supports client openness
 - Limited contact from service after assessment and being admitted
 - 3
 - Supportive staff
 - Detox facilities support accessibility for people with physical disabilities
 - Clients tempted to gamble when allowed to keep their mobile phones
 - Need for more support staff with awareness of mental health issues
 - 4
 - Residential support gave clients a safe space to focus on recovery
 - Group and one-to-one sessions help clients understand root causes for their addictions
 - Extra-curricular activities supported client's physical and mental health
 - Support tailored to clients' needs

4 Treatment (Adferiad)

Focuses on psychological support, substance misuse management and trauma therapy.

Most common
↓
Least common

TREATMENT TYPES	
Individual CBT sessions	Average of 11 sessions
Group CBT sessions	Average of 21 sessions
Psychodynamic therapy sessions	Average of 4 sessions (17% of clients accessed)
Other (non-specified) sessions	Average of 4 sessions (27% of clients accessed)

Over nine in ten clients (92%) received treatment from Adferiad. Remaining 8% left the pathway.

Average length of stay



Mean: 26 nights

DISCHARGE

Almost two thirds (63%) completed their scheduled treatment

One fifth (21%) left before completing treatment

Just over a quarter (16%) were referred to another service outside the pathway

High attendance across all treatment sessions (95%)

- Need for more staff with lived experience and knowledge of gambling addiction
- Rooms not always accessible for people with physical disabilities

DECISION TO MOVE TO GORDON MOODY

- Clients not always included in decision, leading to confusion or disappointment
- Insufficient support for clients with disabilities, complex needs or severe mental health issues led them to leave treatment pathway
- Cost (e.g. for food during their stay) for Gordon Moody prevented some clients to move there

5 Treatment (Gordon Moody)

Nearly a third of clients (27%) went on to receive support from Gordon Moody.

Focuses on gambling addiction treatment with a therapeutic community approach.

Average length of stay (those who completed)



Mean: 54 nights
Men: 72 nights
Women: 37 nights

DISCHARGE

Nearly two-thirds (65%) completed their scheduled treatment.

One third (35%) left before completing treatment

Clients who did not go onto Gordon Moody (73%) were either discharged from the pathway or went on to receive aftercare support.

- Peer support
- Specific focus on gambling issues
- Trauma therapy

- Need for link meetings to happen more frequently, and for greater knowledge at Adferiad about Gordon Moody
- Reflective exercises helped clients understand themselves better
- Practical sessions helped clients prepare to return to the community
- Support tailored to clients' needs
- Group sessions could be repetitive and like those at Adferiad; impacted engagement

- The use of agency staff limited some client/staff rapport
- Limited contact with friends and family to update on progress

6 Aftercare and ongoing support

Aftercare support was intended to be provided by either Adferiad or Gordon Moody depending on which organisation had provided the most recent support. It was possible for clients to receive support from both organisations, if they had completed the full pathway.

Nearly three-quarters (74%) of clients accessed aftercare support.

ADFERIAD	Eight-in-ten (83%) clients accessed welfare calls (daily calls for 2 weeks from staff to check on wellbeing) and nearly a half (47%) accessed aftercare calls (optional one-hour sessions for up to 12 months).	Average of 3 aftercare calls
GORDON MOODY	Nearly a third (33%) of clients received aftercare calls. Though this was 25/26 of clients supported directly by Gordon Moody.	Average of 30 aftercare calls

- Information provided by staff reassured clients that support was in place before leaving pathway
- Staff available to clients when needed
- Aftercare requirements vary by client; some needed more gradual transition into community
- Need for linking clients to other external support services before discharge
- Need for family and friends to be involved in aftercare discussions

There is a high level of need for this kind of support.

This study has shown that there is a high level of need for this kind of service as the number of clients referred for treatment with co-morbidities far exceeded initial expectations. Stakeholders within both organisations told us that at the start they had been worried about getting enough referrals into the service, whereas this had not been a problem once delivery started. All who received treatment had other co-morbidities in addition to gambling harm, including substance misuse, suicidal ideation, severe mental ill-health, and physical health issues. Both organisations reported that they needed to adapt their delivery to the complexity of the clients seeking support and that staff in both organisations gained new skills and knowledge from delivering the service.

The provision of intensive support in a residential setting was key to recovery.

The residential setting was generally seen as an enabler of recovery as it allowed clients to address their complex issues in an intensive, but also safe and supportive environment. Group sessions with others helped to build a strong bond amongst them, while individual meetings with counsellors or therapists enabled them to address particular personal or practical problems. Extracurricular activities were also important as they allowed clients to engage in physical or social activities within a supportive environment and eased their transition back into the community.

There is early evidence of improved outcomes for those struggling with gambling and other co-morbidities.

The provision of treatment in a residential setting and the delivery of a mixture of therapeutic and more practical support appears to have led to some positive short-term outcomes for clients. These include a reduction in gambling behaviour and improvements in their mental health, positive habits such as healthy eating and exercising regularly, quality of life and relationships with others, including a reduction in feelings of isolation.

Quantitative data provided evidence of a statistically significant improvement in clients' level of gambling harm (as measured by the PGSI scale) and psychological wellbeing (as measured by the CORE-10 scale). More specifically, changes in scores between assessment and discharge indicates an improvement in psychological distress scores at both Adferiad, Gordon Moody and across the whole service, and even for those who did not complete their scheduled treatment. PGSI scores reveal little change during the clients' time at Adferiad, which aligns with expectations given the brief duration of their stay and the specific period assessed by the PGSI scale. It did show substantial improvement after leaving treatment at Gordon Moody and around 12 months after completing treatment on the pathway.

This was supported by qualitative evidence, with interviewees reporting that they had fewer urges to gamble, were more aware of some of the triggers of gambling and of some of the approaches used by the gambling industry to encourage gambling. Several clients also reported that they felt happier, less stressed and better able to manage their emotions, while others said that the treatment had helped them to develop healthy habits which improved their quality of life. Almost all indicated that attending the residential pathway had enabled them to develop positive relationships with other clients and reduced their feelings of isolation. There was also evidence that it had helped some to improve or rekindle relationships with friends or family while in, or after leaving, treatment.

Recommendations for the future development of the service

There is a need for closer collaboration between the two organisations delivering the service.

The evaluation has shown that delivery of the pathway was enhanced by the different skills and expertise of staff from the two services delivering the treatment, with Adferiad bringing expertise on treating complex mental health issues and addiction to alcohol and other substances, and Gordon

Moody contributing an in-depth knowledge of treating gambling harm. The transition between the two services, while not without its challenges, also provided a useful step-down for some towards less intensive support as a preparation for returning to the community. At the same time, the evaluation has highlighted some challenges related to the coordination of service provision by two separate organisations with their different systems, processes and approaches, including data collection and monitoring procedures. This highlights the need for both organisations to work more closely with each other to make sure that those accessing the pathway see it as one service, albeit delivered in separate residential settings.

Well-coordinated aftercare support is needed to ensure ongoing recovery.

While the evaluation has provided evidence of short-term outcomes, without ongoing support after leaving treatment there is a high risk of individuals falling back into previous patterns of behaviour. Indeed, even such an intense and extended service (lasting up to almost half a year for some individuals) cannot be expected to resolve entrenched personal issues related to childhood trauma, abuse, mental health, gambling harm and substance addiction without the need for continued therapeutic support. The provision of ongoing support is therefore vital to enable the continued recovery and abstinence of clients after treatment. While several of those interviewed said that they had accessed the aftercare service offered as part of the pathway, others complained that follow-up therapeutic support had not been put in place directly after their treatment which impacted negatively on their recovery and abstinence when back in the community. This suggests the need for such aftercare support to be well organised and coordinated between the two organisations to enable a more seamless transition to support in the community after leaving the pathway. As part of this, services should also ensure that families and friends are fully involved in the care planning process before clients complete their treatment.

Extra-curricular activities need to be fully integrated into the support offer.

The evaluation has shown that extracurricular activities alongside therapeutic support are an important contributory factor to clients' recovery from gambling harm. At the same time, some clients, particularly those with physical disabilities, were not able to benefit from such activities. The activities could also lead to some triggering experiences for some as a result of, for example, walking past a betting shop during an outing. This suggests that when preparing such activities, the service providers need to ensure that they are accessible to all people despite any disabilities, and that they are prepared for any triggering events while out in the community. Indeed, such activities can be a useful learning device for their transition back into the community and should be seen as forming a key part of the service offer.

Implications for future commissioning of services

Commissioning more residential treatment programmes for gambling harm: As noted above, this study has shown that there is a high level of need for this kind of service. This highlights the need for further commissioning of similar services to address issues faced by people experiencing gambling harm with co-morbidities that cannot easily be addressed through existing gambling harm services. However, if this involves commissioning more than one organisation to provide support for the different needs of clients, careful thought and planning needs to be given on how treatments involving several organisations can best be coordinated to ensure consistency of delivery.

Ensuring diversity of clients: Most of those who received treatment were white British and male, although it did attract more female clients than other similar gambling treatment services. However, overall, this still calls for more to be done to attract particular sub-groups of the population who may be less willing to come forward for treatment, be put off by the lack of diversity within residential or other services or encounter cultural barriers to accessing residential treatment. This might suggest the need for some services to target people who experience gambling harm who have particular characteristics, such as ethnic minorities, females and those from the LGBTQIA+ community who are

often under-represented in traditional services for gambling harm and may be reluctant to seek support due to the stigma associated with gambling and other co-morbidities.

Residential services need to cater for different groups of participants: While Adferiad provided mixed-sex residential provision, the Gordon Moody residential centres were single-sex only. The study has shown that these different approaches both had advantages and disadvantages. While some clients preferred to receive support in a single-sex environment, others, for example, with traumatic experiences relating to either romantic or other same-sex relationships preferred to be in mixed settings. This shows the need for residential services to provide the flexibility to respond to different needs and preferences of potential clients and also to be able to accommodate non-binary and trans clients.

Further study is needed to identify the long-term outcomes of residential treatment programmes: While this evaluation has provided some indications of the short-term outcomes of such support and that some of these can persist after the end of treatment, further study with a larger group of participants and longer-term follow-up is needed to ascertain the scale and longevity of such improvements. This could also include more in-depth research to determine what factors enhance the efficacy of this form of treatment, relating for example to the length of engagement, treatment modalities and allied service provision during and after completing the pathway.

1 Introduction

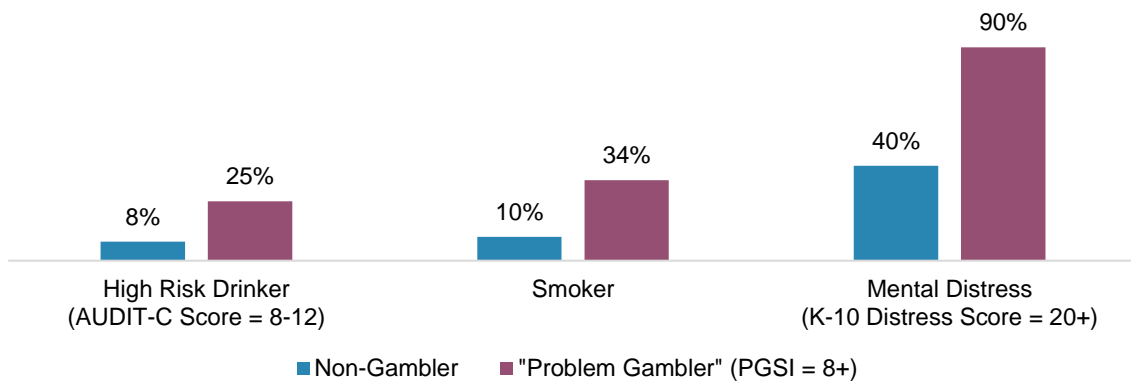
Context and background

In 2021, it was estimated that around 0.3% of England's population suffer from 'problem gambling' and 2.8% were identified as engaging in 'at-risk' or 'problem gambling' according to the PGSI scale within the Health Survey for England.¹ Gambling can have a harmful impact on the mental and physical health of those who gamble as well as on their finances, housing, work, relationships and social life. Furthermore, a higher rate of suicide is linked to those struggling with gambling compared with the general adult population.²

It also has wide-reaching consequences for "affected others" (affected by other people's gambling), including partners, children, the wider family and friends as well as wider society. Based on the 'Great Britain Treatment and Support Survey' collected by YouGov, in 2020 about 7% of the population were negatively affected by someone else's gambling.³ Furthermore, demand for specialist gambling harm treatment is at a record high⁴ which has led to the associated harm being considered a public health issue.

Gambling is often linked with other co-morbidities, and there is a growing body of research exploring the co-occurrence of substance misuse, mental health issues, behavioural addictions, and other (mental) health conditions. For example, the YouGov survey found higher proportions of high-risk drinkers, smokers, and individuals experiencing mental distress among the population of those struggling with gambling as compared to people who do not gamble (see Figure 1).⁵ Gambling harm is also often associated with increased suicidal ideation and attempts compared to the general population. Early onset of struggling with gambling may also increase lifetime risk of suicide. Both co-morbid substance misuse, and co-morbid mental disorders increase the risk of suicide in people with gambling problems.

Figure 1 Gambling and co-morbidities



Source: Annual GB Treatment and Support Survey 2021.

¹ NHS Digital (2012). Health Survey for England, 2021 part 2 [online] [accessed 16th November 2023].

<https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2021-part-2/gambling>

² Public Health England, (2021). *Gambling-related harms evidence review- Quantitative analysis of gambling involvement and gambling-related harms among the general population in England*, [online] [accessed 30th August 2023].

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1020883/Gambling_evidence_review_quantitative_report.pdf

³ Gunstone, B., & Gosschalk, K., (2020). *Gambling Treatment and Support*, [online] [accessed 30th August 2023].

<https://www.begambleaware.org/sites/default/files/2020-12/gambling-treatment-and-support.pdf>

⁴ NHS England, (2023). NHS doubles gambling clinics as referrals soar, [online] [accessed 30th August 2023]

<https://www.england.nhs.uk/2023/07/nhs-doubles-gambling-clinics-as-referrals-soar/>

⁵ Briony Gunstone et al. (2021). *Annual GB Treatment and Support Survey Report 2021* (London: YouGov, 2021).

Despite an increasing demand for, and provision of, treatment for gambling harms, there are still barriers to accessing these services particularly among those with co-morbidities, such as alcohol and other substance misuse or mental health conditions. These include lack of provision or accommodation for their physical and clinical needs. For example, their medication requirements may not be met in a service which does not operate in a clinical setting. The subject of this evaluation report, the new Residential Rehabilitation Service, was set up to reduce these barriers by treating gambling harms and accompanying co-morbidities such as substance misuse and complex mental health in a holistic way.

Overview of Residential Rehabilitation Services for Gambling Disorder with Complex and Co-morbid Presentation

The Residential Rehabilitation Service for Gambling Disorder with Complex and Co-morbid Presentation is a pilot treatment pathway, commissioned by GambleAware over a three-year period from late 2021 onwards. The pilot aims to fill gaps in the provision of treatment in Great Britain (GB) and explore potential uptake of services among those currently underrepresented. It offers residential treatment for those with gambling addiction and encompasses medically managed detoxification and acute mental health support. The service is delivered by Adferiad Recovery (hereafter referred to as just Adferiad), a charity based in Wales supporting those living with mental health, substance misuse and complex needs, in partnership with Gordon Moody, a GB charity supporting those experiencing gambling harms.

The service aims to:

- Reduce barriers and improve referral routes to accessing gambling harm treatment for those with co-morbidities;
- Provide a holistic, joined-up pathway for gambling harm, substance misuse and mental health treatment.

In doing so, it hopes to achieve the following outcomes:

- Minimise the gambling harm experienced by the client, ideally through abstinence;
- Stabilise their mental health and improve their general wellbeing;
- Provide the necessary tools, skills and abilities for relapse prevention.

A more detailed overview of the pathway's context, activities and desired outcomes can be found in the programme Theory of Change⁶ in [Appendix 1](#).

The delivery service centres are staffed 24 hours per day, seven days per week by a combination of managerial staff, support workers, therapists, counsellors, lived experience mentors, session facilitators and night staff. The pathway follows an overall structure, although there is flexibility for it to be tailored to clients' needs on a case-by-case basis. The general structure of the pathway includes a pre-assessment, detoxification (if required), residential treatment at Adferiad to focus on substance misuse and mental health support, and then transfer to a Gordon Moody residential treatment centre to focus on gambling problems, and aftercare provision in the community. Further details of the pathway for different clients are provided in [Chapter 2](#) below.

The implementation of the pathway was piloted from January 2022 onwards after an initial setting up period. In response to project learning, there have been ongoing adjustments to service structure and

⁶ A Theory of Change is an illustration of how change is going to happen in a given context. It maps causal pathways and assumptions from activities to impacts. A Programme Logic Model is a more detailed representation of a service/project without outline cause-and-effect relationships between inputs, activities, outputs, outcomes and impacts, as used for this evaluation. For the sake of simplicity, we use these terms interchangeably.

delivery, relating, for example, to the type of staffing, the location of treatment centres and the duration of treatment for different groups of clients. These adjustments have been made within the context of a continuous learning and improvement approach taken by Adferiad and Gordon Moody in collaboration with GambleAware.

Overview of the evaluation

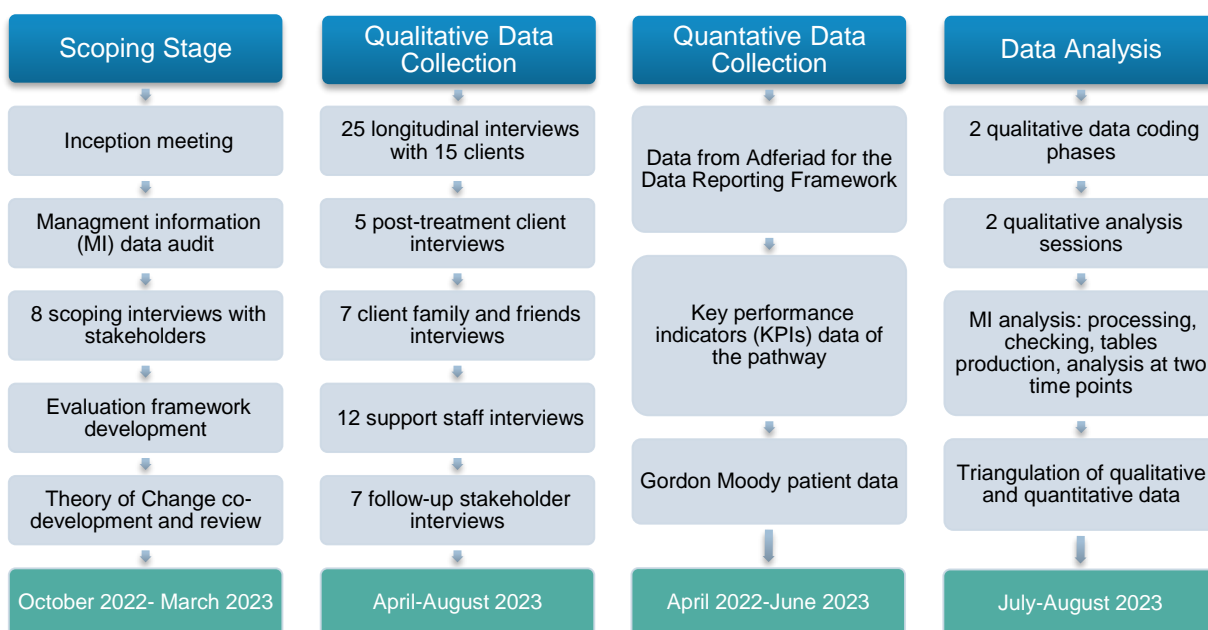
The evaluation of the implementation of the pathway took place between December 2022 and October 2023, using a theory-based, mixed methods approach.

The main objectives of the evaluation were to:

- Establish what currently works well in the delivery of the pathway and what can be improved.
- Understand how different clients experience the pathway.
- Identify any initial outcomes of the pathway for clients and their friends and family.

Figure 2 presents a summary of the evaluation methods used across four stages.

Figure 2 Evaluation summary



A summary description of these stages is provided below, while [Appendix 2](#) contains more details of the evaluation methodology adopted.

Scoping stage

The scoping stage began with an inception meeting with relevant stakeholders from GambleAware, Adferiad and Gordon Moody to finalise the evaluation approach and agree expectations. This was followed by online interviews with eight key stakeholders to gain a more in-depth understanding of the pathway and process behind its commissioning and the collection and review of management information and other key documents. The scoping stage culminated in a workshop in which the evaluation team and stakeholders co-developed a Theory of Change to illustrate the pathway's outcomes (see [Appendix 1](#)). We used this to guide our design of the evaluation framework and develop topic guides for interviews.

Qualitative data collection

The qualitative data collection consisted of in-depth, semi-structured interviews lasting up to 60 minutes. The key focus was on conducting longitudinal interviews, as part of which we aimed to speak to clients after around three weeks of treatment at Adferiad Parkland Place and then again about halfway through their stay at Gordon Moody. In the interim, we offered clients the option to record any thoughts about their experience on the pathway in a journal or audio recording. In total, we received five such journals, including two in written format and three Dictaphone recordings. This data was collected in advance of the second interview so that it could be explored in further depth with the client. Due to the flexible nature of the pathway and some early dropouts, we were not able to speak to all clients at both time points. Where possible, we spoke to them a second or third time while they were still at Adferiad/Gordon Moody or once they had completed treatment instead. In total, we conducted 25 longitudinal interviews with 15 clients. More specifically, we spoke to two clients three times, six at two time points and seven on one occasion.

Otherwise, we also conducted interviews with:

- Five former clients who had left the pathway between two and 12 months ago to find out more about clients' transition back into the community and aftercare;
- Seven friends or family members who had remained in contact with their loved one during the pathway to explore their views on the impact and experience of the support on the client and themselves;
- Twelve residential support staff to focus on their experience of delivering the service and more details of the impact of the residential pathway on those clients they had supported as part of it;
- Seven key stakeholders at GambleAware, Gordon Moody and Adferiad to discuss changes to the pathway since the scoping stage and what they had learned from delivering it so far.

All interviews were recorded and transcribed.

Quantitative data collection

Adferiad and Gordon Moody shared performance and management data covering the period January 2022 to June 2023 for 101 clients, including demographic information, treatment details and outcome indicators.

Data analysis

The evaluation team organised an interim findings workshop with stakeholders in June 2023 to present emerging themes, receive feedback and refine the analysis focus. The workshop was also used to review and update the Theory of Change.

We coded the qualitative data from the interviews and journals according to the evaluation framework and key research objectives, drawing out key themes. These were used to structure the findings presented in this report along with illustrative quotes, as well as to construct illustrative vignettes of clients' experience of the pathway. All staff and client quotes and vignettes were written using pseudonyms, while the personal details, pathway journeys and experiences of clients were often slightly modified to preserve the anonymity and confidentiality of participants.

We cleaned and processed all quantitative data to examine data quality. Data was analysed in line with the evaluation framework and questions. When sample size permitted, we performed subgroup analyses based on key characteristics. Finally, all quantitative data was triangulated with qualitative data where available.

Limitations to the evaluation

One limitation of the qualitative data is that it is potentially biased towards a more positive experience of the pathway. Only clients deemed stable enough by delivery staff were invited to participate, meaning the experiences of those with the most complex needs may have been excluded from the research. Furthermore, those who had particularly negative experiences may have declined to participate or exited the pathway before we had the chance to interview them. Furthermore, most interviews were conducted with clients while they were still on the pathway, which means it was difficult to predict the medium to long term outcomes of the support for them. This was partially addressed by interviewing a small number of those who had completed the pathway – however, it is likely that their experiences may be biased in favour of those with more positive outcomes who had remained in touch with the service providers and were stable enough to complete such interviews.

The quantitative data was limited by data availability and quality issues. The service has been increasing the variables collected across the period covered for analysis, therefore not all data is available for the whole period. There are also some variables that were not collected by the service and so could not be included in the analysis, including long-term follow-up data. We also identified several data quality issues, such as missing or incomplete variables. Whilst we have made every effort to process and clean the data in collaboration with the Adferiad team, it is likely that issues remain. The evaluation team also made efforts to identify an appropriate comparison group. However, due to the absence of historic data from Gordon Moody or another residential rehabilitation service for gambling this was not possible.

Structure of this report

Chapter 2 provides a more detailed overview of the Residential Rehabilitation Service for Gambling Disorder pilot treatment pathway, including its general structure and how it was implemented in practice, while Chapter 3 outlines the number and characteristics of clients referred to and participating in the pathway in the first 18 months of its operation from January 2022 to June 2023.

Following this, Chapters 4 and 5 present the main outcomes of the pathway on clients and others, including friends and family and staff delivering the service, while Chapter 6 explores the main enabling factors and barriers to achieving these outcomes.

Finally, Chapter 7 provides a summary of the main conclusions of the evaluation, some recommendations for the development of the pathway, and some implications for the future commissioning of similar services.

2 The Residential Rehabilitation Service Pathway

This chapter describes the planned structure of the treatment pathway, and how it was implemented in practice for different groups of clients.

Headline findings

- The pathway is tailored to the needs of clients, for example in terms of the duration and the number and type of sessions offered.
- The majority of clients complete their treatment without making the transition to Gordon Moody as it lacks the facilities to support those with particularly complex substance misuse and mental health conditions.

The general structure of the Residential Rehabilitation pathway includes (see Theory of Change in [Appendix 1](#) for further details):

- A pre-assessment for all those referred to the pathway.
- Detoxification at an Adferiad detoxification centre in North Wales (if needed).
- Four weeks group and individual therapeutic sessions in an Adferiad residential centre, Parkland Place, in North Wales focussing on understanding and managing addiction.
- Five to six weeks for female clients at a Gordon Moody residential centre in Wolverhampton or 13-14 weeks for male clients at a Gordon Moody residential centre in Manchester focusing more specifically on gambling problems. The difference in treatment durations is based on Gordon Moody's standard programmes for female and male clients which were not adapted specifically for this pathway.
- Upon completion of the pathway, clients have access to aftercare provision where they have the opportunity to check in with mentors and receive support with maintaining abstinence and harm-reduction. This includes potentially daily welfare calls for two weeks after discharge and hour-long aftercare sessions focused on maintaining assistance and harm-reduction for up to one year.

However, in practice, the pathway is often tailored to the needs of the client, resulting in different journeys for individuals. Further details of the actual implementation of the pathway are provided below.

Assessment and pre-treatment

Following referral, all clients undergo a comprehensive clinical and therapeutic assessment. This is either conducted by Adferiad staff, if the referral was onto the pathway, or by Gordon Moody if the individual was referred to, or contacted, them directly, with a shorter follow-up assessment by Adferiad staff. The assessment covers all personal information, their medication and medical data, their addictions, their mental and physical health, specific needs (such as physical or learning disabilities) and a risk assessment. The assessment is conducted by a staff member from the admission team.

Most people had their assessment carried out promptly after being referred. Based on the analysis of data collected over a six-months period (30 clients) between January and June 2023, the mean waiting time was eight days, with a maximum of 31 days and a minimum of less than one day. Only for 23% of clients the waiting time was longer than one week for an assessment. However, this was sometimes because it took several attempts to make contact with the client for an assessment.

Table 1 Waiting time between referral and assessment (January to June 2023)

	Number of clients	Percentage of clients
Less than 3 days	8	27%
3 to 5 days	10	33%
6 to 7 days	5	17%
More than 7 days	7	23%
Total	30	100%

Source: Adferiad KPI data: Assessment: Referral-assessment waiting time (no. of days). Base: 30 clients. Data only available for January to June 2023.

Multidisciplinary team (MDT) meetings consisting of Adferiad and Gordon Moody staff take place weekly to discuss the assessments and decide on the treatment pathway for individuals. If required, GP and other (mental) health records are requested to provide further information about the individuals.

During this pre-treatment phase a staff member is in regular contact with the individual to keep them engaged and prepare them for treatment start.

Detoxification at Adferiad Hafan Wen centre

If the clinical assessment, which includes assessment of alcohol and other substance misuse, and the subsequent MDT meetings determine that a detoxification from alcohol and/or other substances is required, clients will commence the pathway at Hafan Wen (Adferiad's clinical detoxification site). Hafan Wen offers person-centred support, combining medically managed detoxification and stabilisation with psychosocial group work, individual support and other activities. The approach to detoxification balances clients' clinical and non-clinical needs and integrates elements such as coping strategies, anxiety management and techniques to reduce stress. It prescribes to guidelines and protocols of the Betsi Cadwaldr University Health Board (BCUHB) and is staffed 24 hours a day, seven days a week with a combination of a consultant psychiatrist, doctors, mental health nurses, general nurses, learning disability nurses and recovery workers.

Around half of the clients referred to the pathway (51%, 52/101) went through detoxification. More than half (58%) of these 52 clients needed detoxification for one substance, 37% for two substances and 6% had three substance dependencies. Most commonly, detoxification was for cocaine (31%), alcohol (30%) or cannabis use (26%).

Table 2 Substance issues which required detoxification

	Number of clients	Percentage of clients
Cocaine (including freebase cocaine)	24	31%
Alcohol	23	30%
Cannabis	20	26%
Stimulants	7	9%
Prescription medication	2	3%
New psychoactive substances	1	1%

Source: Adferiad KPI data: Detox required from. Base: 52 clients, including 77 addictions requiring detoxification.

The length of time spent at Adferiad Hafan Wen is dependent on need and clinical assessment. Out of 50 clients who underwent detoxification and for whom we had data⁷, the majority (75%) stayed no more than one week. Nearly a quarter (22%) stayed between eight and 14 nights, and two clients stayed longer than 14 nights. The average (mean) number of nights was eight, with a minimum of two and a maximum of 21 nights. Most clients who completed detoxification went on to receive support from Adferiad at Parkland Place. Only a small number of clients (eight) referred for detoxification did not receive any support from Adferiad Parkland Place and dropped out of the pathway.

Adferiad Parkland Place residential treatment centre

Following detoxification (if required), clients commence treatment at Adferiad Parkland Place. Parkland Place is a 24 hour per day, seven day per week therapeutic rehabilitation facility in North Wales. For the period January 2022 to June 2023, 87 of the 101 individuals who were referred for treatment started at Parkland Place. Of the 14 people referred for treatment who did not move to Parkland Place, six dropped out after assessment and eight during or after detoxification.

The mean waiting time from assessment to starting treatment at Parkland Place was 59 days, with a median of 48 days and a range of seven to 150 days.⁸ Particularly long waiting times were attributed to some clients' reluctance to engage with the service (which meant that they did not start to receive treatment as quickly as they could have done) or a delay in the passing on of necessary information from third parties (e.g. doctors or mental health teams) before treatment could start. It was also anecdotally reported by Adferiad staff that waiting times have increased as demand for support has risen – though Management Information (MI) analysis shows that waiting times until the end of June 2023 have shown little variation.

The main purpose of this stage of the pathway is to stabilise clients' mental health and address underlying social and psychological issues. Around six spaces are reserved for the pathway at any one time and Parkland Place is registered to manage controlled substances. A wide range of staff are involved in the delivery of the pathway at Adferiad: a residential manager, a British Association for Counselling and Psychotherapy (BACP) specialist counsellor, addiction therapists, addiction and recovery practitioners and night support staff (for further details see [Appendix 3](#)).

Adferiad's treatment model can be characterised as a person-centred approach and is based on Cognitive Behaviour Therapy (CBT), Dialectical Behaviour Therapy (DBT), and Acceptance and Commitment Therapy (ACT). Adferiad offers both group and individual therapy sessions, counselling sessions, and recreational activities such as mindfulness and exercise sessions. Extracurricular activities are offered at the weekend, such as outings (e.g., to the beach or a museum), as well as family visits. Some clients with very complex substance-misuse or medical needs complete the pathway at Parkland Place and receive dial-in gambling support from Gordon Moody staff. Adferiad has also recently started offering gambling-focussed sessions, based on content and some online training provided by Gordon Moody staff.

Once in treatment at Parkland Place, session attendance was high among clients (95%). This is likely to do with the fact that attendance was said to be compulsory rather than optional, although some allowance was made in some cases. Clients, for example, do not have to attend sessions if they are feeling unwell or have got other appointments with external organisations.

All clients attended individual and group CBT sessions, while a smaller proportion (17%) received psychodynamic therapy sessions.

⁷ Missing data for two clients. Data from Adferiad aftercare file, as deemed to be more accurate than the data in the KPI file.

⁸ Please note, Adferiad KPI data relating to waiting time between assessment and treatment starting at Parkland Place was only available from January 2023 and relates to only 29 clients due to missing data

Gordon Moody residential treatment centres

Following completion of treatment at Adferiad, clients are expected to transfer to Gordon Moody for intensive gambling treatment. The transition process between the two services is supported by link meetings organised in the last two weeks before transfer, involving Adferiad and Gordon Moody staff and the client. A junior staff member further facilitates the transition by visiting those who have recently transferred to Gordon Moody. Additionally, all documentation including session notes from their time at Adferiad is also shared with Gordon Moody staff. Most clients referred to Gordon Moody also had an informal assessment (in addition to the formal pathway assessment conducted by Adferiad).

The main aim of this stage of the pathway is to address harmful gambling and to prepare clients' transition back into the community. It is delivered in two residential centres: one in Manchester for male clients, the other in a newly opened one in Wolverhampton for female clients. They are both staffed with a residential manager, a therapist, a support worker, and a mental health co-ordinator (for further details see [Appendix 3](#)). There are three beds reserved in the men's residential centre and two beds at the women's centre for the pathway at any one time – with the other beds being taken up by other clients directly referred to Gordon Moody and not part of the pathway. The distribution of clients accessing either facility is in line with the gender profile of clients accessing the pathway: 16 clients (62%) accessed the male residential facility, and 10 clients (39%) accessed a female residential facility.

However, up until June 2023 just over a quarter (27%, 26/95) of clients who received support from Adferiad moved onto Gordon Moody, with most leaving the pathway after treatment at Adferiad Parkland Place. The main reason for this was that Gordon Moody residential centres did not have the facilities to support clients with particularly complex substance misuse and mental health conditions – including those on controlled substances for the management of associated conditions and with suicidal ideation. This has been partially addressed by Gordon Moody by now providing 24 hour a day, seven days a week staffing across all residential facilities, upgrading their clinical quality assurance and appointing a mental health nurse. This was not reflected in a change in the number of transfers to Gordon Moody by June 2023, though it is possible that further time is required for these changes to manifest themselves in the monitoring data.

Gordon Moody's approach is based on CBT, and they deliver a combination of one-to-one and group work. In addition, they offer practical one-to-ones for issues such as financial advice, debt management as well as recreational activities such as yoga and gym sessions. Clients conduct their weekly shops on Wednesdays, and on Sunday they prepare and enjoy a communal meal. Off-site activities take place on Saturdays, and, for example, include bowling, museum visits or boating (for an illustrative timetable of a week at Gordon Moody see [Appendix 3](#)).

While the original project plan was to provide just four weeks of gambling-specific support for all clients, this was adapted in line with existing arrangements at Gordon Moody as part of which men spend around 12-14 weeks and women around five to six weeks at a residential treatment centre.

Level of drop-out and length of engagement

The overall drop-out rate from the pathway was 37% (35/95), excluding the six clients who did not start treatment following assessment. There was no noticeable difference in the profile of clients completing or dropping out of treatment.

All 87 clients left Adferiad either because they had been discharged or moved to Gordon Moody. This includes nearly two-thirds (63%) who had completed the scheduled treatment, a fifth (21%) who left before completing their planned treatment and 16% who had been referred to another service outside the pathway (after partially completing their treatment). As can be seen in Table 3 below, a similar

proportion of clients completed treatment at Gordon Moody as at Adferiad Parkland Place, although the overall drop-out rate was higher (35% compared with 21%).

No data was available on completion and drop-out from detoxification, although as reported above eight clients did not move onto Parkland Place.

Table 3 Reasons for discharge

	Clients who were discharged from Adferiad Parkland Place (n=92)	Clients who were discharged from Gordon Moody (n=26)
Client completed scheduled treatment	63%	65%
Client left before completing scheduled treatment	21%	35%
Client referred to other service outside the pathway	16%	N/A

Source: Adferiad DRF data: Discharges. Base: 92 clients (3 clients had not yet been discharged). Gordon Moody data: Reason for leaving GM (if left earlier than planned). Base: 26 clients.

The level of drop-out from the pathway is not surprising given the complexity of clients' needs and is comparable to drop-out rates from other gambling support services⁹:

- The Leeds and York Partnership Foundation Trust's (LYPFT) Northern Gambling Service showed that of the 73 clients for whom an end reason for treatment was available, 14 (or 19%) were reported to have left before finishing treatment;
- The National Problem Gambling Clinic run by Central and Northwest London NHS Foundation Trust showed that of data available for 96 clients, 51 (or 53%) had either dropped out or declined to continue treatment.

Clients who completed the pathway, on average, stayed eight nights in detoxification and 29 nights at Parkland Place (with a range of 11 to 55 nights) and there were no significant differences relating to the characteristics of clients. Those moving onto Gordon Moody received support, on average, for 54 nights. As intended by the pathway design, men stayed, on average, for more nights at Gordon Moody than women: 72 nights as compared with 37 nights respectively (see [Appendix 4](#) for more details about treatment duration).

Aftercare support

The pathway provides tailored aftercare for people who leave treatment. This includes weekly calls from Adferiad for up to two weeks and six flexible one-hour long aftercare sessions with a therapeutic worker (in-person or online). In addition, Gordon Moody provides clients access to their aftercare offer which is discussed with them before they leave treatment. The offer includes up to 12 months of outreach support, consisting of weekly online sessions. They also refer clients to partner prevention programmes (i.e., Whysup, EPIC Restart Foundation and Betknowmore) for peer-mentoring or one-to-one sessions or a recovery house ran by Gordon Moody, if required.

The monitoring data shows that nearly three-quarters (76%) of clients accessed aftercare support from Adferiad and/or Gordon Moody. Of those, over eight-in-ten (83%) clients received phone calls from Adferiad and nearly half (47%) aftercare sessions (an average of three sessions) from Adferiad.

⁹ IFF Research (2022). Primary Care Gambling Service Pilot Evaluation: Final Report. <https://www.begambleaware.org/sites/default/files/2022-12/11619%20PCGS%20Pilot%20Evaluation%20Final%20Report%20V4.1%20FINAL.pdf>

Nearly all who left Gordon Moody (96%) received phone calls from Gordon Moody with an average of 30 calls and a range of one to 98 calls.

3 Pathway engagement and profile of clients

This chapter describes the level of take-up of the treatment pathway and the characteristics of clients who were referred and entered the pathway.

Headline findings

- The referral numbers were higher than stakeholders expected, highlighting the need for the service.
- Clients revealed complex co-morbidities, with two-thirds presenting with three or more co-morbidities including suicidal ideation, mental health issues, and substance misuse.
- PGSI and CORE-10 scale data show high levels of gambling and moderate to high levels of psychological distress at treatment start.

The referral numbers were higher than stakeholders expected, highlighting the need for the service

As described in [Chapter 1](#), gambling harm is often associated with other issues, including, but not limited to alcohol and substance misuse, mental health conditions and physical co-morbidities. GambleAware commissioned Adferiad to set up and deliver a new Residential Rehabilitation Service in partnership with Gordon Moody to fill a gap in provision of this kind in GB. The design of the service was influenced by people with lived experience.

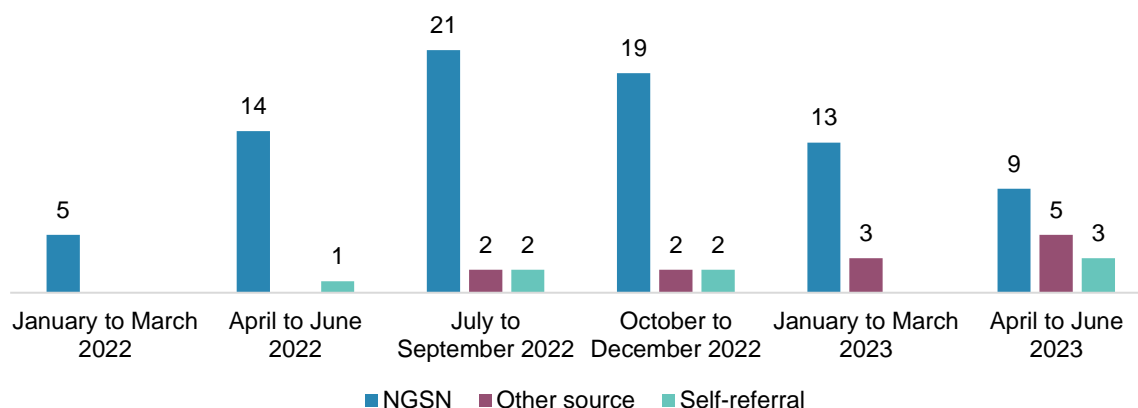
Since it was a new service, demand for it was uncertain at the planning stage, though both delivery partners were anticipating a slow uptake initially. However, referral numbers exceeded expectations – with 101 people referred to the pathway between January 2022 and June 2023. Referrals started slowly in the first six months of delivery but increased between July and December 2022, before reducing slightly between January and June 2023 (see Figure 3).

“I don’t think it captures even the surface of the need that’s out there. It’s a lot more people who need gambling support and very few who come forward.”

Stakeholder interview

Most clients (80%) were referred to the service via the National Gambling Support Network (NGSN). Other referrals came via NHS clinics, other health services (12%) or via self-referral (8%). Only a small number of clients referred to the pathway did not start treatment (6).

Figure 3 Number of referrals and source of referrals



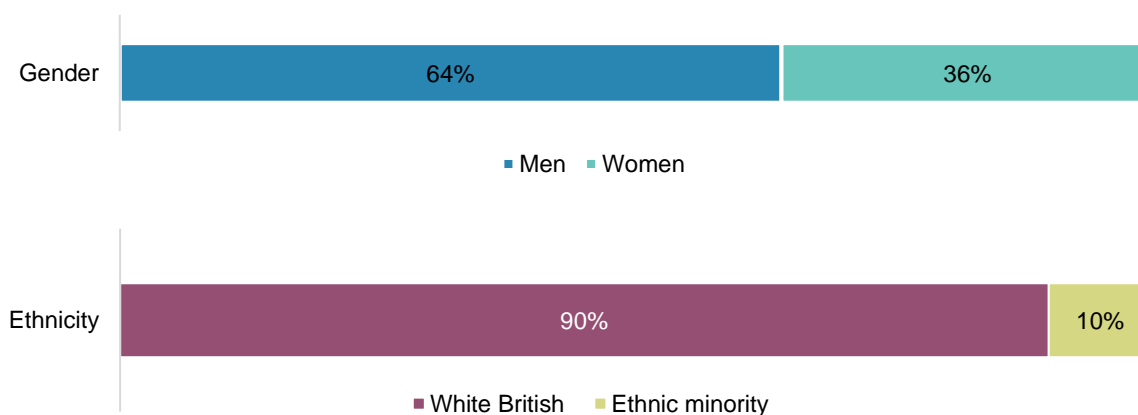
Source: Adferiad KPI data: No. of referrals received from NGSN; No. of self-referrals; No. of referrals from other sources. Base: 101 clients.

The profile of clients highlights complex co-morbidities

Demographic profile of clients

Around two-thirds of the 95 clients that started treatment on the pathway were men (64%), while just over one-third (36%) were women, and the vast majority were white British (90%). The age of clients ranged from 20 to 67, with a mean age of 39 (see Figure 4). This is comparable with the overall profile of patients accessing treatment for gambling across the whole NGSN according to the 2021/22 Annual Report by GambleAware, of which 70% were male, 81% white British, and with a median age of 35.¹⁰

Figure 4 Client demographics – age, gender and ethnicity



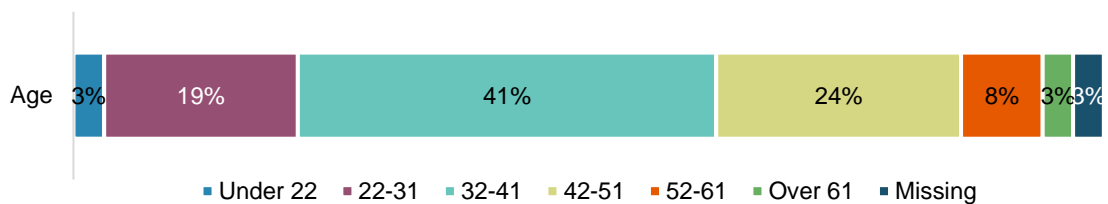
¹⁰ GambleAware (2022). Annual Statistics from the National Gambling Treatment Service Great Britain. 2021/2022.

Source: Gender: Adferiad DRF, using data variable gender identity. Base=76. Ethnicity: Adferiad KPIs. Base=87. Age: Adferiad KPIs, data was collected using the categories described in the data and was not provided as a numeric value.

A high proportion of pathway clients were not in work due to being long-term sick or disabled (54%), compared with the overall NGSN client population (12%). Only 16% of pathway clients were employed (73% of NGSN clients) – this suggests that the pathway was supporting clients with more severe needs and in more precarious financial situations than NGSN clients overall.

Co-morbidities of clients

All Adferiad clients had a co-morbidity, with over half (52%) living with a mental health issue. Most commonly, this included depression, an emotionally unstable personality, and suicidal ideation.¹¹ Nearly a fifth (18%) of clients had both a mental and physical health condition, and a smaller proportion (3%) had only a physical health condition.



Gambling behaviour and psychological distress

Online gambling was the most frequently used form of gambling (56% of clients), followed by gambling through bookmakers (39%) and gambling in casinos (19%). This reflects the increasingly high levels of online gambling across the wider population, as reflected in the overall NGSN data.

As part of the clinical assessment after referral, clients complete the Problem Gambling Severity Index (PGSI)¹² and the CORE-10¹³ scales, which offer further information about their gambling and mental distress prior to commencing treatment. The average PGSI score at the point of assessment was 23, with a minimum of 13 and a maximum of 27.¹⁴ This means that all clients scored higher than the threshold of eight, classifying them as ‘problem gamblers’ in the language of the PGSI scale. This is higher than the proportion of NGSN clients overall – of which 92% had PGSI scores of 8 and above.¹⁵

Psychological distress at assessment was measured using the CORE-10 (Clinical Outcomes in Routine Evaluation) tool.¹⁶ The mean CORE-10 score at the point of assessment¹⁷ was 17 (indicating moderate psychological distress), with a minimum of 0 and a maximum of 33. Four in ten (41%) clients with valid scores showed ‘no or mild clinical distress’ (denoted by a score below 15) and 15% were classified as having ‘severe psychological distress’ (denoted by a score of 25 or more).

¹¹ Due to data quality issues, complete data on range of specific mental and physical health issues cannot be included.

¹² The PGSI is a 9-item standardised measure of “problem gambling” behaviour, based on the common signs and consequences of such behaviour over the last 12 months. A score of 0 means ‘non-problem gambler’; a score of 1-2 is interpreted as ‘low-risk gambler’; a score of 3-7 represents ‘gamblers who experience a moderate level of problems leading to some negative consequences’, and a score of eight or more means ‘gambling with negative consequences and a possible loss of control’. The PGSI was developed for the use in general population surveys and not as a clinical tool. For further detail see: <https://www.begambleaware.org/sites/default/files/2023-11/PGSI%20tech%20report.pdf>

¹³ The CORE-10 is a 10-item measure designed for screening as well as to track change during treatment. Items cover anxiety, depression, trauma, physical problems, functioning and risk to self. Scores can be interpreted according to the following categories: Less than 10 – non-clinical range; 11 to 14 – mild psychological distress; 15 to 19 – moderate psychological distress; 20 to 24 – moderate-to-severe psychological distress; and 25 or above – severe psychological distress.

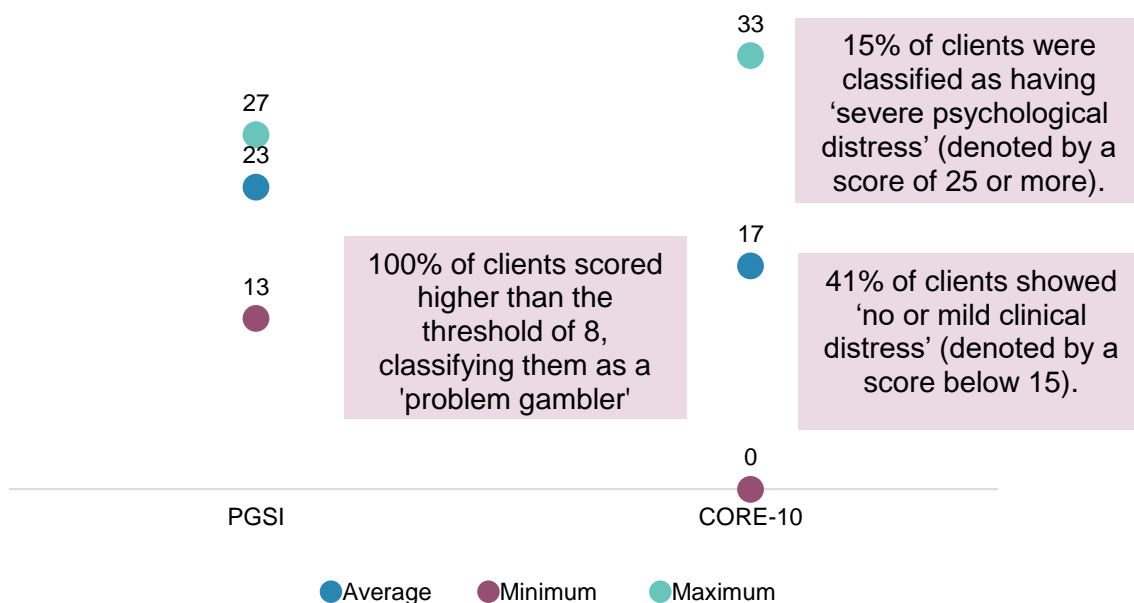
¹⁴ This is based on data for 85 clients.

¹⁵ GambleAware (2022). Annual Statistics from the National Gambling Treatment Service Great Britain. 2021/2022.

¹⁶ <https://www.corc.uk.net/outcome-experience-measures/core-measurement-tools-core-10/>

¹⁷ This is based on data for 86 clients.

Figure 5 PGSI and CORE-10 scores at initial assessment



Source: Adferiad data: Treatment impact. Gordon Moody data: Pretreatment scores. PGSI: N=84 and CORE-10: N=86.

Box 1: Background vignette: “Vinnie”¹⁸

Vinnie is 40 years old and has been gambling since his teens. He had an unstable childhood and suffered from neglect. As a result, Vinnie has always struggled with his mental health. He had a sporadic engagement with primary health care, often missing appointments with his GP to talk about his sense of low self-worth. Following recent self-harming, Vinnie had an assessment with a psychiatrist who said he would attract a diagnosis of emotionally unstable personality disorder.

Vinnie’s gambling habit started with going to the betting shop with his friends after an evening at the pub. He initially saw it as a social activity and a way to let off steam. Slowly and without his loved ones really noticing, Vinnie began to spend more time and money on gambling. As he got older, he started going to the betting shop after work, telling his partner that he had to work overtime. During the Covid-19 pandemic, he turned to online gambling and came up with various excuses as to why he needed to borrow money from his partner. Their financial situation began to cause arguments and Vinnie felt really angry. His relationship was under a lot of strain which served as another reason for Vinnie to gamble in order to cope with the stress.

¹⁸ Pseudonyms have been used throughout this report to protect clients’ and staff identities.

4 Early evidence of outcomes for clients

This chapter discusses the early evidence of the outcomes of the Residential Rehabilitation Service on clients, drawing on qualitative depth interviews and analysis of CORE-10 and PGSI scores at assessment and the end of their treatment. As the main focus of the longitudinal qualitative interviews was on those who were still receiving support, most of the evidence concerns short-term outcomes that have the potential to lead to longer-term outcomes. However, interviews with five former clients who had left the pathway and interviews with family or friends and support staff provide some indications of the potential medium-term outcomes of the pathway.

Headline findings

- It is too early to say whether the service is achieving its intended impacts for clients. However, the evaluation has found early evidence of short-term outcomes which could result in longer-term positive outcomes.
- There was quantitative evidence that the pathway had supported a short-term improvement in clients' mental health and gambling behaviour, as evidenced by improvements in CORE-10 and PGSI scores at the end of treatment.
- Clients also reported feeling happier, less stressed, having fewer cravings related to gambling, and that they had developed coping strategies for difficult situations.
- Several clients reported that they felt better able to manage their emotions, while others said that the treatment had helped them to develop healthy habits which improved their quality of life.
- Almost all indicated that attending the residential pathway had enabled them to develop positive relationships with other clients and reduced their feelings of isolation.
- There was also evidence that it had helped some to improve or rekindle relationships with friends or family while in, or after leaving, treatment.
- In some cases, clients also reported a deterioration in their mental health since joining the pathway, while others indicated that while the support may have alleviated their gambling behaviour in the short-term, they were concerned that it had not given them the tools to prevent them from relapsing in future.

Short-term outcomes

Many clients reported a positive impact on their gambling behaviour

Several of the clients interviewed said that they had fewer cravings related to gambling or that it no longer dominated their thoughts as it had previously.

"I had constant cravings all the time, it was all I ever thought about and it seems to have just gone out [of] my system."

Client

For some, this change in mentality and/or behaviour came from learning that their gambling problems were the symptom of a deeper root cause. Others found that it had given them a better understanding of their problems and some of the approaches the gambling industry uses to encourage gambling:

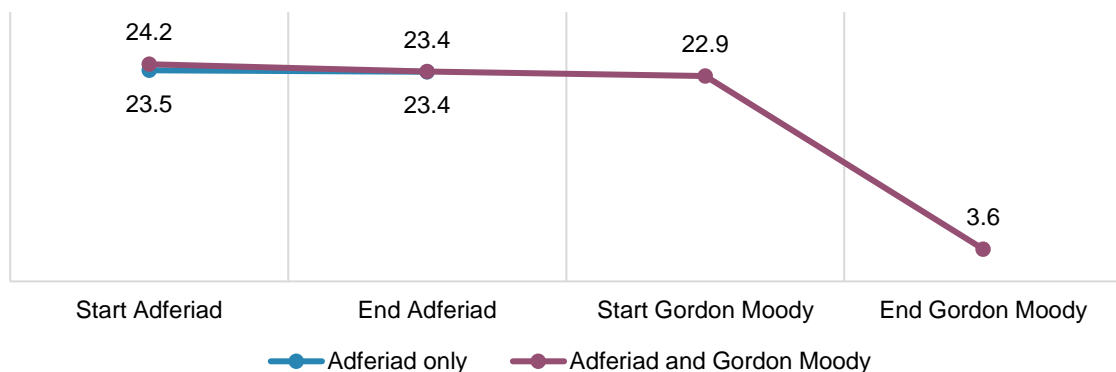
“I’ve made a big life change and I look forward to things now. I look at bookies and I just hate them for what they’ve done, you know what I mean. They made me think I could win. It’s all part of the industry, to get you to gamble.”

Client

Some clients also said that they were using their phones less during periods when they had access to them, which was noteworthy as most had previously been reliant on their phones to facilitate their online gambling.

Reports from clients were supported by changes in PGSI scores which are recorded at assessment and treatment end at both Adferiad and Gordon Moody. While the PGSI scores show little change for clients after completing treatment at Parkland Place as expected (including those moving onto Gordon Moody), the analysis showed substantial improvements after completing the more focused gambling support with Gordon Moody (see Figure 6). This data should be interpreted with caution as the PGSI scale asks clients about the last 12 months¹⁹, so that significant changes on the PGSI scale were not expected to occur in the short term, such as during treatment at Adferiad. For those 13 clients with available pre- and post-treatment scores, the mean score reduced from 24.2 when joining the pathway to 3.6 when leaving Gordon Moody, which is a statistically significant reduction ($p < .001$). At treatment start all 13 clients were classified as ‘problem gamblers’ according to their PGSI scores, while only two fell into this category after leaving treatment with Gordon Moody (for more detailed analysis see [Appendix 4](#)).

Figure 6 PGSI scores



Source: Adferiad data: Treatment impact. Gordon Moody data: Pretreatment and posttreatment scores. Adferiad only: N=25; Adferiad and Gordon Moody: N=13.

However, some clients we interviewed admitted that it was easier to stop their gambling while they were in a residential setting and expressed concerns about how they would feel once they were back in the community.

Clients’ mental health improved in many ways.

Many clients reported positive changes in their mental health. This was demonstrated through interviews with staff members and family and friends, as well as quantitative analysis of the CORE-10 scale data.

Several clients said that they felt happier, less stressed, better able to manage their emotions and had developed coping strategies for difficult situations. For many, this had a direct impact on their behaviours, with examples ranging from increased confidence in interacting, and establishing positive

¹⁹ Note both Adferiad and Gordon Moody indicated that they use the standardised scale and ask clients about the previous 12 months.

relationships, with others, to lower levels of suicidal ideation or episodes of self-harm. Several of them also expressed more positive attitudes towards themselves and their future well-being:

“It’s helped me realise that what I’m telling myself isn’t true. That I am worthy of a life.”

Client

Many clients said that the support had given them a deeper understanding of their past traumas and how these had impacted them, what their core beliefs were relating to themselves and others, and how they responded to positive and negative stimuli. They thought that this improved self-awareness had helped them to manage their emotions and had made them more aware of what triggered their own gambling behaviour.

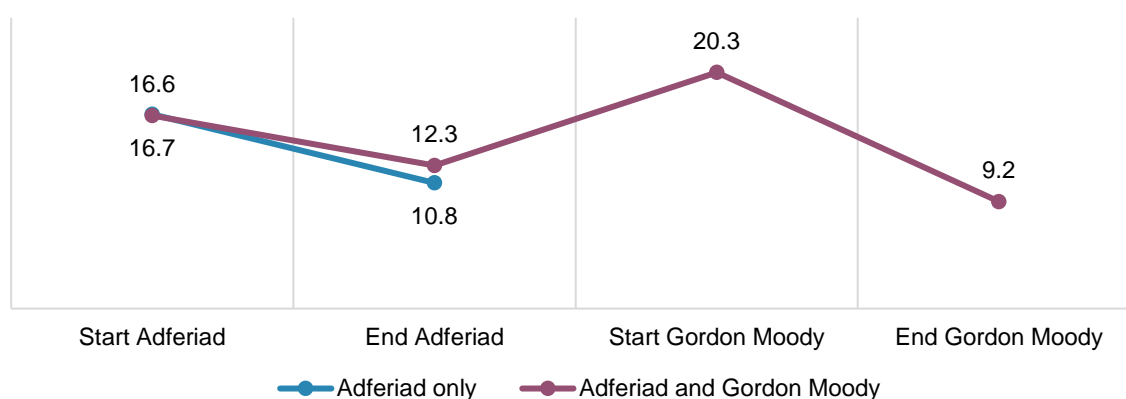
“I never used to understand why I wouldn’t have a gamble for X amount of time and then, just out of nowhere, I would have a relapse ... but I learned about that. I understand now, and so I am getting somewhere.”

Client

Similarly, CORE-10 scores showed a statistically significant improvement for clients leaving treatment at Adferiad or from Gordon Moody, including even those who did not complete their scheduled treatment length. As Figure 7 shows, the average score decreased from 16.7 to 10.8 for those receiving treatment from Adferiad only, indicating an average change from ‘experiencing moderate psychological distress’ to ‘mild distress’ ($p < 0.001$). This equates to an effect size²⁰ of 0.85 – which represents a large effect size according to standard conventions.²¹

Figure 7 shows that, on average, CORE-10 scores for clients moving to Gordon Moody initially deteriorate to a level even worse than at assessment (potentially caused by the stress of moving to a new treatment location and awareness of different processes and facilities), before improving significantly by the end of their treatment. Comparing the scores from pathway start to end revealed an overall average change of around 7.5 points on the CORE-10 scale ($p < .001$), which is equivalent to an average change from ‘moderate psychological distress’ to ‘a non-clinical range of distress’ (for further analysis see [Appendix 4](#)). Analysis showed no substantial variation across age, gender, ethnicity, health status and employment status of clients, though this may reflect small base sizes.

Figure 7 CORE-10 scores



Source: Adferiad data: Treatment impact. Gordon Moody data: Pretreatment and posttreatment scores. Adferiad only: N=50; Adferiad and Gordon Moody: N=19.

²⁰ Effect sizes indicate the magnitude of an effect, here the standardised difference in mean score.

²¹ Primer, A. P. (1992). Quantitative methods in psychology. *Psychological bulletin*, 112(1,155-159).

However, a small number of clients reported that their mental health had deteriorated since joining the pathway and that it had left them feeling even more negative, stressed and vulnerable as it had resurfaced past trauma for them. There was also some concern that they would struggle once back in the community without the additional daily support received as part of the pathway.

Clients felt more financially resilient.

Several clients said that they were more financially resilient because of the support received. This included help with budgeting and managing their finances. In other cases, service staff had helped with other financial needs including accessing benefits, getting support with their bills, and putting them in touch with debt management services.

“Most positive thing was sorting my debt out for me and coming to an agreement with my bank.”

Client

Some clients pointed out that the fact that they were no longer gambling had improved their financial situation.

“Where before I was using every last penny I had on gambling, now, since I’ve been in there, I’ve always had money in the bank.”

Client

Many clients felt that they now had the practical and emotional tools to prevent them from relapsing.

Several clients said that the pathway had given them some practical tools to prevent future relapse. This included learning how to create a daily schedule to give their lives structure and developing crisis plans in response to upsetting events or circumstances. Furthermore, some individuals felt that the CBT-based sessions had given them tools to better manage their emotions.

“I definitely think now I’ve got the right tools in place and I learnt a lot about how to cope when I’m triggered ... which has definitely made a massive impact on how I cope with it.”

Client

Others mentioned how useful they had found the worksheets that they had been given during group sessions and that they regularly re-read these or felt secure knowing that they would be able to use them when needed. One family member talked about a particular incident where they felt the tools their loved one had gained from the pathway had actively prevented him from relapsing:

“He received some bad news one day a few weeks ago and he ended up for half an hour with an urge and this horrible feeling like he could relapse. And he did everything in his toolbox to prevent that from happening and it didn’t happen ... And now he actually feels proud of himself.”

Family/friend

On the other hand, some felt that while the support may have alleviated their gambling behaviour in the short-term, it had not given them the tools to prevent them from relapsing in the future without the ongoing support from professionals.

“It is hard to suppress them, those thoughts, without a therapist.”

Client

However, it is worth noting that some clients said that the positive experience of the pathway and the one-to-one counselling received while on it had encouraged some to seek help in future either to overcome a particular issue or a particular crisis.

Clients experienced an improved quality of life.

Clients provided many examples of the way spending time in residential treatment had helped them to develop better habits which had impacted positively on their quality of life. This included maintaining a higher level of personal hygiene, keeping their personal space tidy, eating more healthily, doing more physical exercise, and reaching a healthier weight, sleeping better and socialising more with others.

“I’ve seen so much change in myself, like my sleeping’s better, my eating habits are better. My life’s really changed for the better and things are looking really well for me now.”

Client

Others reported having learnt new skills like cooking, cleaning or a new hobby. In addition, the improved financial situation of many clients meant that they were now able to buy themselves things like new clothes and self-care products that they had not been able to afford previously.

Reduced feelings of isolation.

Almost all the clients interviewed said that attending the residential pathway had helped them develop relationships with others and reduced their isolation. In particular, many reported feeling comfortable and accepted within a group of people who all shared similar experiences to them, while others said they had benefited from a strong bond with staff members, especially with those with lived experience of gambling and/or substance addictions.

“I do feel like they’re a family. I do. And I’ll be sad to leave them. Because in a short period of time, you just become so close [with the staff].”

Client

In some cases, links with other clients had persisted beyond the pathway, by keeping in touch via text messages or group chats – or in one case, plans to meet up in person. These groups were usually formed through the initiative of the clients themselves, although a couple of interviewees commented that they would have liked the services to play a more active role in encouraging this type of continued contact.

“Actually both of them have met people that are going to be in their lives forever now and real friends rather than acquaintances or gambling acquaintances, or bad influences or people that would harm them in any way. They now actually recognise that there’s people out there that do care just for the sake of caring.”

Staff

There was no particular difference for this outcome in relation to the gender of clients – as suggested in the Theory of Change. However, some women who had felt isolated before joining the pathway were said to have benefited particularly from living in a same-sex facility set up by Gordon Moody, as illustrated by the following vignette:

Box 2: Short-term outcomes vignette: “Pam”²²

Pam had always felt that her friends and family members looked down on her and did not value her as a person. This had had a significant impact on her confidence and self-esteem, which had been one of the factors that led to her developing gambling and substance addictions. When she arrived in the treatment centre, she found herself surrounded by other women who all openly cared for, supported and respected her. Being within a group of supportive women was a new experience for Pam, and this played an important role in improving her mental health. Over the next few weeks at the centre, she transformed into a brighter, more confident person.

There was also evidence that the pathway had helped clients to improve or rekindle relationships with friends and family while in, or after leaving, treatment. This was a result of several factors, including increased confidence, a heightened sense of self-worth, or changes in their addictive behaviours. Furthermore, some said that they now had a better understanding of what constituted a healthy relationship and felt more able to recognise and nurture positive relationships in future.

“Me and my son were estranged but he’s been on the phone, we’ve been interacting. And he’s told me he’s very proud of me. And we’re moving on from this.”

Client

Medium-term outcomes

Post-treatment interviews showed that some of the short-term outcomes identified above had persisted beyond the end of treatment for at least some. This included improved relationships, reduced gambling harms and improved mental health outcomes. In many cases, this can be seen as a result of the positive experiences on the pathway and the way it had helped them to develop and maintain habits to avoid relapse. This included having a more active social life, exercising, doing voluntary work and taking steps to further their career. Some also talked about how they hoped to, or had already started to, support other people struggling with gambling.

“The last time I spoke to her ... she’d been to a friend’s, she was going out walking every day ... instead of being isolated in her own space and not doing anything.”

Staff member

In some cases, clients had managed to maintain good financial habits after being discharged from the pathway, suggesting the potential for longer term improvement in their financial situation.

“He’s managing his own bills; he’s managing his own finances and that’s something he couldn’t do beforehand at all ... Now he can go and get his own shopping and come back with change.”

Family/friend

Furthermore, longer term follow-up of clients who had completed treatment about 12 months ago by Adferiad²³ revealed a statistically significant reduction in mean PGSI scores from 23.9 to 8.8 among 15 clients from assessment to follow-up.²⁴ This indicates that for at least this small group of clients, there was a significant and sustained improvement in their gambling behaviour following treatment

²² Pseudonyms have been used throughout this report to protect clients’ and staff identities.

²³ We were unable to validate if all were completed at 12 months. Therefore, results should be treated with caution.

²⁴ For the majority this is the PGSI score at assessment at Adferiad, where this was not available, we used the Gordon Moody assessment score instead.

($p < .01$).²⁵ All 15 clients reduced their score, though some (eight) could still be classified as 'problem-gamblers' according to their PGSI score.

The following vignette also illustrates how the pathway could help clients to avoid falling back into old habits.

Box 3: Medium-term outcomes vignette: "Sarah"²⁶

Sarah had been gambling since she was a teenager, and it had become a ritual for her to visit the local bookies on the way to her weekly shop. She struggled a lot during her first few days on the pathway as gambling was all she could think about, and she had never spent this long without being able to place a bet. Over the weeks that she was supported by the service, her one-to-one sessions helped her to realise that she was using her addiction as a coping mechanism to suppress emotions that she found difficult to express, and staff members helped her to develop alternative coping strategies that she could use now and, in the future, to help her manage these emotions. Once she was back in the community, we conducted an interview with a close friend of hers who told us that they had been out shopping together recently and gone down the street with the bookies that Sarah had previously been visiting almost every week previously. This time, Sarah did not even look at it as they walked past.

However, there were others who reported that they had found it hard to avoid such triggers. One individual interviewed a couple of months after completing treatment admitted that they had experienced gambling triggers as soon as they had returned home.

"All week I was just thinking about gambling ... literally, seeing myself going in the betting shop."

Client

This was often an issue for those with particularly complex needs and who were not able to continue with some form of treatment or ongoing support once they left the pathway, as illustrated by the following vignette. This highlights the need for clear plans to be in place to support the transition of clients back into the community – explored further in [Chapter 5](#).

Box 4: Medium-term outcomes vignette: 'Peter'²⁷

Peter had found the pathway a positive experience and felt that he had learnt a lot about himself as a result of it. In particular, his therapist had helped him to realise that his gambling was a response to deep-rooted childhood trauma that he had never previously spoken about to anyone and, therefore, had not been able to process. Talking about this had made him aware of the triggers that caused him to resort to gambling or other addictive behaviour to alleviate his anxiety. However, once he returned to the community, he found that he still had a lot of distressing thoughts and emotions that he was unable to manage on his own. He reported feeling extremely stressed and upset while he was waiting for the service to arrange further counselling to address his trauma.

²⁵ We excluded follow-up scores of 0 from the analysis due to the uncertainty about their accuracy and whether they represent missing data; therefore the analysis can be treated as a conservative estimate of impact.

²⁶ Pseudonyms have been used throughout this report to protect clients' and staff identities.

²⁷ Pseudonyms have been used throughout this report to protect clients' and staff identities.

5 Early evidence of outcomes on others

This chapter discusses the early evidence of the outcomes of the Residential Rehabilitation Service on family and friends and support staff in the two organisations delivering the service.

Headline findings

- Early evidence of outcomes on friends and family suggests that the pathway has benefits for them not only by improving relationships with clients but also by reducing their anxiety and stress linked to the gambling behaviour of their friend or loved one.
- Others said that the time away had given them some valuable respite and time to reflect on their relationships.
- Support staff in both organisations delivering the pathway reported that they had gained new relevant knowledge relating to the difference between gambling disorder and substance addiction and how to support clients with co-morbidities.
- Most staff felt though that they would have benefited from more training to increase their ability to support people on the pathway.

Outcomes for family and friends

Improved impact on relationships with clients.

As described in [Chapter 4](#), there was some early evidence that the service had a positive impact on the clients' relationships with families and friends or that they intended to rebuild relationships. Some of the family members interviewed also reported improved relationships with the person who had undergone treatment because of the impact of the treatment on them. Some described that since returning home from the pathway their loved one had shown increased regulation of their behaviour and emotions and improved ability to manage conflicts and to have conversations. The positive impact of this on others is illustrated in the following vignette.

Box 5: Impact on family and friends vignette: 'Sean' and 'Ryan'²⁸

After Ryan lost his job working in a pub, he had to move back in with his father, Sean. It had become quite tense in the house, and they argued frequently. Sean tried to encourage his son to apply for other jobs. But Ryan just stayed in his room, smoked cannabis and gambled on his phone. Ryan often asked for money and the occasional twenty-pound note went missing. Sean worried about his son's future, and the stress was affecting his sleep and relationships.

During Ryan's time on the pathway, Sean spoke to him on the phone every week. He noticed a change in the way Ryan spoke; he sounded happier and more positive. After returning home, Ryan was able to maintain some of the healthy routines developed on the pathway; it had also helped him to recognise the impact his gambling and substance misuse had on other people. He started to open up to his father about how he was feeling, which allowed them to have better conversations which did not end in confrontation or recriminations. Sean noticed a determination in Ryan to improve his life, which gave him more hope for the future and reduced his own anxiety and stress.

²⁸ Pseudonyms have been used throughout this report to protect clients' and staff identities.

Positive impact on friends and family.

Others reported that the time their partner spent in treatment allowed them to focus on their own needs and anxieties and gave them the space to reflect on how their partner's gambling behaviours had impacted on their relationship.

“And I think when Bradley went away, I was able to reflect and, actually, there was a turning point where I went from being really angry at Bradley for what he'd done to actually just feeling really sorry for him. And I felt it actually empowered me because I knew that I could be without him, so it wasn't like I'm with him because I have to be with him.”

Partner

In some cases, however, family or friends were said to have actually found it difficult to adjust to changes in the behaviour or confidence of those returning home. In one case, for example, a staff member reported that a former client's sons and daughters were struggling to adjust to new habits and skills their parent had developed as a result of the therapeutic support, including a new and improved parenting style with clearer rules and boundaries:

“They've been so used to Erica parenting in the way that she did for so long that now she is starting to put her foot down or say no to things, they are finding that difficult themselves.”

Staff member

However, such a change may of course result in improved relationships in the long-term.

Outcomes for staff

Staff gained some new knowledge about gambling, mental health and co-morbidities.

Some of the support staff at both Adferiad and Gordon Moody reported that they had gained new relevant knowledge since delivering the pathway, relating to the difference between gambling and substance addiction (e.g., behaviour, brain activity), approaches used by the gambling industry to encourage gambling behaviour, and greater awareness about co-morbidities. Such learning resulted from experience of delivering the service (on-the-job learning), self-study (accessing documentaries or online materials) or via online training provided to some staff by the two organisations.

However, support staff in both organisations said that they would have benefited from more training to increase their ability to support people in the pathway. This included a need for more sharing of knowledge held in the two organisations, so that Adferiad staff were more aware of gambling-specific knowledge (e.g., its impact on the brain and how it differs from other addictive behaviour) and those in Gordon Moody could learn more about substance misuse (including its impact on the body and the use of detox facilities) and medication (including theoretical and practical knowledge). Furthermore, staff from both organisations mentioned the desire for more training on co-morbidities, reflecting on the increased complexities in the client group. They also reported a desire to develop better links among staff in the two respective organisations via online meetings or visits in order to also ease the transition between the two services (see [Chapter 6](#)).

6 Enablers and barriers to achieving positive outcomes

This chapter presents the main enablers of the different stages of the Residential Rehabilitation Service to help clients to achieve the positive outcomes outlined in [Chapter 4](#) and [5](#) above. This includes: joining the pathway including assessment and detox, receiving support as part of the pathway, and the provision of aftercare. Within each section, we also outline some of the barriers identified to achieving successful outcomes and supporting the recovery process of clients.

Headline findings

- Most clients were satisfied with the process and speed from referral to treatment start, including detoxification where needed. Where delays did occur, they appreciated the weekly pre-treatment calls to keep them engaged and allay anxieties.
- Group sessions helped to build a strong bond with other clients in a safe environment, while individual meetings with empathetic counsellors or therapists enabled clients to address particular personal or practical problems.
- Extracurricular activities supported the recovery process, by allowing clients to engage in physical or social activities and giving them a sense of normality. However, some clients with particular physical needs could not always benefit from such activities, while others found that they could lead to triggering events that threatened their recovery.
- The residential setting was generally seen as an enabler of recovery as it allowed clients to address their complex issues in an intense, but also safe and supportive environment. For some people though the length of time away from home proved to be a challenge.
- Developing good habits, crisis plans and being given more independence towards the end of the pathway were seen as easing the transition back home. However, several clients were concerned that they would not be able to maintain their recovery without ongoing support.
- This means that the provision of effective and flexible aftercare services was a key enabler of maintaining the positive outcomes achieved as part of the pathway. This included signposting or arranging further support.

Joining the pathway: assessment and detoxification

Speedy and smooth process from referral and assessment to treatment start.

Most clients interviewed were satisfied with the speed and ease of the process from referral to treatment start (see [Chapter 2](#) for more information about waiting times).

“My process happened so quick, it was within a week I was assigned to detox.”

Client

However, for some the process took significantly longer. Reasons for this included external services taking a long time to send over necessary information, such as GP summaries or information from secondary health care. In some cases, the delay following assessment was intentional to stabilise clients' medical needs and prepare them for treatment in a residential setting. In those cases, the pre-treatment team provided weekly calls (discussed more below) to keep them engaged. In a few cases, a delay in the treatment start led to increased gambling and/or substance misuse.

“When I heard, I was going to rehab and it was delayed and put off, I went full-blown drinking and gambling”

Client

Box 6: Joining the pathway vignette: ‘Ruby’²⁹

Ruby has struggled with gambling and substance addictions for years. She tried various forms of support without much success, including most recently Gamblers Anonymous. Her drug use increased, leading to increased gambling as a means to fund her addiction. This destructive cycle took a toll on her mental health. After experiencing a family bereavement, Ruby reached her lowest point having suicidal thoughts. Her partner, who has always been supportive, searched online for help as they increasingly felt worried and helpless. The organisation they called within the NGSN for help referred to the pathway. Initially, Ruby was hesitant to join, as she was unsure about participating in residential treatment, away from her home. However, after just one week, she realised that this pathway could be a lifeline for her and decided to join.

Assessment giving mostly detailed information about clients.

Overall, clients reported good experiences with the assessment process. The staff were accommodating with arranging the date and time of the assessment, and the process itself was experienced as non-judgemental and not rushed, which encouraged them to be open about their needs.

However, in some cases, staff reported that the assessment process did not go into sufficient detail, so that additional needs or complexities were only discovered after treatment start. Furthermore, sometimes the details from the assessment were not shared between the two services, which meant that important information was not available to Gordon Moody when preparing for the transition of the client.

Keeping in touch with clients until being admitted.

Reassuring and determined staff supported clients from assessment to treatment start. Weekly pre-treatment calls helped to keep them engaged and to allay anxieties. Continuity of staff members further strengthened the feeling of trust in the service and commitment to recovery.

“And I got the feeling that this guy’s committed to helping me change. So that kind of prompted me to always answer his calls.”

Client

However, some of the people interviewed reported that they had not been aware of the structure of the pathway, including how many weeks they would be expected to spend in a residential rehabilitation service and the level of contact they would have with their family and friends.

Supportive environment of detoxification facilities viewed as first step towards recovery.

Clients highlighted the accessibility of the detoxification facility, including the building and rooms, for people with physical disabilities, the around-the-clock availability of on-site medical staff, supportive and friendly support, and the general facilities (e.g., rooms, meals) as key enablers of completing the detoxification process successfully. Others commented on the fact that it helped having other

²⁹ Pseudonyms have been used throughout this report to protect clients’ and staff identities.

residents around going through the same experience and that they had access to their mobile phones to contact family and friends:

“It was the fact that there were people on hand 24/7 that he felt he could talk to. Even though he had his mobile and he was able to talk to us while he was there, what helped him the most was that there were other addicts there who knew exactly what he was going through and what he was feeling, and the counsellors and staff were there to pick him up when he needed it. And that really put him in good stead for the rehab.”

Family member

However, some experienced difficulties adjusting to detoxification and feeling isolated from staff and other residents. There was one report of a lack of support staff with awareness of the mental health issues they were facing. Also, some commented that while it helped them to overcome their substance addiction, being given unlimited access to their mobile phones meant that they were still able to access online gambling sites:

“I don’t think gambling there was seen as an addiction. I didn’t feel like it was taken seriously. I was left with my phone, and I was the one who went to them and said: ‘Look, I can’t have my phone because you know even now, I sat down and was thinking shall I just have a gamble!?’.”

Client

Residential rehabilitation

Group work with other residents supported the recovery process.

Therapeutic group sessions based on cognitive behavioural therapy (CBT) in the two settings, as well as dialectical behavioural therapy (DBT) and acceptance and commitment therapy (ACT) at Adferiad, were viewed as supporting the recovery process in many ways. The group setting was valued as a safe space to talk about and share personal issues related to their gambling behaviour with other clients who had very similar experiences:

“Even though we’ve all got different lives, we’ve all got the same understanding of this disease that we’ve got. And you begin to understand how your mind works: ‘Oh, I didn’t realise that’s why I’d done that!’. And to think that there’s other people – we’re all in the same boat.”

Client

The regular group meetings were also seen as a way of establishing strong bonds between clients, based on mutual trust and understanding and creating a sense of community. As argued in [Chapter 4](#) above, this helped to reduce their sense of isolation and to establish relationships of support with each other.

However, some people struggled with the size of groups or adapting to the behaviour of other people. This was particularly the case for those with high levels of trauma or neurodivergence who sometimes found it difficult to engage with others in such a group setting. As participation in the groups was a condition of continued engagement in the pathway, in some cases this led to drop-out or people being encouraged to seek alternative treatment. Others though were able to overcome their initial reluctance to engage and, eventually, benefited from their involvement:

“He didn’t want to do the groups at first, cause he’s quite shy on people he doesn’t know. But, you know, he sat in the groups, they said: ‘You don’t have to speak, you just come in and be with us’, and, in the end, he was talking.”

Staff member

Individual sessions were used to address personal and practical issues.

The one-to-ones complemented the group sessions as they allowed the clients to focus on specific personal issues and behaviours related to their addiction and past experiences. In Adferiad, BACP accredited counsellors used transactional analysis to explore how clients’ personal issues, including childhood experiences and traumas, might be causing their addiction.

“I really felt that having it once a day was really, really helpful because I was so bad that I really needed that one-to-one support to get me to a point where I was like becoming comfortable and speaking about how I am.”

Client

Staff in both services also used the CBT model as a way of challenging core beliefs about themselves and to interrupt established patterns of thoughts and subsequent behaviours.

“Yeah, the therapy. I think that’s what she brought back. That’s why I’m able to speak to my mum a lot better as well without her like not being able to like getting upset or angry with it”.

Family/friend

In Gordon Moody, several one-to-one sessions were also focused on discussing and resolving practical problems that were negatively affecting clients’ mental health and general well-being.

“She was helping me with my phone bill and getting that sorted; she was literally: ‘We are going to drive there now, I am going to support you and I am going to make sure we get this sorted for you!’. So, they were absolutely brilliant when it comes to practical stuff like that”.

Client

However, some clients complained about a lack of focus on gambling as part of one-to-one counselling delivered by Adferiad, while others with particularly severe mental health issues or childhood trauma said that they wanted more support to address their needs. Some people also said that there was some lack of continuity between the one-to-one support provided by the two services which impacted negatively on their recovery.

Extracurricular activities were supportive of recovery.

In addition to the timetabled group therapy and one-to-one sessions, the extracurricular activities and outings organised by the two services were reported to have had a significant positive impact on clients’ recovery.

“Really enjoyed and benefited from going out most days (...). It did the mind and body good. Exercise is a big part of recovery I have realised.”

Client journal entry

These included daily activities such as yoga, boxercise and snooker, as well as walks in the countryside, trips to the zoo or days out at the beach on weekends. Such outings provided a window into a life some had not previously imagined for themselves.

“Being able to experience climbing mountains and going to waterfalls opened my eyes to a whole world out there full of opportunities. That was really important.”

As well as such transformative experiences, simple activities such as going to a coffee shop in the local town centre gave some clients a sense of normality and a gentle reminder of life back home without taking away all supportive measures. They could test their learning through situations which previously had induced anxiety, such as paying for items in a café or buying food for the week. Spending free time with others in the group also provided them with an insight into healthier relationships and the possibility of enjoying different experiences without gambling.

Box 7: Residential rehabilitation vignette: ‘Elena’³⁰

Elena was initially nervous about the treatment and apprehensive about living with new people. However, when she started on the pathway, Elena was greeted warmly, and she felt much more at ease. Being away from home and not worrying about the stresses of family life was a welcome break for Elena. The pathway offered a structured timetable which helped Elena to focus on herself and her recovery. She had one-to-one sessions with Klara, her support worker, where she was able to understand more about her patterns of behaviour and the reasons why she turned to gambling and alcohol. Klara gave Elena the space to talk about issues she had not spoken about before. The group sessions provided useful tools on relapse prevention and made Elena realise she was not alone in her suffering. Practical support, such as help applying for Universal Credit, ensured that Elena felt much more secure about her future. The pathway also opened Elena’s mind to other things she may enjoy besides gambling; outings such as walks on the beach and trips to the zoo gave Elena a sense of normality while on the pathway.

However, not all clients were able to benefit from such extracurricular activities in the same way as others. There were some reports of those with physical needs or reduced mobility not always being sufficiently supported to participate in such outings. While trips into the community provided clients with a welcome sense of normality, they also risked triggering experiences such as walking past a betting shop. Some said that they had not felt prepared for this.

“They took us for a haircut and we turned onto the road where the barbers is. Instantly, my eyes went ‘bing, bing, bing’ and I noticed two bookies. That goes to show that, even though I’ve steered away from it and I’m feeling much more confident, I noticed those places straightaway”.

Client

The knowledge, skills and experience of service staff were seen as key to achieving positive outcomes.

Clients generally reported positive experiences with staff on the pathway, including therapists, support workers, managerial staff and counsellors, describing them as welcoming and caring. They particularly appreciated the way they were supportive, always willing to listen to them, and had complementary experience and expertise – such as knowledge of addiction theory, the gambling industry or lived experience of addiction.

“Ida’s always just got a massive smile on her face. She was the first person I met. I was quite scared at first, but she put me at ease straightaway. She has lived experience which really helps. She’s inspirational.”

³⁰ Pseudonyms have been used throughout this report to protect clients’ and staff identities.

Client

Some critical comments were made though in relation to the use of agency staff to cover night shifts, as they were said to sometimes lack awareness of the behaviour rules agreed with other staff or of the particular needs of clients.

“The workers swapped and changed too much, there was no consistency, which can be really unsettling in a place like that. With the daytime staff, it was more personal, whereas for night staff, it was just a job for them.”

Client

In addition, some clients complained that some therapists lacked the knowledge and skills to address mental health issues they faced relating to intense trauma.

The residential setting enabled clients to address their issues in a safe environment.

Interviews with clients suggested that the residential nature of the pathway, although not without its problems, was a key enabling factor of many of the positive outcomes reported in [Chapter 4](#). In particular, it provided those with complex needs a safe space in which to receive treatment away from often stressful situations at home and the triggers to gambling. Some also felt that the daily sessions and continuous engagement was better able to encourage them to address their addictions than if they had accessed such support over a longer period of time within the community. There were also examples where being separated from family, friends and partners allowed clients to focus better on their own recovery.

“It’s the way you’re taken out of your life, from your loved ones. Even though it sounds really harsh, I think you need to have that complete separation from everyone. To get better, you have literally got to look at yourself and have no input from anyone else from the outside. Even though it’s going to affect everyone who you love and loves you, it’s your journey to get well.”

Client

Nevertheless, being away from loved ones without regular contact proved too challenging for some clients, particularly for those with caring responsibilities. This was exacerbated by the fact that while on the pathway they were only allowed limited use of their mobile phones to contact loved ones (one hour per day at Adferiad and only around one day per week at Gordon Moody or decided on a case-by-case basis) and in-person visits. In some cases, the prospect of such limited contact with their family was too distressing for some and they chose to withdraw from the pathway.

“I was expected to stay for ten weeks or twelve weeks in a programme where I wasn’t going to see my daughter at all, and I was going to call her once a week and I don’t think that is sufficient. I think that hinders your recovery. I feel it’s too long to be away from family without regular contact.”

Client

The flexible and adaptable nature of the service design and delivery was key to keeping clients engaged.

As discussed in [Chapter 2](#), the pathway was designed to have a standard structure whereby clients spend a set amount of time at Adferiad and Gordon Moody. However, in practice, the delivery team take a person-centred approach and often adapt the pathway structure to suit individual needs and circumstances. Examples of this flexibility include clients joining the pathway later than originally planned to accommodate other commitments or extending their stay due to last-minute setbacks in their recovery or the risk of returning to a particularly unstable home environment. Also, many of

those with particularly complex mental health and medical needs remained at Adferiad Recovery for the entirety of the pathway. In some cases, this approach enabled clients to receive treatment as part of the pathway when they may have otherwise missed out.

Aside from the pathway structure, flexibility is incorporated into treatment delivery itself. As the implementation of the pathway progressed, both organisations adapted the service delivery to respond to the complex needs of participants. In Adferiad Recovery, for example, counselling was increasingly provided for those with a history of trauma and support was often tailored to those with neurodivergence or additional needs.

“We’ve adapted our one-to-ones for certain service users with anxiety and presenting behaviours. We work more visually with them because we’re recognising that that’s working better.”

Support staff

At Gordon Moody, the practical support was also often tailored to clients’ needs to ease their transition back into the community and overcome financial or other challenges.

However, there were some challenges associated with the flexibility of the treatment. Some clients reported not always being involved in the process of deciding the structure of their pathway or the timing of their transition to Gordon Moody or to leaving the service. They felt that such decisions were sometimes made at short notice, with very little or no consultation with them and their families and friends.

“That was something that was decided without consulting us. That was a bit of a shock for me because I was expecting her to be away until April and then, all of a sudden, that meant she would be out at the beginning of January.”

Family/friend

Some clients who were not transferred to Gordon Moody due to particularly challenging mental health or medical needs also felt that this reduced their exposure to more gambling-specific support.

“I was meant to be going to Gordon Moody after Adferiad but they wouldn’t accept me because I’m on controlled medication. So that was a bit of a downer. Knowing now, coming out, I could have done with that extra support.”

Client

Others also reported some lack of flexibility or ability of the services to adapt to particular needs of individuals, such as neurodivergence, complex mental or physical needs or limited literacy levels needed to engage with the paperwork used in sessions and as part of self-study.

The transition to Gordon Moody provided a useful step-down towards living back in the community.

At Adferiad, clients enjoyed a very high level of practical support, including having their laundry done, rooms cleaned, and food cooked for them. Indeed, this first stage of treatment was designed to minimise everyday stress and settle them into an environment where they feel relaxed and able to focus solely on recovery. At Gordon Moody, clients are expected to carry out a lot of these tasks themselves, go on supervised food shopping trips and need to stick to a weekly budget. In this sense, the transition between the two residential centres provides a step-down towards more independence. For some, this was a beneficial change which helped them prepare for returning to the community, by offering them the chance to learn new skills such as cooking a hot meal or practicing managing their income and outgoings in a safe and supportive environment.

Box 8: Residential rehabilitation vignette: ‘Benjamin’³¹

Benjamin’s gambling and cocaine misuse were closely linked to his social circle and work life. As a result, he had begun to neglect himself: he was not eating properly, he had not cleaned his flat in weeks and he had fallen into rent arrears. Being on the pathway was a chance for Benjamin to get away from his chaotic lifestyle. At Adferiad Parkland Place, he had three balanced meals cooked for him every day and all his washing was taken care of. This period allowed him to ‘reset’ and realise his previous patterns of behaviour were not healthy.

He was nervous about moving to Gordon Moody and felt the independence would be too challenging. The first week was tough as he struggled to adjust. However, with the support of his peers and the staff, Benjamin slowly began to learn new skills to help him cope. Graham, a fellow client, took the time to teach Benjamin how to cook lasagne. Angie, his support worker, helped him work out a budget so he could do his weekly shop without feeling anxious. As the weeks went by, he became more confident in his own abilities and looked forward to taking his learning home with him.

However, this transition presented some challenges for other clients particularly for those with more complex needs, as they struggled to adapt to the less supportive and structured environment.

“So, at Parkland you go up to the pharmacy room where there’s a member of staff and the medication is all locked away. And then they give you the medication. So, I thought that would happen at Gordon Moody because the medication and stuff that I’m on, I need prompting to do certain things and certainly with the medication, I’ve no experience of doing that. And they said: ‘Well you can take your own medication’. So, I was a bit baffled by that.”

Client

In the last week of the pathway, rules surrounding phone use and supervision were relaxed, giving clients more independence. Some reported that this was a helpful method of supporting their transition back into the community as they had a chance to trial new freedoms. However, others reported that they would have benefited from being prepared better by going out in public by themselves. Others were concerned that even though the pathway had helped them in many ways, it had been like living in a bubble and the transition back home would be very challenging as they would lack the regular support while still being exposed to the same temptations as before.

“You get used to being in that bubble for two months and then you’re kind of back into the real life and there isn’t much of a transition period to get you back into normal life.”

Client

Some also expressed frustration that while they had changed, their home life had not.

“I am anxious about coming home. I am scared. I thought that things were going to change but they haven’t. I am different but my situation isn’t because I am coming home to the same things.”

Client

³¹ Pseudonyms have been used throughout this report to protect clients’ and staff identities.

Aftercare

Clients found it important to be offered a variety of aftercare options.

There was a wide range of measures put in place to ensure that individuals would be adequately supported once they left the service. This ranged from being offered phone calls or face-to-face sessions with dedicated outreach workers to being supported with finding somewhere to live or being referred to primary care, counselling services or support groups. This variety helped to ensure that clients were given the specific help that they needed to continue their recovery.

Box 9: Aftercare vignette: 'Fran'³²

Fran was anxious about returning to the community, but in the week before she left, her support worker, Tina, used their one-to-one sessions to work out a daily schedule to give her week some structure and they also talked through what action she would take and who she would call if she started to feel tempted to gamble. Since Fran still wanted to continue working with a counsellor to further her recovery, Tina identified a local counselling service and said that they would fund ten sessions for her. In addition, once she was back in the community, she received regular phone calls from an outreach worker with whom she built up a good rapport and who was able to support her on the days that she was struggling. Together, these support mechanisms helped Fran to build a safety net that made her feel secure and helped her to continue the progress she had made while at the centre.

On the other hand, for some clients the aftercare that they were offered was not suitable for their needs. Some suggested other types of support that would have benefited them, which included having video calls rather than phone calls, group calls with therapists, or group chats with staff members who could advise them on local support services. Others were referred on to further support, but in some cases this referral was not made soon enough, and they found that they were left feeling unsupported for several weeks. They suggested that sessions with a therapist from one of the two services could have bridged this gap and maintained their ongoing recovery.

“So, the stuff that you spoke to your therapist about for five weeks, you have your check in with your therapist and then all of a sudden, you’re just cut off.”

Client

Clients appreciated aftercare being delivered flexibly.

Many individuals said that they had benefited from the fact that their aftercare was very flexible. In particular, the phone calls they received from staff were usually scheduled for once a week but could be done more frequently if clients were going through a difficult time. Some individuals also felt secure knowing that they could get in touch with staff as and when they needed to, knowing that they could rely on someone to be there to support them whenever they were going through a crisis or were thinking about gambling.

“Even if I don’t have a scheduled call with him, I can pick up the phone and be like, ‘I am having a bad day,’ and he’ll talk me through what’s happened. So yes, the support there is definitely above and beyond.”

Client

³² Pseudonyms have been used throughout this report to protect clients’ and staff identities.

However, others reported that there had been a lack of consistency with their aftercare. Some said that they had never received the phone calls that had been scheduled, while at the same time seeing that others who had been on the pathway with them were receiving this support. For those who were receiving phone calls, some said that they would have liked these calls to be more frequent, while others said that they would have liked them less often, which suggests that there is still scope to enhance the flexibility of the aftercare service provided based on individuals' needs.

Box 10: Aftercare vignette: 'Victor'³³

Victor was told by staff that he would receive a call every day for two weeks after he had returned to the community, which reassured him that he would have the support he needed to prevent him from relapsing. After receiving phone calls the first two days, he said that nobody phoned him on the third day. Victor tried to get in touch with the services to enquire about this but did not receive a response. He did not understand why he was no longer receiving this aftercare, so instead started to look for local support groups that could help him within his community.

Friends and family felt that it would be beneficial for them to be more involved in their loved one's aftercare.

One of the aims of the pathway at the outset was for 'service users, along with their families and loved ones [to be] actively involved in the care planning process, creating a system that is person-centred, goal-orientated and strengths-based'³⁴. However, interviews with friends and family revealed that this had not been implemented in many cases. Indeed, several said that they would have liked to have had more contact with the services about the aftercare that their loved one would be or were receiving. They believed that this would give them a clearer idea of what aftercare was being provided and when, and also benefit the service by giving them another perspective on how the client has been coping since returning to the community. However, the involvement of family and friends may not always be possible due to consent issues.

"I don't know whether he's engaging well, I don't know whether they contact him and it's just they need to keep in touch with family as well."

Family/friend

In addition, some friends and family members would have liked to have received information about gambling and substance addictions, including advice on how they could support the clients who had been through the pathway in their recovery.

"By taking on education and gaining the knowledge that we need for Zoe, I think that will put us all in good stead and would certainly reduce the risk of Zoe relapsing again."

Family/friend

³³ Pseudonyms have been used throughout this report to protect clients' and staff identities.

³⁴ GambleAware (2022, July). Evaluation of Residential Rehabilitation Services for Gambling Disorder with Complex and Co-morbid Presentation: Invitation to Tender.

7 Conclusions and recommendations

This chapter provides overall conclusions from the evaluation of the Residential Rehabilitation Service pilot, recommendations for its future development and some implications for future commissioning of similar services.

Conclusions

Overall, the evaluation of the service provides some early evidence of positive outcomes for people struggling with gambling and other co-morbidities despite some ongoing challenges and limitations. The provision of treatment in a residential setting and the delivery of a mixture of therapeutic (including detox, one-to-one counselling, and group work) and more practical support appears to have led to some positive short-term outcomes for clients. These include a reduction in gambling and improvements in their mental health, positive habits, quality of life and relationships with others, including a reduction in feelings of isolation.

Quantitative evidence identified a statistically significant improvement in clients' level of gambling (as measured by the PGSI scale) and psychological wellbeing (as measured by the CORE-10 scale). This was supported by qualitative evidence, with interviewees reporting that they had fewer desires to gamble, were more aware of some of the triggers of wanting to gamble and of some of the tricks used by the industry to encourage harmful gambling. Several clients also reported that they felt happier, less stressed and better able to manage their emotions, while others said that the treatment had helped them to develop healthy habits which improved their quality of life. Almost all indicated that attending the residential pathway had enabled them to develop positive relationships with other clients and reduced their feelings of isolation. There was also evidence that it had helped some to improve or rekindle relationships with friends or family while in, or after leaving, treatment.

There are also indications that some of these outcomes can persist after the end of treatment, although further study with a larger group of participants and longer-term follow-up is needed to ascertain the scale and longevity of such improvements. The study also provided evidence that without ongoing support after leaving treatment there is a risk of individuals falling back into previous patterns of behaviour. Indeed, even such an intense and extended service (lasting up to almost half a year for some individuals) cannot be expected to resolve entrenched personal issues related to childhood trauma, abuse, mental ill-health and gambling and substance misuse without the need for continued therapeutic support.

Recommendations for the future delivery of the pathway

As argued above, the provision of ongoing support is vital to enable the continued recovery of clients after treatment. While several of those interviewed said that they had accessed the aftercare service offered as part of the pathway, others had either turned it down or complained that it had not been suitable for their needs or had not been able to access the support they felt they wanted. Some also complained that follow-up therapeutic support had not been put in place directly after their treatment which impacted negatively on their recovery and abstinence when back home.

Recommendation: This suggests the need for such aftercare support to be well organised and coordinated between the two services to enable a more seamless transition to support in the community after leaving the pathway. As part of this, services should also ensure that families and friends are fully involved in the care planning process before clients complete their treatment.

The evaluation has shown that extracurricular activities alongside therapeutic support are an important contributory factor to clients' recovery from gambling addiction. At the same time, some

clients, particularly those with physical disabilities, were not able to benefit from such activities, and the activities could also result in some triggering experiences for some.

Recommendation: This suggests that the service providers need to ensure when preparing such activities that steps are taken to make them accessible to all people despite any disabilities, and that clients are prepared for any triggering events such as walking past a betting shop. Indeed, such activities can be a useful learning device for their transition back into the community.

The evaluation has shown that delivery of the pathway was enhanced by the different skills and expertise of staff from the two services delivering the treatment, with Adferiad bringing expertise on treating complex mental health issues and addiction to alcohol and other substances, and Gordon Moody contributing an in-depth knowledge of treating gambling addiction. The transition between the two services, while not without its challenges, also provided a useful step-down towards less intensive support as a preparation for returning to the community. At the same time, the evaluation has highlighted some challenges related to the coordination of service provision by two separate organisations with their different systems, processes and approaches, including data collection and monitoring procedures. One particular issue concerned the rules around the use of mobile phones while in treatment, with different approaches adopted in the two organisations. In Adferiad Parkland Place, clients were allowed to use their phone for one hour each day, while in Gordon Moody such use was often restricted to one day per week. Several interviewees complained about such limited access, while others said that it actually helped them to focus on their own recovery.

Recommendation: This suggests that there is no easy solution to this issue, but that rules around the use of mobile phones need to be clearly explained and consistently applied across the pathway – the need to avoid access to online gambling and other distractions could also be circumvented by allowing the use of non-smartphones to keep in contact with friends and family.

Implications for future commissioning of services

This last point also has implications for the future commissioning of similar services involving more than one organisation. As this study has shown, such differences can introduce significant barriers and challenges. Indeed, as discussed in [Chapter 4](#), there was an initial decline in wellbeing for those moving from Adferiad to Gordon Moody, as measured by the CORE-10 scale.

Recommendation: This suggests that careful thought and planning needs to be given on how treatments involving several organisations can best be coordinated to ensure consistency of delivery and to ensure that any transfer between them is well planned to limit drop out and any negative impact on clients' wellbeing.

This study has also shown that there is a high level of need for this kind of service as the number of clients referred for treatment with co-morbidities far exceeded initial expectations. Stakeholders within both organisations told us that at the start they had been worried about getting enough referrals into the service, whereas this had not been a problem once delivery started. Indeed, very little effort was made to market the service as there was a concern that this would lead to unmet demand for treatment.

Recommendation: This highlights the need for further commissioning of similar services for people with a gambling addiction with co-morbidities that cannot easily be addressed by gambling treatment alone.

As discussed in [Chapter 3](#), most of those who received treatment as part of the service were white British and male, although it did attract more female clients than other similar services.

Recommendation: This still highlights the need for more to be done to attract particular sub-groups of the population who may be less likely to come forward for treatment or be put off by the lack of diversity within residential or other treatment services. This might suggest the need for some services to target people experiencing gambling harm with particular characteristics, such as ethnic minorities, females and those from the LGBTQIA+ community who are often under-represented and may be reluctant to seek support due to the stigma associated with gambling and other co-morbidities.

In relation to this last point, it is also worth noting that while Adferiad Recovery provided mixed-sex residential provision, the Gordon Moody residential centres were single-sex only. The study has shown that these different approaches both had advantages and disadvantages. While some clients preferred to receive support in a single-sex environment, others, for example, with traumatic experiences relating to either romantic or other same-sex relationships preferred to be in mixed settings.

Recommendation: This shows the need for residential services to provide the flexibility to respond to different needs and preferences of potential clients and also to be able to accommodate non-binary or trans clients.

8 Appendices

Appendix 1: Theory of Change

The model below represents the updated version of the Theory of Change, following the second stakeholder workshop in June 2023. It broadly remained the same with a small number of changes to better reflect the service and its outcomes.

Changes to 'Inputs': The evaluation found that 'extracurricular activities' are an essential component of the service; this was therefore added. During the implementation of the pathway, Gordon Moody changed their staffing levels, and it was noted that while Adferiad and Gordon Moody reserve a certain number of beds for pathway clients, there is flexibility depending on need.

Changes to 'Outcomes': A number of outcomes were added to better reflect the range of intended changes for clients, including reduced social isolation; improved relationships with family and friends; greater awareness of financial understanding and issues; and reduction in suicidal ideation.

Changes to 'Risks': An additional financial risk was added due to the higher number of referrals than anticipated.

The final analysis supports the Theory of Change, though some of the outcomes and impacts were out of scope for this evaluation.

Residential-Rehabilitation Service Theory of Change



Appendix 2: Evaluation methodology further details

Scoping phase

Following the inception meeting, we conducted a management information audit which included a review of documents related to the governance and delivery of the service: grant agreement, promotional materials (e.g., brochures); GDPR and safeguarding procedures; assessment form. We also conducted a data audit and review of existing data to understand the use for the evaluation including: KPI template; recovery wheel; and DRF template. This phase also included the establishment of necessary data sharing agreements.

The scoping interviews were conducted online with staff involved in the operational and strategic delivery of the pathway and consisted of interviews with three stakeholders from GambleAware, two from Adferiad Recovery and three from Gordon Moody.

The online workshop to co-develop a Theory of Change was attended by the evaluation team and stakeholders from GambleAware, Adferiad Recovery and Gordon Moody. We used the interactive tool Miro as well as group discussions to populate a Theory of Change template. The resulting Theory of Change was further refined by the evaluation team following the workshop and reviewed by the stakeholders. The Theory of Change was then further revised as part of the early insight stakeholder workshop following the interim analysis.

The work undertaken during the scoping stage contributed to the creation of the evaluation framework, which delineates the data sources for addressing all evaluation questions, as well as the development of the evaluation plan, which details the evaluation methods and tools to be used.

Qualitative Data Collection

Recruitment process

The Heads of Service for Adferiad Recovery and Gordon Moody supported the evaluation team by identifying clients and individuals in post-treatment to be invited to take part in the study. They were provided with a recruitment guidance and were encouraged to keep in mind a target sample when recruiting for longitudinal interviews and to only consider individuals who were deemed stable enough to participate. Recruitment for client interviews was undertaken on a rolling basis as Adferiad Recovery have around six available beds for the pathway at any one point.

The following table includes further details on the characteristics of clients we spoke to as part of the longitudinal interviews. We were not able to obtain the same data for post-treatment interviews conducted.

Table A1: Characteristics of clients who were interviewed as part of longitudinal qualitative data collection

Category	Detail	Number of clients
Gender	Male	10
	Female	5
Age	21-35	8
	36-45	3
	46+	4
Co-morbidity	Mental Health	4
	Drugs&Mental Health	6
	Drugs&Alcohol or Drugs&Alcohol&Mental Health	5
Detox period	No detox period	4
	1-10 days	7
	11-30 days	4
Parent	Yes	8
	No	7
Pathway make-up	Adferiad Recovery and Gordon Moody*	9
	Adferiad Recovery only	6

Note: Base: 15; * Including clients who had an early exit from Gordon Moody; some categories were merged due to small numbers.

We provided documentation for delivery staff so that they understood how the research process worked and how to best support participants. Clients were given a participant information sheet (in two versions: a plain text version and 'easy read' version) which outlined the research in more detail, ensuring they were able to provide informed consent to take part in the study. All participants had the opportunity to ask questions prior to taking part in the evaluation as well as during the interview.

We invited clients to consider whether they had a friend or family member who might be interested in participating in the research. It was necessary that they were in contact with them throughout the pathway so that their loved one could better comment on their experiences. Clients first asked their friend/family member's permission before passing on their contact details to the evaluation team.

Post-treatment interviewees and family/friends were sent participant information sheets via email and the research process was explained during an introductory call.

Topic guides

Interviews were in-depth and semi-structured with researchers using a topic guide to lead the discussion. The topic guides included questions which aimed to fulfil the following objectives:

- To determine the client's journey to the pathway and whether this could be improved.
- To understand the client's experience of their time at the detoxification centre, Adferiad and Gordon Moody including the positives, the negatives and anything they would like improved.

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- To discover the client's experience of their transition to Gordon Moody and back to the community and whether this could be improved.
 - To understand clients' experience of the pathway and its impact from the perspective of friends and family as well as support staff.
 - To identify any areas of improvement from the perspective of friends, family and support staff.
 - To understand any learning or changes made by stakeholders since the Residential Rehabilitation Service inception, focusing on barriers and enablers to service delivery.
 - To check stakeholders' assumptions within the Theory of Change regarding links between activities and outcomes/impacts.

Interviews

Where possible, the same researcher was allocated to interview a client, their family member or friend and their associated support staff. This was implemented to better build an entire picture of the client experience and to create a stronger rapport with interviewees.

The interviews with support staff focused on a particular client whom they knew well. We spoke to six members of support staff from Adferiad Recovery and six from Gordon Moody. Most support staff and stakeholder interviews took place on Microsoft Teams.

The majority of client, post-treatment and family/friend interviews took place over the telephone, unless they expressed a preference for an online video call. Members of the evaluation team also visited the residential centres: Parkland Place (Adferiad Recovery), Gordon Moody men's centre in Manchester and Gordon Moody women's centre in Wolverhampton. Where possible, face-to-face interviews with clients and staff were conducted during these three visits. It was also an opportunity to collect observational data such as descriptions of the setting and atmosphere at the residential centres. This data provided useful contextual information, but it was not used directly in the report findings.

All interviewees, aside from support staff and stakeholders, received a gift hamper as a mark of gratitude for taking part in the research.

Alternative approach

Not all clients recruited for longitudinal interviews completed the pathway. If a client indicated they wanted to leave before the end of treatment, we looked to schedule a second interview before they left or one shortly after they returned to the community.

Where this was not possible, we undertook ad-hoc interviews with clients targeted at those on a particular stage in the pathway, experiencing a particular comorbidity or another aspect in order to fill any gaps in the data.

In total, for the longitudinal interviews, we spoke to:

- Eight clients completing the pathway at both Adferiad Recovery and Gordon Moody
- Six clients at Adferiad Recovery only (who did not transfer to Gordon Moody)
- One client at Gordon Moody only (who had been at Adferiad previously).

The post-treatment interviews helped to ensure we had enough data from clients who stayed at both residential centres. We spoke to:

- Four individuals in post-treatment who stayed at both Adferiad Recovery and Gordon Moody
- One individual in post-treatment who stayed at Adferiad Recovery only.

Qualitative data analysis

All interviews were transcribed or written up as extensive notes. The transcriptions were coded in Microsoft Word using the comment tool to assign sections of text to a theme from the evaluation framework. The text linked to comments was then extracted to Excel using a macro. Enabling a drop-down list in Excel allowed us to search for all text related to a particular theme and analyse it accordingly. This exercise was also used to find relevant quotes for the Final Report.

Quantitative data collection and analysis

The evaluation team analysed management information collected by the Residential Rehabilitation Service. All data covers the period January 2022 to June 2023 unless otherwise stated and relates to 101 clients contained within the key performance indicators. Table A2 provides information on the data available and analysed for the evaluation.

Table A2 Management information analysed

	Content	Source
Key performance indicators	Demographics, whether and how long detoxification accessed, number and type of treatment received at Adferiad, PGSI and CORE-10 data for clients accessing Adferiad treatment (at assessment and discharge). Waiting time data between referral and Adferiad treatment starting is only available from January to June 2023.	Adferiad
Aftercare data	Engagement in support upon discharge from leaving Adferiad. This includes whether the client engaged in any daily phone calls to check on their welfare ('welfare calls'), whether they engaged in any one-hour long targeted support ('aftercare calls'), the number of aftercare calls accessed, and PGSI score at follow-up in April/May 2023.	Adferiad
Adferiad's submission to the Data Reporting Framework (DRF)	Profile and demographic information about clients accessing Adferiad support on the pathway (including detoxification).	Adferiad
Gordon Moody client data	Nights of residential clients stayed, PGSI and CORE-10 data at start and end of residential (not follow-up), and the number of phone calls made after clients leave Gordon Moody to check on their wellbeing ('aftercare').	Gordon Moody

The data, and therefore data analysis is limited in the following ways:

- **Data availability:** the service has been increasing the variables collected across the period covered by the MI available for analysis (January 2022 to June 2023) and so there are places where data is not available for the whole service provision period. There are also some variables where data was not collected from clients by the service and so could not be included in the analysis. This includes number of clients who accessed peer support or community therapy, outreach support and relapse prevention programme. No data was available on the number and profile of referrals who declined an assessment or treatment.
- **Data quality:** data quality issues within the datasets include overlapping categoric variables, different totals for variables that should have the same base number and missing data. Whilst the evaluation team has made every effort to process and clean the data and has worked closely with the Adferiad team, gaps remain that limit our analysis. Our suggestions for improving data collection can be found at the end of this document.
- **Sub-group analysis:** this has been undertaken wherever possible and described in this note where meaningful differences have been found. If no differences are mentioned, the reader should assume that there were no differences or that the base sizes of sub-groups meant analysis could not be undertaken.

Appendix 3: Further pathway details

This Appendix provides further information about the delivery of the pathway by Adferiad and Gordon Moody.

Staff

The table below outlines the roles of staff at Adferiad and Gordon Moody who are involved in the implementation or management of the pathway.

Table A3 Staff working on the pathway

Gordon Moody	Adferiad Recovery
Clinical Director	Director of Hospital and Residential services
Head Of Service Development	Residential Manager
Pre-Treatment Manager	Head of Service Gambling Harms
Women's Residential Manager	BACP Specialist Counsellor
Women's Residential Team: 1 x Therapist FTE 1 x Support Worker FTE 1 x Night Worker FTE 1 x Mental Health Co Ordinator	Addiction & Recovery Practitioners Detox Manager Nursing Team – (General Nurse (RGN); Mental Health Nurse (RMN); Learning Disability Nurse (RLD)) Recovery Workers
Men's Residential Manager	Lead Addiction Therapist
Men's Residential Team: 1 x Therapist FTE 1 x Support Worker FTE 1 x Night Worker FTE 1 x Mental Health Co Ordinator	Night Staff Office Manager Finance Director of Insights and Impact

Treatment details

Exclusion criteria

Though the pathway is equipped to treat a wide range of individuals with a gambling disorder and complexities, including comorbid disorders, there are a number of exclusion criteria:

- Individuals that are actively suicidal
- Individuals who are sectioned under the Mental Health Act
- Individuals that have physical health morbidities that require interventions on a general ward, such as cannulation or intravenous treatment
- Individuals that cannot meet the basic functions of self-care.

Treatment

The tables below provide detailed information about the activity schedule at Adferiad Recovery and Gordon Moody for one example week.

Table A4 Example week at Adferiad Recovery

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
7.30 - 8.30	Breakfast	Breakfast	Breakfast	Breakfast	Breakfast		
8.30 - 9.00	Meditation & Diary	Meditation & Diary	Meditation & Diary	Meditation & Diary	Meditation & Diary		
9.30 – 12.00	Psycho-Educative Group: Intro to CBT	Psycho-Educative Group: Stages of change & Core Beliefs	Psycho-Educative Group: ABC Model & Destructive behaviour	Psycho-Educative Group: Self-esteem and boundaries	Psycho-Educative Group: Relationships & Assertiveness	Saturday Outing	Recovery Groups
12.15 - 1.00	Lunch	Lunch	Lunch	Lunch	Lunch		
1.00- 4.00	2-3 one to one with Therapist	2-3 one to one with Therapist 3-4 Counselling Session	2-3 one to one with Therapist	2-3 one to one with Therapist 3-4 Counselling Session	2-3 one to one with Therapist	Saturday Outing	Family Visits 2.30-5pm
	Afternoon Tea	Afternoon Tea	Afternoon Tea	Afternoon Tea	Afternoon Tea		
4.00- 5.00	4:15 Mindfulness	4:15 Yoga (via YouTube instructor)	4:15 Art Therapy	4:15 Acupuncture	4:15 Mindfulness		
5.00	Reflections	Reflections	Reflections	Reflections	Reflections	Sleep Hygiene	
6.00 – 7.00	Dinner	Dinner	Dinner	Dinner	Dinner		
8.00 – 9.00	Evening Activity	Evening Activity	Evening Activity	Evening Activity	Evening Activity		

Table A5 Example week at Gordon Moody (male service)

Time	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
8.00 - 9.00	Breakfast Club Reflection	Breakfast Club Reflection	Breakfast Club Reflection	Breakfast Club Reflection	Breakfast Club Reflection	Activity Day	Communal meal
9.00 – 9.30	Meditation / Mindfulness / Relaxation	Meditation / Mindfulness / Relaxation	Meditation / Mindfulness / Relaxation	Meditation / Mindfulness / Relaxation	Meditation / Mindfulness / Relaxation		
9.30 – 10.30	Therapist 1:1 or Journal time or Outcome star	Therapist 1:1 or Journal time or Outcome star	Therapist 1:1 or Journal time or Outcome star	Therapist 1:1 or Journal time or Outcome star	Reflection and reading time		

10.30 – 11.00	Downtime / group prep time	Downtime / group prep time	Downtime / group prep time	Downtime / group prep time	Whysup wk 1	Reflection is at 10.30	Reflection is at 10.30
11.00 – 12.30	Support Group	Foundation Pt 1	Foundation Pt 2	Support Group	Library wk 2		
		Downtime / reflection			Epic wk 3		
12.30 – 1.00		Lunch	Lunch		Lunch		
1.00 – 1.30	Lunch			Lunch			
1.30 – 2.00		Shopping	Art and Creative Therapy		Shopping		
2.00 – 3.30	Honesty/Relapse Prevention			Communal Contribution, gardening, jobs etc			
3.30 – 4.00		Support Worker 1:1s	Support Worker 1:1s	Beyond Recovery Group	Celebration event		
4.00 – 4.30	Residential meeting (designated staff and residents)	Yoga or Breathe work alternating weekly.	Residents House meetings	Film Club	Phone use day		
4.30 – 5.00							
5.00 – 5.30	Gym /Free activity time / constructive downtime			Film club discussion	Gym / free activity time / constructive downtime		
5.30 – 6.30		Foundation Pt 2 prep / homework	Gym / free activity time / constructive downtime	Communal meal			
6.30 – 7.00							
7.00 – 7.30							
7.30 – 8.00							

Appendix 4: Further figures

Table A6 Nights stayed for each part of the pathway

	Mean average	Min	Max	Standard deviation
Clients who completed support at Adferiad as planned				
Detoxification (n=22)	8	3	15	4
Adferiad Parkland Place (n=38)	29	11	55	10
Clients who left Adferiad before completing scheduled treatment				
Detoxification (n=10)	10	5	21	6
Adferiad Parkland Place (n=14)	15	4	29	6
Clients who left Adferiad to be signposted to another organisation outside of the pathway				
Detoxification (n=1)	9	N/A	N/A	N/A
Adferiad Parkland Place (n=5)	31	17	60	16
Clients who completed support at Adferiad and Gordon Moody as planned				
Detoxification (n=10)	6	3	11	2
Adferiad Parkland Place (n=16)	26	13	68	13
Gordon Moody (n=16)	54	25	88	27
Clients who left Gordon Moody before completing scheduled treatment				
Detoxification (n=4)	8	2	21	8
Adferiad Parkland Place (n=9)	28	18	42	8
Gordon Moody (n=8)	20	3	36	10

Source: Adferiad data: Detox and Adferiad nights. Gordon Moody data: GM nights. Base as per table. Note: missing data.

Table A7 PGSI and CORE-10 scores at Adferiad

	Scale	N	Adferiad start	Adferiad end	Mean diff	SD	p	Effect size (Cohen's d)
All clients	PGSI	40	23.6	23.4	0.28	2.11	0.42	0.13
	CORE-10	74	16.8	11.2	5.62	6.10	<.001	0.9
Adferiad only (combined)	PGSI	25	23.5	23.3	0.16	1.43	0.58	0.11
	CORE-10	50	16.7	10.8	5.90	6.93	<.001	0.85
Adferiad only (completed treatment)	PGSI	14	24.0	23.6	0.43	1.7	0.41	
	CORE-10	36	17.0	10.1	6.86	6.4	<.001	
Adferiad only (left before completing)	PGSI	6	22.8	22.8	0		1	
	CORE-10	8	19	13.8	5.25	7.0	0.63	
Adferiad only (referred to other service)	PGSI	5	23.0	23.4	-0.4	1.67	0.56	
	CORE-10	5	14.2	13.0	1.2	10.0	0.69	
Adferiad and Gordon Moody (combined)	PGSI	14	24.0	23.6	0.43	1.65	.35	0.26
	CORE-10	36	17.0	10.1	6.86	6.38	<.001	1.08
Adferiad and Gordon Moody (completed treatment)	PGSI	10	24.6	24.3	0.3	0.95	0.32	
	CORE-10	16	17.5	13.3	4.25	3.66	<.01	
Adferiad and Gordon Moody (left before completing)	PGSI	5	22.2	21.4	0.80	5.36	1	
	CORE-10	8	16.1	9.5	6.63	4.14	<.05	

Source: Adferiad data: Treatment impact. Gordon Moody data: Pretreatment and posttreatment scores. Base as per table.

Table A8 PGSI and CORE-10 scores at Adferiad and Gordon Moody

	N	Adferiad start	Adferiad end	Gordon Moody start	Gordon Moody end	Mean diff (Adferiad start to Gordon Moody end)	p
PGSI	13	24.2	23.4	22.9	3.6	20.6	<.001
CORE-10	19	16.6	12.3	20.3	9.2	7.5	<.001

Source: Adferiad data: Treatment impact. Gordon Moody data: Pretreatment and posttreatment scores. Base as per table. Analysis is limited to those who transfer to Gordon Moody with start and end scores at both Adferiad and Gordon Moody.

Table A9 PGSI scores at treatment start and 12 months follow-up

	N	Treatment Start	12 months follow-up	Mean diff	p
PGSI	15	23.9	8.8	20.6	<.01

Source: Adferiad data: Treatment impact. Analysis is limited to those who have a valid 12 months follow-up and treatment start score. Note where the Adferiad assessment score was not available the Gordon Moody assessment score was used.