



ADDICTIONS FOUNDATION OF MANITOBA

Evaluation Report:

AFM's Problem Gambling Residential Rehabilitation Program

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*Building
hope for over
50 years*

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Addictions Foundation of Manitoba

The Addictions Foundation of Manitoba is responsible for providing rehabilitation and prevention services for Manitoba citizens relating to substance use and problem gambling.

VISION:

Manitobans living free from the harms of alcohol, other drugs and gambling.

MISSION:

To enhance the health of Manitobans by reducing the harm of alcohol, other drugs and gambling through leadership in education, prevention, and rehabilitation.

VALUES:

We believe our greatest asset is our staff, and acknowledge their contribution and passion in supporting the following organizational values:

- *The dignity and diversity of each individual;*
- *The capacity of clients and communities for change;*
- *Collaborative relationships with stakeholders, partners and the self-help community;*
- *Continuous improvement and best practices;*
- *A continuum of services and programs; and*
- *A safe and respectful work environment.*

This evaluation project would not be possible without the financial support from Manitoba Lotteries Corporation (MLC). In addition, the staff at Parkwood have been absolutely essential in the evaluation process and the authors would like to thank them for their contributions to this project. A special thanks to Brian Broszeit who has been extremely helpful in providing data from the intake and assessment files. Last but not least, a big thank you to all of the clients who have provided consent and have shared their thoughts and feelings with the staff at AFM. Without their participation this project would never have taken off the ground, and for that we are very thankful.

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1. EXECUTIVE SUMMARY

The Problem Gambling Residential Rehabilitation Program (PGRRP) is a 14 day intensive residential program based in Brandon, Manitoba for individuals who are having problems with gambling that has had serious consequences on various aspects of their life and for which no other forms of treatment have helped. The PGRRP opened in October of 2002 and aims to help clients by providing them with the knowledge and skills to deal with their gambling (short-term objectives) as well as promoting long term positive outcomes such as reduced frequency of gambling, reducing harmful and problematic gambling, improving health, and decreasing financial issues (long-term objectives).

The program at Parkwood is open to all residents of Manitoba and is funded by Manitoba Lotteries Corporation. A variety of activities are offered during the two week stay including daily counseling sessions (individual and group) and family counseling; financial/money management education; mental health & cross addiction education/support; educational and experiential sessions on issues related to problem gambling; and gender specific group counseling. As with all of the AFM programs, once the client has completed the sessions, participants can receive ongoing support through their local AFM office.

Over five years ago a decision was made to evaluate the program. Since that time several brief summary reports in addition to two comprehensive documents have been completed. Stakeholders agreed upon an outcome-based model for evaluation, and as such, information was collected from clients at intake and after the two week program. If clients consented to be contacted for a follow-up, information was collected at 3, 6, and 12 months post program completion. This information was used to evaluate the program's success with regards to its short and long term objectives and to identify any qualitative information from the clients that could be used to improve services. The current report explores the following questions:

1. Are clients learning the program material (knowledge)?
2. In regards to positive life outcomes, are clients improving (gambling frequency, risk of problem gambling, financial effects, etc.)?
3. In their own words, what do clients think about the program?

To date, results indicate that the program is effective in improving clients' gambling-related knowledge and coping skills from baseline levels. The current analysis reveals similar trends in the evaluation results. Post program completion, significant improvement was seen in clients' knowledge of: (1) gambling, (2) mental health issues as they relate to gambling, (3) impact of gambling on family/significant others, (4) relapse management strategies, (5) financial strategies, (6) life skills (7) support/resources in the community, and (8) benefits of having a recovery plan. The follow-up results indicate that the program was successful in helping clients deal with the legal and financial issues reported at intake. The proportion of clients who are gambling one year post program completion also decreased substantially from baseline levels (97% to 45% respectively). Most importantly, clients are reporting to gamble at lower risk levels over time compared to their initial assessment. At intake 97.3% of clients are gambling at high risk levels; this percentage drops to 17.7% at 3 months post program, 30.4% at 6 months, and 29.3% at one year. In addition, the proportion of clients reporting suicidal ideation also decreased substantially (76% at intake to 17% one year later). Improvements are also shown over time in regards to financial issues and legal troubles due to gambling.

Clients were given several opportunities to express how they felt about the program. Results from the long answer questions provided a wealth of information with regards to what clients consider the most important things learned through the program and how they think the program can be improved. Key themes that emerged from the comments include knowledge about gambling, social supports available, spirituality, self-appreciation/awareness, and the importance of forgiveness, peace, and strength in the recovery process. Overall, most clients reported high satisfaction with the program. Of those who provided suggestions for program improvement, the majority identified issues with program content, organization and structure. Some clients suggested improved amenities/services and the need for more family involvement. Less than 10% of the clients who provided comments felt that the program should be extended for one more week. Several suggestions were made in regards to program improvement including more involvement of the family in the recovery process and improved amenities/services provided at the residential facility (i.e. better food, furniture etc). Suggestions for program content (i.e. more training on time management, communication, assertiveness training etc), program structure (i.e. having smaller groups, interactive sessions etc.), and program materials (i.e. updating videos, handouts etc.) were also offered.

Although clients offered suggestions for program improvement, the data suggest that the program was effective in meeting both its short and long term goals. Clients' positive evaluation of the program as seen in their responses to the long answer questions of the follow-up questionnaire validate these findings:

“The program was very, very good. Not only did it show me what I was doing to myself but my family as well. The program met all my needs to get me started in my recovery.”

“I came with an open mind and I feel I am leaving with everything that I came for. I do not feel any yearning for something I could be lacking. I feel fulfilled and will strongly recommend this program to anyone in my future.”

“You used a variety of tools, you challenged our thinking with active listening, care, respect and a genuine desire to help us.”

“All in all, wonderful program, wonderful staff, and a very warm loving atmosphere. Thank-you for having such a program available for those who suffer and are lost.”

“Excellent program and excellent staff.”

Over the years, summary and final reports on the program have consistently resulted in similar findings. Through their own words, clients are not only enjoying the program but several short-term and long-term objectives are being met. Clients continue to learn important information about gambling and they are also gaining skills that will assist them in leading healthier lifestyles. At follow-up clients appear to be reporting less harm due to their gambling. It is recommended that the program should be evaluated periodically but that the current project should be considered completed. Future evaluations should involve a revised plan (this could involve standardize measurement instruments such as the GAMTOMS) developed with the assistance of Program staff, evaluation staff and former clients.

Evaluation Report: Addictions Foundation of Manitoba (AFM)'s Problem Gambling Residential Rehabilitation Program

2. INTRODUCTION

2.1 Background

Although in the past the Addictions Foundation of Manitoba (AFM) provided a variety of services for individuals struggling with gambling issues (individual counseling, community-based programs, group counseling, province-wide gambling help-line, and a Responsible Gaming Information Centre¹ in both of Manitoba Lotteries Corporation's Casinos of Winnipeg), there appeared to be a gap existing for those clients who were assessed as potentially benefiting from a more intense form of rehabilitation. Therefore, in response to an internal review of AFM services and increasing community pressure to offer more intensive problem gambling rehabilitation, AFM sought funding from Manitoba Lotteries Corporation (MLC) to develop a pilot residential rehabilitation program for individuals with significant problems due to gambling. The Problem Gambling Residential Rehabilitation Program (PGRRP) opened out of Parkwood in October of 2002.

The PGRRP is a 14-day co-ed intensive residential program for individuals who are harmfully or dependently involved with gambling and who have suffered severe consequences as a result of their gambling in several life areas. Typically these clients have not been able to reduce their harm from gambling with less intrusive programming or live in remote or rural areas where they are unable to access any type of problem gambling rehabilitation services.

As the program was one of the first of its kind, a pilot was developed several years ago with an evaluation component. The focus of the PGRRP continues to be on group counseling, individual counseling, gender specific group counseling, mental health, couple counseling, financial management education, and educational seminars on various gambling-related issues. Clients have to maintain abstinence while in the program. The program also provides an introduction to the support programs of Gamblers Anonymous (GA) and Gam-Anon (a self-help program for the family members and friends). Clients are expected to attend at least two GA meetings per week while in the program. As of November 2008, over 80 waves of clients (over 300 individuals) have successfully completed the program. This report will include data collected until the summer of 2008. At this point, a decision was made to discontinue data collection with this group and to complete a report for early winter 2008/09. This report will highlight the results of the evaluation project.

2.2 Program Objectives

Several years ago AFM gambling staff, MLC and AFM Research & Quality Monitoring met to develop the research questions for the PGRRP evaluation. The accountability model provided a framework upon which the research questions were based and ensured that the activities in the program were linked to measurable objectives (short and long-term). Given that the program is only 14 days long, it was suggested that the short-term goals measure knowledge and skills learned over the

¹ This exciting initiative is staffed by AFM rehabilitation counsellors and preventative education consultants. The MLC provides funding for the Responsible Gaming Information Centres (RGICs).

short stay. The following is a list of short-term objectives that were identified by staff as achievable by the end of the PGRRP ²:

1. Increase life skill capacity,
2. Increase knowledge of relapse management strategies,
3. Develop financial strategies,
4. Develop an ongoing written recovery plan,
5. Increase knowledge about gambling,
6. Increase knowledge about mental health issues,
7. Increase knowledge of impact of gambling on family, and
8. Increase knowledge of community support.

The long-term objectives of the program were developed based on literature in the gambling field that suggests that cognitive approaches to gambling treatment (changing the thoughts and cognitions → with the goal of having a positive impact on behaviour) should lead to positive outcomes in the long-term (Bujold, Ladouceur, Sylvain & Boisvert, 1994). The following is a list of the long-term objectives:

1. Reduce harm from gambling
2. Reduce financial effects from gambling
3. Reduce mental health issues (specifically suicidal ideation)
4. Reduce work-related issues (not measured in this evaluation)
5. Reduce legal issues

2.3 Methods

Information was collected from the gambling clients at five different points of time. Management Information System (MIS) forms (core intake and gambling program), a consent form (see Appendix A) requesting participation in a follow-up evaluation at month 3, 6 and 12, and a pre-test for knowledge were administered to the clients at intake (see Appendix B). After the program clients were given a post-test (see Appendix C). Three months later, and based on their consent, the client was telephoned surveyed (15 minutes) followed by a 6-month and 1-year evaluation. Questions from the follow-up survey (see Appendix D) were developed to measure the long-term objectives of the program. Level of problem gambling risk was measured with the Manitoba Gambling Involvement Scale (Brown & Smitheringale, 2002) which was developed in 2002. The scale is comprised of five questions and was designed to identify risk for gambling-related problems in the forms of a valid, reliable and simple screening tool (see Appendix E). Risk is determined by the most intense question endorsed – this scale leads to low risk, moderate risk and high risk categories. The Problem Gambling Severity Index (from the Canadian Problem Gambling Index) was incorporated into the follow-up surveys but due to small numbers the results are not presented in this report. An accountability model was developed with program staff input to identify the expected long-term impacts of the program. In 2005/06 the logic and accountability models were revised but the evaluation framework and methodology remained the same.

² Note that the goal of the program is not abstinence. Like many harm-reduction programs, AFM recognizes that abstinence from gambling may be an important goal for some clients. However, abstinence is not required for participation in after-care services at AFM.

3. CLIENT DESCRIPTION

3.1 AT INTAKE: DEMOGRAPHICS

From October 2002 to the end of August 2008, a total of 319 clients were admitted to the PGRRP (with 21 of these completing the program two times or more). Of these, 88% completed the program. There were 79 waves of clients with an average of 4 clients per group. As shown in Table 1, the majority of clients who completed the program were male (54%). Over 60% of the clients were between the ages of 35 to 54 years of age. Approximately 17% of clients were 25-34 years of age. Aside from identifying as “Canadian” the largest ethnic/cultural group was “Aboriginal”³ comprising approximately 13% of the total sample. In terms of marital status, 36% were single and another 36% were married/common law. Close to one in three (28%) reported no children, 24% currently had two children, and 21% reported having one child. Most had completed high school (28%) and 17% had a university or college degree. Approximately 42% were employed full-time with 23% reporting unemployment and 13% were on disability/leave. Finally, in terms of household income, 16% reported making between \$30,000 and \$39,000 per year. Interestingly, 14% reported making \$70,000 or more. Another 13% indicated being at the other end of the scale making between \$10,000 and \$19,000 per year (see Table 1 for more detailed information on client demographics at intake).

Table 1: Demographics of PGRRP Clients⁴

Demographics	Number of Clients	Percent of Clients
Gender		
Male	146	53.7
Female	126	46.3
Total	272	100.0
Marital Status		
Single	90	35.7
Married/Common Law	90	35.7
Divorced/Separated	61	24.2
Widowed	7	2.8
Other	4	1.6
Total	252	100.0
Age		
18-24 years old	8	2.9
25-34 years old	47	17.3
35-44 years old	90	33.1
45-54 years old	78	28.7
55-64 years old	40	14.7
65+	9	3.3
Total	272	100.0

³ For the purposes of this report the term “Aboriginal” will be used to describe all First Nations peoples which include a wide array of different groups.

⁴ Sample sizes will vary.

Table 1: Demographics of PGRRP Clients (Cont'd)

Demographics	Number of Clients	Percent of Clients
Education		
Less than grade 9	11	4.1
Some high school	58	21.8
High school complete	75	28.2
Some college/university	62	23.3
Univ/college degree	46	17.3
Other	14	5.3
Total	266	100.0
Employment status		
Working fulltime	115	42.3
Working part-time	20	7.4
Unemployed	63	23.2
Leave of absence	17	6.3
Student	4	1.5
Disability/leave	34	12.5
Retired	18	6.6
Homemaker	5	1.8
Total	276	*
Household income		
Less than \$10,000	23	8.7
\$10 - \$19,000	35	13.3
\$20 - \$29,000	30	11.4
\$30 - \$39,000	41	15.6
\$40 - \$49,000	34	12.9
\$50 - \$59,000	18	6.8
\$60 - \$69,000	13	4.9
\$70,000 ≥	36	13.7
Don't know	18	6.8
Declined/refused	15	5.7
Total	263	100.0

Note. *Percentages do not add up to 100 as clients could select more than one response.

3.2 AT INTAKE: PAST HELP-SEEKING-BEHAVIOUR

At the intake session, clients were asked to fill in several forms that included questions pertaining to clients' past help-seeking behaviour. At intake, the majority of clients (79%) reported that they had experienced problems related to gambling in the past. Video Lottery Terminals (VLTs) were the form of gambling that had caused the majority of clients (79%) the most problems followed by slot machines (10%) and casino table games (6%). Approximately 48% of clients indicated they had called the Manitoba Problem Gambling Help-Line and 42% indicated they had gone for help for their gambling-related problems within the past year. Of these, 60% sought help through the Addictions Foundation of Manitoba, 56% through Gamblers Anonymous, and 36% through a private therapist

(psychologist, psychiatrist, or social worker)⁵. Further, over half (53%) had attended a rehabilitation program for their problem gambling and of these, 53% had completed the program.

3.3 AT INTAKE: MENTAL HEALTH

Questions about the clients’ mental health were also assessed at intake. The intake form at AFM asks clients to reflect on their mental health history including the nature of specific problems (see Table 2) and treatment modality. It is important to note that the results of this section are based on self-reports and do not necessarily indicate a diagnosis of mental health issues. In addition the mental health issues discussed in this section only include those identified within the forms and may be excluding others. Over half (58%) of clients reported having received treatment for mental health issues in the past. As shown in the table below, depression (84%), anxiety (47%), and stress (34%) were the most common problems experienced by clients. The most common forms of treatment included prescribed medication (71%) and counseling (59%). Clients were also asked if they were currently being treated for emotional or mental health issues. Approximately 47% were currently being treated for mental health problems. The most common issues clients were currently being treated for included depression (88%), anxiety (58%), and stress (46%). Likewise, the most common forms of treatment included prescription medication (84%) and counseling (55%). Clients were also asked about suicidal ideation. Over three quarters (76%) reported suicidal ideation in their lifetime and 9% reported currently feeling this way.

Table 2: Percentage of Clients Reporting Mental Health Issues and Treatment Received in the Past and at Intake

Mental Health Variable (self-reported)	In the Past (%)	At Intake (%)
Nature of Problem		
Depression	84	88
Anxiety	47	59
Stress	34	46
Manic Depression	7	11
Schizophrenia	3	4
Other	13	12
Treatment Modality		
Prescribed medication	71	84
Counseling	59	55
Hospitalization	26	14
Over the counter medication	4	4
Other	6	5

Note. Percentages do not add up as clients could select multiple responses.

3.4 AT INTAKE: INVOLVEMENT IN THE LEGAL SYSTEM

Clients’ involvement in the legal system was also assessed at intake. Approximately 14% of clients reported being involved in the legal system. The nature of their involvement in the legal system was mostly related to bankruptcy (38%), fraud (32%), theft (32%), abstinence from gambling (27%), and separation/divorce (22%). Further, 7% of clients indicated they had court appearances pending and 6% indicated they were on probation.

⁵ Percentages do not add up as clients were asked to select all responses that applied.

4. RESULTS & DISCUSSION

4.1 PRE AND POST PROGRAM COMPLETION RESULTS: KNOWLEDGE & SKILLS LEARNED

Various short-term objectives were identified for clients completing the 2 week program. These pertained to acquiring knowledge about gambling, coping skills, and the ability to identify available resources in the community. A short questionnaire was used to gather data from clients regarding their knowledge and skills before and after completing the program (see Appendix B and C). The table below shows the average score for each content area before and after the program as well as the effect size describing the pre and post scores. An effect size is used to determine not only whether an intervention had a statistically significant effect, but also the size of any observed effects (in this case, the difference between the pre and post test scores). Effect size values range from small (0.2), to medium (0.5), and high (0.8).

Table 3. Knowledge and Skills of Clients Before and After Program Completion

Content area	Possible score	Average pre-test score	Average post-test score	d (Effect Size)
General gambling knowledge (n = 261)	4	3.42	3.72*	0.42
Impact of gambling on family (n = 263)	3	2.52	2.80*	0.44
Mental health issues related to gambling (n = 264)	3	2.40	2.58*	0.23
Recovery plan (n = 259)	2	1.77	1.88*	0.21
Life skill capacity (n = 266)	3	1.82	2.29*	0.47
Relapse management (n = 265)	3	1.77	2.42*	0.67
Financial strategies (n = 262)	3	1.80	2.26*	0.55
Support and community resources (n = 263)	3	1.62	2.19*	0.62
Total Knowledge score	24	17.20	20.23*	

*p < .05

Note. Some clients did not answer all questions. Therefore, sample sizes vary.

As seen in the table on the previous page, there was a significant improvement in clients' knowledge of: (1) gambling, (2) mental health issues as they relate to gambling, (3) impact of gambling on family/significant others, (4) relapse management strategies, (5) financial strategies, (6) life skills (7) support/resources in the community, and (8) benefits of having a recovery plan from pre to post program completion. Overall, knowledge of available support/resources in the community, relapse management and financial strategies improved substantially. Only knowledge about mental health issues as it relates to gambling and recovery as well as knowledge about the benefits of having a

recovery plan had small effect sizes. Overall, results indicate that clients' knowledge of the material covered during the program significantly improved from baseline levels.

4.2 FOLLOW-UP RESULTS: 3, 6, AND 12 MONTHS POST PROGRAM COMPLETION

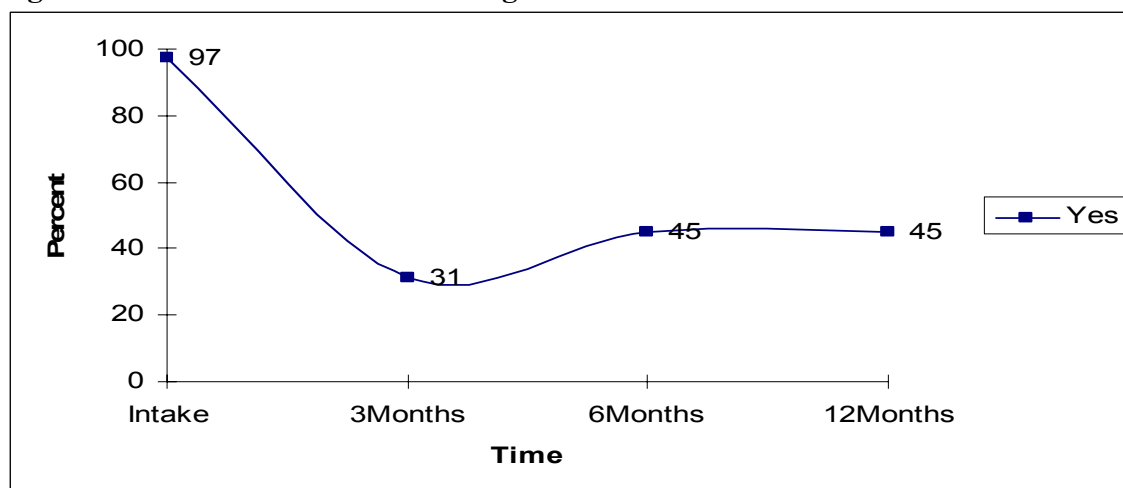
In order to assess how clients were doing after the 2 week program, clients were contacted at 3, 6, and 12 months after they completed the sessions. A total of 289 follow-up calls were made throughout the course of the evaluation. With informed consent, research assistants from AFM contacted clients by telephone. The average follow-up call was 20 minutes in duration. However, calls ranged from 5 to 45 minutes. A follow-up questionnaire was used to guide the interview process. The questionnaire included questions pertaining to gambling behaviour, harm associated with gambling, financial effects, legal issues and more (see Appendix D). Overall, 57%⁶ of clients were contacted at 3 months, 58% of clients were reached at 6 months and less than 50% were contacted at the one year follow-up call.

The data collected from clients at follow-up was examined to determine whether clients: (1) are gambling at the time of follow-up and the type of gambling they are engaging in, (2) report risk for problem gambling due to their current gambling (3) report to have a problem with gambling and know of someone who is concerned with their gambling, (4) report current suicide ideation, and (5) report having legal or financial problems. Clients were also asked to provide feedback on the program in their own words. Results are discussed in the subsections that follow.

4.2.1 Client Gambling Behaviour

Clients were asked if they had gambled on any activity at 3, 6, and 12 months post program completion. In addition, type of gambling reported by client was also examined (see Table 4) as we know that the majority of clients who attend the residential program are having problems with VLT gambling. From intake to 3 months, there was a significant decrease in gambling (97% to 31%) on any activity. At 6 months, 45% of clients are gambling. This proportion remains constant thereafter as seen in the figure on the next page.

Figure 1. Percent of Clients Gambling

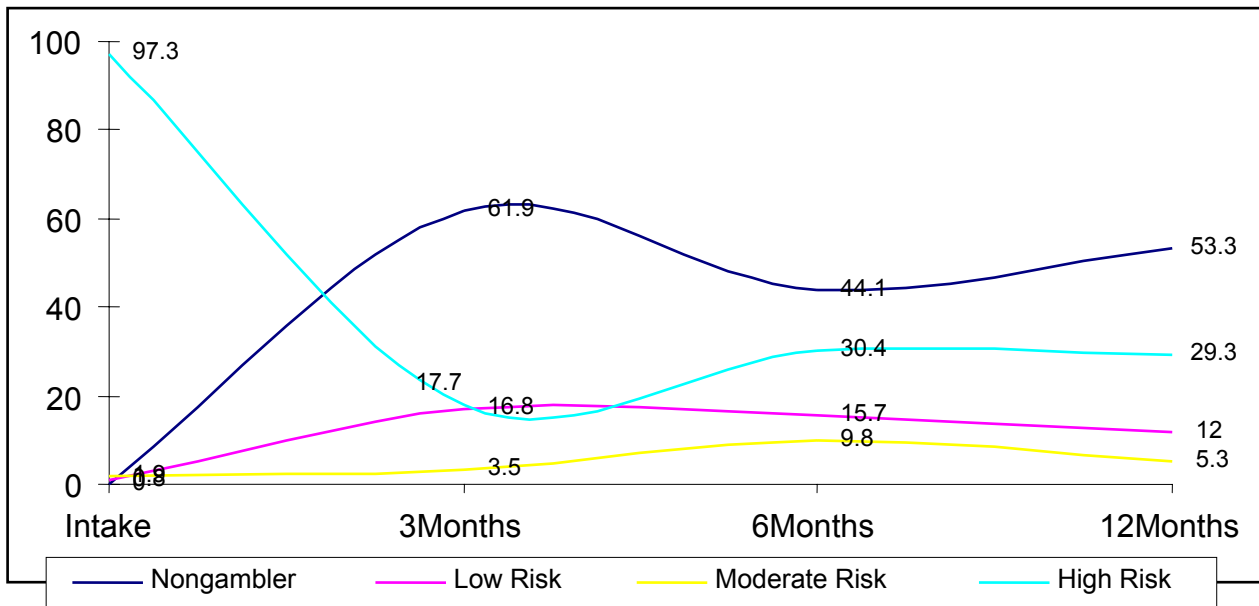


⁶ This is the percentage of clients who were successfully contacted out of those that completed the program and consented to follow-up. At the 6 month and the 12 month follow-up data collection points, the percentage of successful calls was determined to be out of those that could be reached (e.g., they consented, they finished the program, they were accessible – phone numbers were still in service, they still lived in the same residence, etc).

4.2.2 Gambling Behaviour: Level of Risk

Clients were also asked five questions that were used to assess their level of risk for problem gambling (see Appendix E: MGIS). At intake, almost every client was gambling at a high risk level and this percentage drops to 18% at the 3 month follow-up call. At the 6 month follow-up call, approximately 1 in 3 clients met the criteria for high risk of problem gambling and this percentage stabilizes into the 1 year follow-up call. About half of the clients report no gambling after one year of completing the program. The increase in “high risk” from 3 months to 6 months is consistent with similar increases in those reporting to gamble since the program (many clients referring to this as a “relapse”). Figure 2 is encouraging as it shows that almost all clients at intake were high risk and one year later we find that this number drops significantly.

Figure 2. Percent of Clients by MGIS Categories



Clients were also asked to indicate whether they had engaged in various gambling activities. The table below shows that the proportion of clients who reported playing VLTs, slot machines, and lottery tickets decreased overtime. However, it is interesting to note that the proportion of clients who reported playing VLTs and lottery tickets increased from 6 months to the 1 year follow-up. The percentage of clients who reported playing slot machines remained constant following the 6 months follow-up. Finally, the number of clients engaging in gambling activities such as internet wagering, sports betting, horses, keno, scratch tickets, and cards decreased over time.

Table 4: Type of Gambling Reported by Clients at Intake and at 3, 6, and 12 Months Post Program Completion

Type of Gambling	Intake ¹		3 Months ²		6 Months ²		12 Months ²	
	(%)		(%)		(%)		(%)	
	Yes	No	Yes	No	Yes	No	Yes	No
VLTs	97.9	2.1	81.5	18.6	80.7	19.3	88.6	11.4
Slots	65.5	34.6	26.1	73.8	31.7	68.4	31.5	68.6
Lottery Tickets	86.5	13.5	21.3	78.6	17.7	82.5	31.5	68.6
Bingo	50.1	50.0	3.6	90.5	7.1	93.0	11.5	88.6
Cards (ie. Poker)	42.0	58.0	9.6	90.5	7.1	93.0	2.9	97.1
Table games (ie. Blackjack, roulette)	36.1	63.8	-	100	5.3	94.7	2.9	97.1
Breakopens/ Scratch Tickets	63.1	36.9	7.1	92.9	5.3	94.7	-	100
Keno	33.6	66.3	4.8	95.2	3.6	96.5	-	100
Sports Betting	24.8	75.2	4.8	95.2	3.6	96.5	-	100
Horses	12.4	87.7	-	100	3.6	96.5	-	100
Internet Wagering	12.0	87.9	-	100	-	100	-	100
Other	8.5	91.5	2.4	97.6	1.8	98.2	6.0	93.9

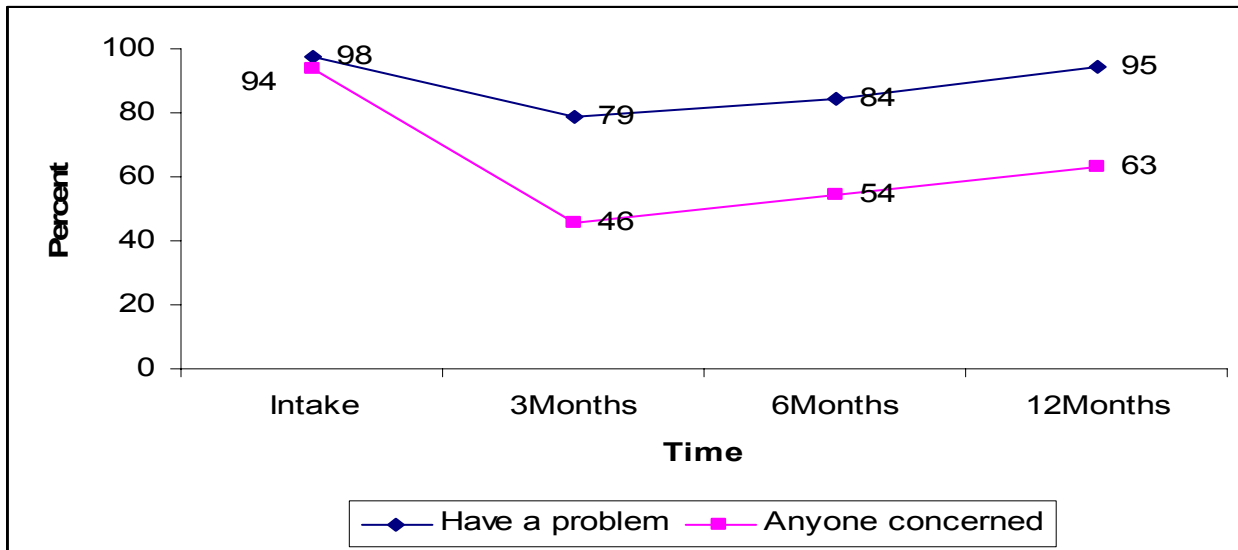
Note. Percentages may not add up to 100 due to rounding.

¹Intake percentages are based on all clients who enrolled in the program. ²Percentages are not based on all clients who were contacted at follow-up, but out of those who reported gambling since the program or since the last follow-up call.

4.2.3 Client Assessment of Problem and Self-Reported Concern from Others

Clients were asked if they felt they had a problem with gambling 3, 6, and 12 months post program completion. As seen in the figure below, there was a substantial decrease in the proportion of clients reporting they have a gambling problem from intake to the 3 months follow-up (98% to 79%). However, this proportion increases thereafter with 95% of clients reporting they have a gambling problem one year later. When asked if someone they know is concerned with their gambling, 94% of clients at intake report knowing of someone who is concerned. This proportion drops to 46% three months post program completion. However, the percentage of clients reporting that someone is concerned with their gambling increases thereafter but remains under baseline levels one year later. Despite an overall decrease in gambling and an overall decrease in high risk of problem gambling, clients consistently self-report that they have a problem. The reasons for this are beyond the scope of this evaluation but would be worthy of future research.

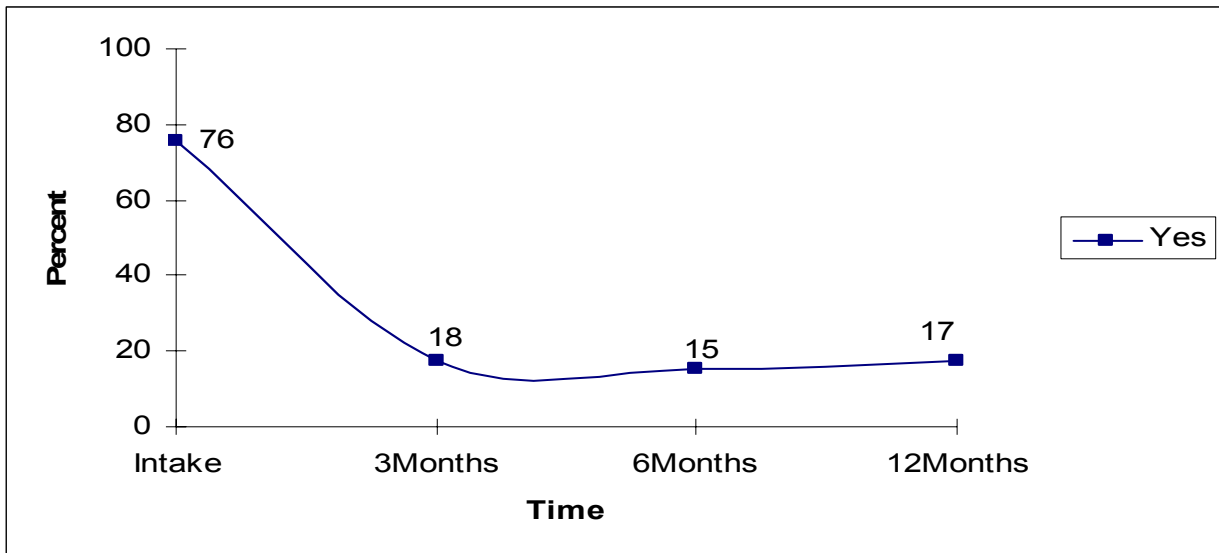
Figure 3. Percent of Client Assessment of Having a Problem and of Others' Concern About their Gambling



4.2.4 Mental Health Issues – Suicidal Ideation

The majority of clients present with mental health issues such as current and past history of depression, anxiety and suicidal ideation. Although the evaluation team agreed that mental health was an important variable to explore over time, it was apparent that questions needed to be prioritized due to limited time for questioning on the follow-up calls. As such, a decision to explore suicidal ideation was made as it was determined to be an important issue that required immediate attention and one that the research team could serve to provide appropriate referrals to address crises. For example, at intake almost 80% of clients reported having thoughts about suicide (lifetime). From intake to 3 months post-program completion, the proportion of clients reporting suicidal ideation decreased substantially (see Figure 4 on the next page). This proportion further decreased to 15% at the 6 months follow-up. One year later, the proportion of clients reporting suicidal ideation increased by 2% but is still under baseline levels.

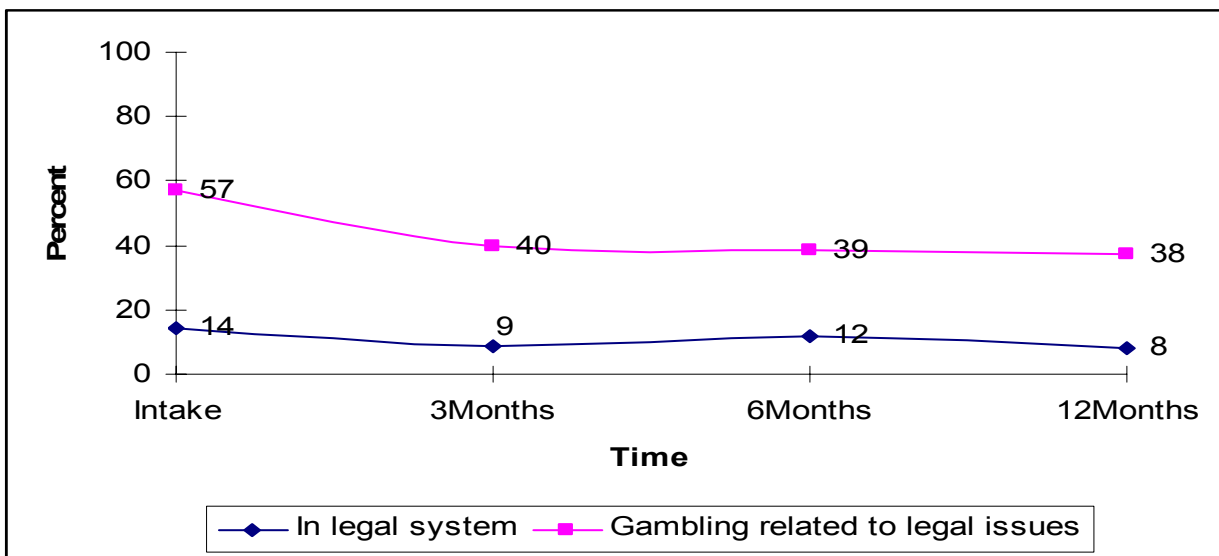
Figure 4. Percent of Clients Reporting Suicidal Ideation



4.2.5 Legal and Financial Problems

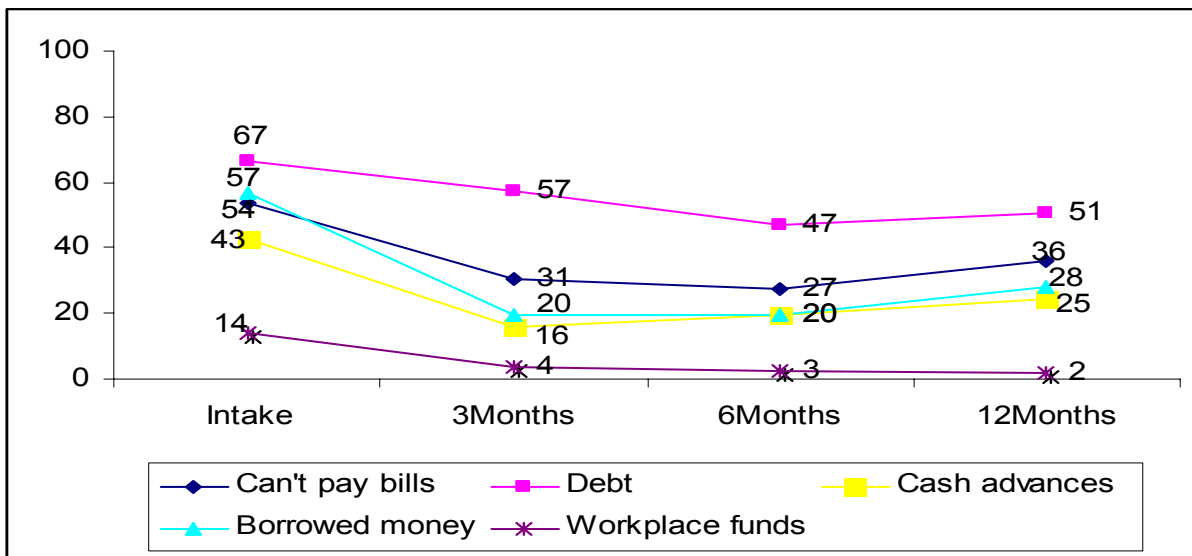
Clients' involvement with the legal system was also explored. At intake, 14% of clients reported being involved in the legal system with 57% reporting that their involvement was due to gambling. Clients' involvement in the legal system decreased overtime (see Figure 5 below). Similarly, the proportion of clients reporting that their involvement with the legal system was due to gambling also decreased over time. The decrease in involvement with the system is a very positive finding as legal issues can be stressful for individuals with gambling problems.

Figure 5. Percent of Client Legal Issues



In addition to legal issues, financial problems are also stressful for people who are having problems with their gambling. At intake, 67% of clients reported being in debt and 57% reported borrowing money from family or friends to finance their gambling. One year later, only 51% of clients report significant debt and only 28% are borrowing money to finance their gambling. Further, while 14% of clients reported using workplace funds to support their gambling at intake, only 2% reported using workplace funds for that purpose one year later. As seen in the figure below, the financial effects of gambling reported by clients at intake appear to improve overtime.

Figure 6. Percent of Clients Reporting Various Financial Effects



4.3 IN THEIR OWN VOICES: PROGRAM PARTICIPANTS

The post-test knowledge questionnaire contained two open-ended questions. These included: (1) what are the most important things you feel you have gained from being in this gambling residential program? and (2) What are some things we could have done better? A content analysis of responses was performed and common themes were identified. The themes present in the responses to each of these questions as well as excerpts to exemplify the themes are presented in the subsections that follow.

4.3.1 Important Things Learned Through the Program

Various themes emerged from clients' responses to this question. These pertain to knowledge learned through the program; social support; spirituality; qualities such as honesty, forgiveness, serenity/peace, pride, strength; acceptance of having a problem; self appreciation/awareness; self-reflections and positive comments about the program and clients' future. Below are some examples. Please note these have not been edited in order to accurately represent the thoughts and comments of the clients. For a detailed list of subthemes found within the above mentioned themes, see Appendix F.

Knowledge

Clients indicated that important things learned through the program included general knowledge about gambling-related concepts, knowledge about the nature of gambling (e.g., many clients were able to

articulate what “gambling” meant to them), and specific tools they could use to help them recover from their problem gambling.

‘Randomness. Bubble theory’

‘Greater understanding of addictions, self help groups, moderation, balance in life, patience, admittance to gambling, one day at a time, try harder to change what needs to be changed in life.’

‘The most important thing that I learned here is that this is a disease and with help, caring and learning we can recover.’

‘Tools and knowledge to assist me in avoiding relapse’ ‘Wonderful tools to deal with stress, setting boundaries, relapse prevention management. Wonderful communication skills, assertiveness training.’

Social Support

Clients also indicated having learned that there is help/support for them, how important it is for them to have this support, and that they learned they are not alone.

‘There are always supports around me when I need them.’

‘Talking to a sponsor friend or counselor or RCW is very, very helpful.’

‘I’m not alone.’

Spirituality

Clients also commented on having learned about the importance of spirituality and a higher power. Comments about being given hope and faith to keep going were also prevalent.

‘Importance of prayer and daily meditation.’

‘The most important thing I’ve gained is my spiritual awakening, to trust and have faith in my Higher Power.’

‘Hope that there are solutions to problems.’

Honesty, Forgiveness, Peace, Pride, Strength

Program participants also indicated having learned about honesty, forgiveness, peace/serenity, pride, and strength:

‘The program has taught me to be honest with myself and others.’

‘But most of all I have learned to let go of the stigma that is attached to a problem gambler. I have forgiven and let go of the burden I carried in my past about my self being.’

‘I’m at peace with myself.’

‘Swallow your pride. Let other people help you with your pain.’

‘Feelings of strength and love never thought possible.’.....’How to be strong in all aspects of my life especially in communicating.’

Acceptance of Having a Problem

Clients also indicated that one of the most important things they had gained from being in the program was learning to accept that they had a problem.

‘I’ve accepted that I am a person with an illness that can be treated overtime.’

‘That I admitted my addiction.’

‘Being able to admit to my problems and able to accept and control my problems.’

Self-Appreciation/Awareness

Clients indicated learning more about themselves through the program. They also indicated learning that they are not a ‘bad’ person and to respect, love, and believe in themselves again. Comments about regaining self-confidence and self-esteem were also prevalent.

‘Also, I’ve learned a lot about myself- some of my character defects, that I have to work on.’

‘The most important thing for me is the opportunity to gain back my self-respect.’

‘I’ve learned to love myself which for a life time I have not been able to.’.....’Believe in myself.’

‘I’m a ‘good’ person and don’t need to feel not good enough because of my past.’

‘I have started to regain my self-confidence and self-esteem.’

Self-reflections and Positive Comments About the Program

Responses provided by clients also indicated self-reflection and positive attitudes towards the program.

‘Time away gave me time to think and direction to go in.’

‘Being away from my family was tough but made me rely on myself and look at myself in the mirror with little distraction.’

‘I thank God for this program here at Parkwood and all the staff who are all terrific in doing their job.’

‘But I feel the program has got me on the right path, bless you all. Thank-you.’

‘It’s an excellent program.’

Positive Comments About the Future/About their Life

Finally, the content analysis of clients' responses also revealed that clients have a positive outlook on life after the program.

'I can be successful in fighting my addiction.'

'I came in with so much shame, remorse and sadness. I am leaving with no shame, proud of myself for talking the time for me, and so thankful for this program.'

'And I know that I am leaving today feeling good about myself. And I am looking forward to putting my tools to work.'

'I don't feel the hopeless, helpless I used to feel, I can actually feel I can cope with this disease and carry on with my journey.'

4.3.2. Ideas for Program Improvement

Clients were also asked for suggestions on how the program could be improved. The majority of the suggestions offered pertained to the program itself in the form of comments on program content, organization and structure. Less than 10% of the comments involved discussion around extending the program. In addition, about one in ten clients who provided comments suggested improvements for program amenities provided at the residential facility such as food and bedding. Some clients felt that there needed to be a larger emphasis on family involvement in the recovery process. Overall, positive comments about the program were also prevalent in the responses to this question.

Program

Clients provided suggestions with regards to program content, structure, organization, delivery (consistency, implementation by staff), rules, and materials used. Suggestions for program content ranged from having more one-on-one counseling sessions, group therapy, group outings and activities to more training on assertiveness, relaxation techniques, communication and time management. Suggestions for program structure included having smaller group sessions of an interactive nature. Clients suggested the program should be run on time and that clients should be better informed about intake procedures before entering the residential facility. Finally, suggestions were also provided with regards to updating program material (videos, handouts) and ensuring residential care workers receive enough training and/or counseling before they lead groups. A detailed list of subthemes or suggestions offered by clients can be found in Appendix G. Sample comments follow.

'More assertiveness training. Better relaxation techniques.'

'Touching more on spirituality.'

'Letting the clients talk more in sessions rather than the RCWs doing all the talking. Having the clients complete work on flip charts or on the boards, doing energizers, having a fun day with all the groups together –doing or going somewhere together ie. movie, bowling, swimming.'

'Run program on time.'

‘More detailed instructions on what to bring and how those things are handled here ie. Over the counter meds, personal grooming tools and supplies.’

‘Make information sheets for clients better.’ ‘Better video resources.’

‘Some RCWs need more training and/or counseling before they lead programs. Felt that some of the sessions would have lasted longer if there had been more encouragement/questions/direction from the group leader.’

‘Do not send mixed messages to some clients if one decision is made no matter the consequences.’

Program Extension

Program participants suggested more money be put into the program. Some clients also expressed the desire to have the program extended for an extra week.

‘I really feel that a 3 week program would be better to ensure all areas in one’s life are dealt with before leaving.’

‘Have it a 3 week recovery instead of 2 weeks especially if someone has multiple addictions.’

‘The program could be one week longer as it’s hard to let everything sink in, more time to go over certain points or struggles. May be using 2 weekend days as part of the week for those who only have 2 weeks holidays.’

‘Put more money into the gambling program because it is a very terrible addiction.’

Residential Facility Amenities

Clients also provided suggestions regarding food offered at the residential facility, furniture, phone availability, and washrooms/showers.

‘Not enough to eat.’

‘Buy some furniture (chairs).’

‘Better beds and pillows, large meal at supper, mirrors in rooms, more washrooms.’

‘Access to cellphones’ ‘ Phone booth for incoming calls’

‘Better hygiene in upstairs washroom.’ ‘Disinfectant spray bottles for showers.’

Family Involvement

Clients also commented on the desire to have family involvement as part of the recovery process.

‘More family awareness; include or have available more spousal or family contact as part of the recovery process if the family is supportive and willing.’

‘More family sessions.’

‘More time with family.’

‘I think a section dedicated to friends and family that are negative influence on you, so you can learn whether to cut them loose or be able to communicate and save it.’

Positive Comments About the Program

Finally, the content analysis also revealed clients’ positive evaluation of the program.

‘The program was very, very good. Not only did it show me what I was doing to myself but my family as well. The program met all my needs to get me started in my recovery.’

‘All in all, wonderful program, wonderful staff, and a very warm loving atmosphere. Thank-you for having such a program available for those who suffer and are lost.’

‘I think everyone did a fantastic job and I thank everyone of you from the bottom of my heart. God bless you all.’

‘I came with an open mind and I feel I am leaving with everything that I came for. I do not feel any yearning for something I could be lacking. I feel fulfilled and will strongly recommend this program to anyone in my future.’

5. CONCLUSION

The evaluation of the Problem Gambling Residential Rehabilitation Program (PGRRP) revealed similar findings to previous reports in the past (Lemaire & Patton, 2004). Clients are learning the material that is presented to them in the program and they are more likely to have a better idea of relapse prevention and management after the two weeks. At the end of the program clients are also more likely to be aware of resources in the community.

In regards to gambling behaviour, clients are gambling at lower levels and for those who are gambling, they are gambling at less risky levels. Follow-up with the clients in the program reveals improvements in several life areas: financial, legal, and areas relating to mental health (suicidal ideation). Overall, clients expressed that they were very satisfied with the program. Key themes that emerged from clients' responses on the most important things they achieved from the program included knowledge about gambling, social supports available, spirituality, self appreciation and awareness, and the importance of forgiveness, peace, and strength in the recovery process. Some suggestions for change were also identified and those mostly centered on program content, structure and organization. Less than 10% of the clients who provided comments felt that the program should be extended for one more week. Other suggestions included more involvement of the family in the recovery process and improved amenities/services provided at the residential facility (i.e. better food, furniture etc).

As with all research projects, limitations exist and should be acknowledged. Interpretation of the research findings should be done with caution due to the self-reported nature of the data collection. For some follow-up groups, client numbers are small and comparison should be made with this in mind. A control group was not included, so comparisons could not be made with participants who did not receive the treatment. Some clients could not be reached at later follow-up data collection points and this may have impacted the results. In addition, no recognized measurement instruments were utilized - although the MGIS was used and has demonstrated reliability and construct validity.

Overall, the objectives of the program have been met and this has been established consistently over the years. After the two week program, clients report to learn information on gambling and at follow-up they are less likely to be gambling and if they are gambling it is of a lower level of risk for problem gambling.

REFERENCES

- Brown, D., & Smitheringale, B. (2002). *Manitoba Gambling Involvement Scale*. Developed for the Addictions Foundation of Manitoba.
- Bujold, A., Ladouceur, R., Sylvain, C., & Boisvert, J. M. (1994). Treatment of pathological gamblers: An experimental study. *Journal of Behaviour Therapy and Experimental Psychiatry*, 25(4), 275-282.
- Lemaire, J., & Patton, D. (2004). *An Evaluation of the Addictions Foundation of Manitoba Problem Gambling Residential Rehabilitation Program (PGRRP)*. An internal report for the Addictions Foundation of Manitoba.

**Appendix A
Consent Form**

CLIENT CONSENT TO PARTICIPATE IN PROGRAM EVALUATION

The AFM will be evaluating this program. This allows us to ensure that we provide the most effective and relevant services possible. We would appreciate your consent to participate in this evaluation. Whether or not you agree to participate will have no effect on the services you receive. Your participation is completely voluntary and can be withdrawn at any time. If you agree to participate, you will be contacted by telephone at approximately 3, 6 and 12 months following the completion of your program. If you would like more information, please talk to your counsellor or contact the AFM's Director of Research and Quality Monitoring. All responses given by you will be completely confidential. You will not be identified through any report.



I AGREE to participate in this evaluation of AFM Services.

(please fill in)

I DO NOT AGREE to participate in this evaluation of AFM Services.

I wish to be contacted at the following phone number: _____.

I can be contacted at the during the **day** / **evening at this number.**

Print Name: _____

Client's Signature

Date

Signature of AFM Employee

Date

Appendix B
Pre-Test Questionnaire

Residential Gambling Program Evaluation

Thank you very much for taking the time to fill out this evaluation form. Using these forms helps us to continually improve our services and our programs.

Gender: _____

Age: _____

Instructions

Please circle the number from 1 to 5 that best answers each question below. In most cases, a statement is given, and you should indicate whether you agree or disagree with that statement. In some cases, a question is asked and you should indicate your answer to the question based on the possible answers provided. In all cases, please circle a number from 1 to 5.

1. How often do problem gamblers experience depression?

Rarely		Can't Decide		Often
1	2	3	4	5

2. As soon as a problem gambler stops gambling, everything will be fine in the family.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

3. The best way to solve a problem is to always go with your "gut" feeling.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

4. Relapse MANAGEMENT and relapse PREVENTION are the same thing.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

5. It is possible to predict when a VLT is going to pay.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

6. In gambling, the pay out odds of each game are structured to ensure that the house always makes money over time.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

7. In general, if a person declares bankruptcy, they will lose their home.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

8. Clergy, financial counselors and family members are all possible community resources for problem gamblers.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

9. When problem gambling is no longer a secret, family members' sense of shame often DECREASES.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

10. It is best to keep a recovery plan secret.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

11. It is helpful to deal with mental health issues and problem gambling at the same time.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

12. It is helpful to view recovery as a family issue.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

13. If a coin is flipped, and comes up “heads” nine times in a row, the next flip is most likely to be “tails”.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

14. A problem gambler can be in relapse without gambling.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

15. It is best to have a structured action plan to support recovery.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

16. It only takes 15 minutes to review a monthly budget.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

17. Rarely do problem gamblers have problems with alcohol or other drugs.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

18. It is important that my sponsor is a member of a self-help recovery program.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

19. Problem gambling can have a long-term financial impact on family members.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

20. For most problem gamblers, there is great risk in having easy access to money.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

21. Cravings to gamble can be managed without returning to gambling.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

22. "Aggressive communicators" are usually respectful of other people's feelings.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

23. There is nothing a person can do if they are having an anxiety attack in public.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

24. Problem gamblers are more likely than responsible gamblers to chase after previous gambling losses.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

Thank you very much for helping us by filling out this form

For Office Use Only
Client Code: _____
Pre-Test

Appendix C
Post-Test Questionnaire

Residential Gambling Program Evaluation

Thank you very much for taking the time to fill out this evaluation form. Using these forms helps us to continually improve our services and our programs.

Gender: _____ Age: _____

Instructions

Please circle the number from 1 to 5 that best answers each question below. In most cases, a statement is given, and you should indicate whether you agree or disagree with that statement. In some cases, a question is asked and you should indicate your answer to the question based on the possible answers provided. In all cases, please circle a number from 1 to 5.

1. Rarely do problem gamblers have problems with alcohol or other drugs.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

2. For most problem gamblers, there is great risk in having easy access to money.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

3. It is important that my sponsor is a member of a self-help recovery program.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

4. It is best to keep a recovery plan secret.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

5. How often do problem gamblers experience depression?

Rarely		Can't Decide		Often
1	2	3	4	5

6. It is possible to predict when a VLT is going to pay.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

7. It is best to have a structured action plan to support recovery.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

8. Problem gambling can have a long-term financial impact on family members.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

9. There is nothing a person can do if they are having an anxiety attack in public.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

10. The best way to solve a problem is to always go with your "gut" feeling.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

11. In general, if a person declares bankruptcy, they will lose their home.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

12. If a coin is flipped, and comes up "heads" nine times in a row, the next flip is most likely to be "tails".

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

13. As soon as a problem gambler stops gambling, everything will be fine in the family.

1	2	3	4	5
Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree

14. It only takes 15 minutes to review a monthly budget.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

15. Clergy, financial counselors and family members are all possible community resources for problem gamblers.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

16. Relapse MANAGEMENT and relapse PREVENTION are the same thing.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

17. In gambling, the pay out odds of each game are structured to ensure that the house always makes money over time.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

18. A problem gambler can be in relapse without gambling.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

19. It is helpful to view recovery as a family issue.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

20. "Aggressive communicators" are usually respectful of other people's feelings.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

21. When problem gambling is no longer a secret, family members' sense of shame often DECREASES.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

22. Cravings to gamble can be managed without returning to gambling.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

23. It is helpful to deal with mental health issues and problem gambling at the same time.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

24. Problem gamblers are more likely than responsible gamblers to chase after previous gambling losses.

Strongly Agree	Agree	Can't Decide	Disagree	Strongly Disagree
1	2	3	4	5

26. What are the MOST IMPORTANT things you feel you have gained from being in this gambling residential program? (Feel free to write on the back of this page if you need more room)

27. What are some things we could have done BETTER? (Feel free to write on the back of the page if you need more room)

Thank you very much for helping us by filling out this form

For Office Use Only

Client Code: _____

Post-Test

Appendix D
Follow-up Survey

Group #: _____ () 3 months () 6 months () 12 months

Name: _____ Client Code: _____ Phone: _____

Date of Program Completion: _____ Date of Follow-up: _____

Contacted on last attempt: () Yes () No () N/A

AFM Counsellor: _____

Client contacted: () Yes () No

If no, reason why client was not contacted:

- () Phone disconnected
- () No longer residing at that #
- () Did not return message
- () Could not make contact (5+ attempts)

The information you give us is strictly confidential, and your name will never be associated with your answers or used in any analysis or report so we ask that you be completely honest in your responses. I need to inform you that I am a member of the research department at the Addictions Foundation and I am not a trained counsellor.

1.) In the past *three* months have you attended Gamblers Anonymous? If yes, how many times?

_____ times in the past *three* months

2.) In the past *three* months have you seen an AFM counsellor? If yes, how many times?

_____ times in the past *three* months Who? _____

3.) Have you gambled in the past *three* months?

- () Never → **Go to question 12**
- () Less than monthly
- () About once per month
- () About once per week
- () Several times per week
- () Daily

Type of Gambling	Daily	Several Times Per Week	About Once Per Week	About Once Per Month	Less Than Monthly	Never	Money Spent in a Week
Keno							\$
Bingo							\$
Cards (i.e. poker)							\$
Table games (i.e. blackjack, roulette)							\$
Horses							\$
Lottery Tickets							\$
Breakopens/ Scratch Tickets							\$
VLTs							\$
Slots							\$
Sports Betting							\$
Internet Wagering							\$
Other:							\$

4.) In the past *three* months, have there been days when you gambled more than you intended? (MGIS 1)

- Yes
- No

5.) In the past *three* months, have there been days when you tried to make up for earlier losses by gambling more or by going back the next day? (MGIS 2)

- Yes
- No

6.) In the past *three* months, have there been days when you tried to hide how much you lost gambling? (MGIS 3)

- Yes
- No

7.) The following question are about troubles that you may have had as a result of gambling. In the past *three* months has gambling caused you to:
(MGIS 4)

	Yes	No
Be unable to pay bills		
Argue with others		
Miss time at work/school		

8.) The following questions are about recurring problems that you may have had due to your gambling? In the past three months were you: (MGIS 5)

	Yes	No
Unable to get out of debt		
At risk of loosing your job		
At risk of loosing your spouse or friends		

9.) In the past *three* months have you.

	Yes	No
Used cash advance from credit card to finance gambling		
Borrowed money from friends and/or family to finance gambling		
Gambled with company/workplace funds		

10.) Thinking about it in the past *three* months how often have

	Never	Sometimes	Most of the time	Almost Always
You bet more than you could really afford to lose?				
You needed to gamble with larger amounts of money to get the same feeling of excitement?				
You gone back another day to try to win back the money you lost?				
You borrowed money or sold anything to get money to gamble?				
You felt that you might have a problem with gambling?				
People criticized your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?				
You felt guilty about the way you gamble or what happens when you gamble?				
Gambling caused you any health problems?				
Your gambling caused any financial problems for you or your household?				

11.) In the past *three* months, has anyone been concerned with your gambling?

- Yes
- No

Who has been concerned about your gambling? (All that apply)

- Your Spouse/Partner
- Your Parent
- Your Child (or children)
- Other family members
- Friends
- Employer
- Co-Workers
- Others: _____

12.) Which category best describes YOUR income?

- Less than \$10,000
- 10,000 – 19,999
- 20,000 – 29,999
- 30,000 – 39,999
- 40,000 – 49,999
- 50,000 – 59,999
- 60,000 – 69,999
- Greater than 70,000
- Retired
- Disability
- Don't know
- Refused

13.) What is your present marital status?

- Single
- Married/Common law
- Divorced/Separated
- Widowed
- Other _____

14.) Which category best describes your HOUSEHOLD income?

- Less than \$10,000
- 10,000 – 19,999
- 20,000 – 29,999
- 30,000 – 39,999
- 40,000 – 49,999
- 50,000 – 59,999
- 60,000 – 69,999
- Greater than 70,000
- Retired
- Disability

- Don't know
- Refused

15.) What is your current employment status? (please pick the best one)

- Employed full-time
- Employed part-time
- Unemployed
- Leave of absence
- Student
- Disability leave
- Retired
- Homemaker

16.) In the past *three* months, have you been concerned that someone in your family has a problem with gambling?

- Yes
- No

Who? (all that apply)

- Spouse/Partner
- Your mother
- Your father
- Your brother or sister
- Your child
- Other family members (living with you)
- Other family members (not living with you)

17.) Are you currently involved in the legal system?

- Yes
- No

18.) Do you have any court appearances pending?

- Yes
- No → **Go to question 23**

19.) Please indicate the general nature of your involvement in the legal system (indicate all that apply)

- Restraining Order against someone else
- Assault (as the victim)
- Assault (as the perpetrator)
- Separation/Divorce
- Child Custody
- Child and Family Services Order

- Protection Order against you
- Impaired Driving
- Theft
- Fraud
- House Arrest
- Possession/Trafficking
- Bankruptcy
- Abstinence from Alcohol or Drugs
- Abstinence from Gambling
- Recognizance
- Other: _____

20.) Was Gambling related to your involvement in the legal system?

- Yes No

21.) Are you currently on probation? Yes No

22.) Are you currently on parole? Yes No

23.) Have you thought about suicide in the past *three* months?

- Yes
 No → **END**

24.) Are you currently thinking about suicide?

- Yes
 No

If Yes, ask the following questions to help assess whether there is a need to refer immediately to Klinik:

25.) Have you made a plan for what you would do?

- Yes
 No

If Yes, What is it? _____

26.) Do you have the means to follow through with this plan?

- Yes
 No

If Yes, Details? _____

27.) When are you thinking of going through with this plan?

Details: _____

Klinik: 786-8686

Mobile Crisis Unit: 946-9109

Gambling Helpline: 944-6382

If at immediate risk follow procedures to transfer to Klinik

May we contact you again in ___ months to see how you are doing?

- Yes
- No

Qualitative

This completes the formal part of the evaluation. Is there anything that you would like to add about your experiences in the Brandon Residential Program.

Appendix E
Manitoba Gambling Involvement Scale

Manitoba Gambling Involvement Scale

Brown, D., & Smitheringale, B. (2002)

Questions are listed from least intense to most intense

1. In the past year, have there been days when you gambled more than you intended?
2. In the past year, have there been days when you tried to make up for earlier losses by gambling more or by going back the next day?
3. In the past year, have there been days when you tried to hide how much you lost gambling?
4. In the past year, have there been days when you had troubles due to your gambling?
(for example, you were unable to pay bills, argued with others, or missed time at work or school)
5. In the past year, have you had enduring problems due to your gambling?
(for example, you were unable to get out of debt, were at risk of losing your job, were at risk of losing your spouse or a friend)

Scoring and Interpretation

The score is determined by identifying the highest question answered as 'yes' (from 1-5). It does not matter how many questions in all were answered as 'yes'. If no questions are answered as 'yes' then the score is 0.

Scores of 0 or 1 can be interpreted as lower risk for harm.

Scores of 2 or 3 can be interpreted as moderate risk for harm.

Scores of 4 or 5 can be interpreted as higher risk for harm.

Appendix F
Themes and Subthemes Analysis: Things that Clients Learned from the Program

Themes and Subthemes Analysis: Things that Clients Learned from the Program

Theme 1: Knowledge

- **General Knowledge** (concepts learned through the program)
- **Gambling as an Addiction** (recovery, triggers, other addictions and gambling)
- **Tools** (time management, coping skills, stress management, assertiveness training, communication skills, resources available, other co-occurring health problems, relapse management, financial management, relaxation etc)

Theme 2: Social Support

- Support (there is help/support, importance of this support)
- Not Alone (they are not alone)

Theme 3: Spirituality

- Spirituality (importance of spirituality and a higher power in recovery process)
- Hope/Faith (learned about hope/faith, gained hope/faith through program)

Theme 4: Qualities Learned

- Honesty
- Forgive/Learning to let go/Not to feel ashamed
- Serenity/Peace
- Pride
- Strength

Theme 5: Acceptance of/Admitted to Having a Problem

Theme 6: Self-appreciation/awareness

- Self-awareness (learned more about themselves)
- Self- appreciation
 - Respect for self; Love for self; Belief in self (regained these)
- Self-esteem/Self-confidence (regained)
- Not a bad person (awareness/acceptance that they are not ‘bad’)

Theme 7: Self-reflections and Positive Comments About the Program (self reflections on how the program has helped them)

Theme 8: Positive Comments About their Future/Life

Appendix G
Themes/Subthemes Analysis: Suggestions from our Clients for Improvement

Themes/Subthemes Analysis: Suggestions from our Clients for Improvement

Theme 1: Program

- **Content/Curriculum** (more one-on-one counseling, group therapy, group outings/activities, more workshops on values/stressors, more training on relaxation techniques, assertiveness, time management, communication, more focus on spirituality)
- **Structure** (interactive sessions, smaller group sessions, orientation should include a component on cultural awareness/respectful language to avoid conflict, keep gambling and AOD groups separate, better group meetings on weekends)
- **Organization** (run program on time, make program changes known through verbal as well as written notices)
- **Delivery**
 - **Consistency** (adhere to rules)
 - **Staff**
 - **Implementation** (RCWs need more training and/or counseling before they lead groups; RCWs need training on presentation and facilitation skills)
 - **Treatment of Clients by Staff** (more accessible to clients, could be friendlier, should be open to suggestions)
 - **Need for First Nations/Aboriginal Staff Involvement**
- **Rules and Regulations** (inform participants about intake procedures before entering program, detoxification for alcohol/drugs before entering the program should be a requirement)
- **Material Used** (update videos, handouts; give free material at end of program (on tools learned); Letter of encouragement for incoming program participants and certificates for those completing the program).

Theme 2: Program Extension

- Extend the Program
- Invest Money into the Program

Theme 3: Residential Facility Amenities (suggestions regarding food, furniture, phones, washroom/showers)

Theme 4: Family Involvement (desire to have family involved in recovery process)

Theme 5: Positive Comments About the Program



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