

**An Evaluation of the Addictions Foundation of
Manitoba Problem Gambling Residential
Rehabilitation Program (PGRRP)**

**Parkwood
Brandon, Manitoba**

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1. EXECUTIVE SUMMARY

The Problem Gambling Residential Rehabilitation Program (PGRRP) located at Parkwood in Brandon, Manitoba is one of only a few gambling specific programs available. It is an intensive 14-day program that offers a specific residential milieu that is designed to facilitate the change process and provide an effective means of helping problem gamblers reduce the harm resulting from their gambling. In the past, the most intensive programs available to problem gamblers offered by the Addictions Foundation of Manitoba (AFM) were residential rehabilitation programs located in Winnipeg, Brandon and Ste. Rose Du Lac. These programs were initially designed for people with alcohol or other drug problems, with some additional gambling specific information and individual counselling offered by a gambling counsellor. In contrast, this program was developed to specifically meet the needs of problem gamblers.

Problem gamblers are known as a difficult group to treat (Grant, Kim & Kuskowski, 2004; Winters & Kushner, 2003) They often delay seeking help until they are in crisis, and often return to gambling once the crisis has been alleviated. The extent of their problems is noted in the group (n = 62) of individuals that have been seen in the early stages of this program. They have been identified as high risk for harm due to gambling by their high scores on a gambling screening measure. Many of them have previously been for treatment for gambling and other addictions, often with poor results and rarely completing the program.

By the end of this program they have learned factual information about gambling and coping skills for relapse prevention and management. A knowledge test showed that, on average, they know more about the myths and fallacies around gambling, and have the basis for developing better coping skills and financial management techniques. In addition to completing a brief questionnaire at the end of the program, the clients were contacted by telephone at 3, 6, and 12 months after discharge. Many (n=26) were still meeting with an AFM counsellor on an out-patient basis. Follow-up response rates were excellent (on average 87%), which leads to increased confidence in the results. Of those contacted at follow-up, 36%, 63% and 46% are gambling at 3, 6, and 12 months, respectively. High risk for harm due to gambling has decreased from 94% at intake to 42% (on average over 3, 6, and 12 months). In addition, frequency of VLT and slot playing significantly decreased over time. Financial impacts and consequences have improved and at 12 months only 8% of clients are still involved in the legal system (compared to 18% at intake). Although the proportion of clients feeling suicidal has increased by about 10%, many reasons may exist to explain this. For example, 53% have a past history of mental health issues with 59% of these clients being prescribed medications for depression. Previous research suggests that mental health issues and other co-occurring concerns can complicate the recovery process (Winters & Kushner, 2003). This is especially true in programs, such as the PGRRP, where the primary focus is on problem gambling and not mental health rehabilitation (although mental health is certainly discussed). It should be noted that AFM has taken the lead with the Co-occurring Disorder Initiative (CODI), which is working to fill in the gaps that currently exist between mental health and addiction services.

The evaluation of the residential gambling program suggests that the clients have learned material and, as a result, have reduced harm due to gambling in various life areas. However, continued monitoring of this program is needed and more long-term data will provide more evidence for the impact over time. Almost all of the short-term objectives were met, and of those who have returned to gambling, harm has been significantly reduced in the long-term. Fewer clients report financial impacts and legal issues. Anecdotal reports from the clients indicate that the program has had a significant impact on themselves and their families.

2. INTRODUCTION

2.1. Background

A recent report from Statistics Canada (2004) highlights the important interprovincial differences in gambling rates and per capita spending. Manitoba consistently ranks high in terms of the percent of the population that plays video lottery terminals (VLTs), slot machines and visits casinos. Consequently, Manitoba also ranks high among provinces in terms of per capita spending on gambling activities.

Although AFM currently provides a variety of services for individuals struggling with gambling issues (individual counselling, community-based programs, group counselling, province-wide gambling help-line, and a responsible gaming information centre¹ in a Winnipeg casino), 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 PGRRP opened out of Parkwood in October of 2002.

The PGRRP is a 14-day co-ed intensive residential program for people 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 is one of the first of its kind, a pilot was developed with an evaluation component. The focus of the PGRRP is on group counselling, individual counselling, couple counselling, male and female group sessions and financial management 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 Gamanon (for affected family members). Clients are expected to attend at least two GA meetings per week while in the program. As of May 2004, 19 waves of clients (62 individuals) have successfully completed the program. This report will highlight the results of the evaluation.

2.2. 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 requesting participation in a follow-up evaluation at month 3, 6 and 12, and pre-tests for knowledge were administered to the clients at intake. After the program

¹ This exciting initiative is staffed by AFM rehabilitation counsellors and preventative education consultants. The MLC has provided funding for the Responsible Gaming Information Centre (RGIC).

clients were given a post-test. 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 were developed to measure the long-term objectives of the program. An accountability model was developed with program staff input to identify the expected long-term impacts of the program. A copy of the model is included as Appendix C.

2. 3. Program Objectives

AFM gambling staff, MLC and AFM Research met to develop the research questions for the PGRRP evaluation. The accountability model provided a framework upon which the research questions were based and to ensure 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 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 prevention and 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 way gamblers' think) leads to more positive outcomes in the long-term (Bujold, Ladouceur, Sylvain & Boisvert, 1994) While AFM is aware that we are not the only source of support that will impact a problem gambling client in the long-term, it is anticipated that we will have an impact over the short-term and that this contribution should have a favourable effect for our clients. In addition, the accountability model should help to identify any gaps in the program continuum. 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
4. Reduce work-related issues
5. Reduce legal issues

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

Between October 2002 and April 2004, 71 clients were admitted to the PGRRP. Of the 71 admitted, 62 successfully completed the program (one client completed the program twice). Altogether there were 19 waves of clients with an average of just over 3 clients per group. More men completed the program than women (68% versus 32%). Marital status revealed a relatively even dispersion with 35% married/common-law, 28% divorced/separated and 31% single. Over 40% of the clients were between the ages of 40 and 49, 26% between the ages of 50 to 59 and 21% in the 30 to 39 age category. Most (59%) had completed high school or less and approximately 21% have a university/college degree. Quite a few (45%) work full time, however, 20% were unemployed and 14% on disability/leave. Almost half reported a household income of less than \$40 000. The majority were self-referred (64%) although family comprised a secondary referral source (20%). A variety of cultures were identified including Canadian, Ukrainian, Polish, Aboriginal, English and French. Canadian (77%) and Aboriginal (13%) clients were the largest groups represented. Almost half (44%) have at least two children but only 11 clients reported that their children live with them. At intake, 67% were concerned that someone in their family may have/had a problem with alcohol, other drugs or gambling. Over half (55%) reported that gambling caused problem with their employment/schooling. At intake, 10 clients were involved in the legal system with 6 indicating that gambling was related to their court system involvement. Table 1 shows the demographic characteristics of the clients at intake.

TABLE 1: Demographics of PGRRP Clients³

Demographics	Number of Clients	Percent of Clients
Gender		
Male	42	67.7
Female	20	32.3
Total	62	100.0
Marital Status		
Single	16	31.4
Married/common-law	18	35.3
Divorced/separated	14	27.5
Widowed	1	2.0
Other	2	3.9
Total	51	100.0

³ Sample sizes will vary.

TABLE 1: Demographics of PGRRP Clients (cont.)

Demographics	Number of Participants	Percent of Participants
Age		
20-29 years old	4	6.5
30-39 years old	13	20.9
40-49 years old	25	40.3
50-59 years old	16	25.8
60-69 years old	4	6.5
Total	62	100.0
Education		
Less than grade 9	5	9.4
Some high school	12	22.6
High school complete	14	26.4
Some college/university	9	17.0
Univ/college degree	11	20.8
Other	2	3.8
Total	53	100.0
Employment status⁴		
Working fulltime	25	Multiple responses allowed
Working part-time	3	
Unemployed	11	
Leave of absence	5	
Student	1	
Disability/leave	8	
Retired	3	
Homemaker	1	
Total	56	
Household income		
Less than \$10,000	4	7.3
\$10 - \$20,000	9	16.4
\$20 - \$30,000	3	5.5
\$30 - \$40,000	11	20.0
\$40 - \$50,000	10	18.2
\$50 - \$60,000	3	5.5
Over \$60,000	9	16.4
Don't know	2	3.6
Declined/refused	4	7.3
Total	55	100

⁴ These numbers will add up to over 56 because multiple responses were allowed. For example, one client reported working part-time and was also a student.

3. 2. At Intake: Gambling Activities

Clients gamble at a variety of activities. The most frequent were VLTs (37% playing daily) and slot machines (21.1% playing daily). Internet wagering and horses were the least frequently played by the clients. Table 2 shows the frequency of gambling activities played at intake. Only one client had never played VLTs and over 80% played VLTs several times per week or more frequently. Betting on horses and gambling on the Internet was only reported by a couple of clients.

TABLE 2: Frequency of Gambling Activities

Gambling Activity	Daily (%)	Several Times Per Week (%)	Once Per Week (%)	Monthly or Less (%)	Never (%)
Keno	2.6	2.6	10.5	28.9	55.3
Bingo	5.3	7.9	10.5	23.7	52.6
Cards (poker)	2.8	2.8	2.8	47.2	44.4
Table games (black jack)	5.1	2.6	7.7	35.9	48.7
Horses	0.0	0.0	0.0	11.7	88.2
Lottery tickets	2.7	13.5	29.7	48.6	5.4
Break opens/scratch tickets	5.4	2.7	5.4	62.1	24.3
VLTs	37.0	43.5	13.0	4.3	2.2
Slots	21.1	13.2	13.2	23.7	28.9
Sports Betting	0.0	2.8	5.6	16.7	75.0
Internet Wagering	2.8	0.0	5.6	2.8	88.9
Other	0.0	0.0	0.0	4.3	95.7

In addition to gambling activities, PGRRP clients were asked how frequently they have gambled at certain locations over the past year. Table 3 shows frequency of visits to gambling locations. Those that are gambling more frequently are much more likely to be gambling in a hotel lounge or restaurant. Few of the clients gambled frequently at either Winnipeg casino. The only other location at which gambling occurred with any frequency was at lottery kiosks, which reflects the purchase of tickets. These findings suggest that problem gambling clients may benefit from information/intervention services targeted at local bars, hotels with VLT machines and lottery kiosks.

“The program has taught me to be honest with myself and others, how to deal with urges, financial problems, stress, physical and mental problems. I would not be here today if it wasn’t for that program”

PGRRP client

TABLE 3: Frequency of Visits to Gambling Locations

Gambling Location	Daily (%)	Several Times Per Week (%)	Once Per Week (%)	Monthly or Less (%)	Never (%)
Local hotel/bar/restaurant/legion	25.5	55.3	6.4	10.7	2.1
Club Regent Casino (Wpg)	7.7	5.1	10.3	53.9	23.1
McPhillips Street Station Casino (Wpg)	7.3	7.3	9.8	46.3	29.3
First Nation Community	5.4	0.0	0.0	8.1	86.5
Lottery Outlets/Kiosks	2.7	18.9	10.8	43.2	24.3
Race Track	0.0	0.0	0.0	13.5	86.5
Private Residence	0.0	0.0	0.0	16.2	83.8
Another Province	2.6	7.7	0.0	15.4	74.7
United States	0.0	0.0	0.0	10.8	89.2
Others	3.8	3.8	7.7	0.0	84.6

3. 3. At Intake: Gambling (MGIS) and Alcohol/Drug Use (CAGE) Scores

As part of the intake process clients were asked a series of questions about their gambling and alcohol use. Two screening instruments are included: the Manitoba Gambling Involvement Scale (MGIS) and the CAGE (to screen for alcohol/drug dependence). The MGIS (questions 2-6 in Appendix B: Follow up Questionnaire) is a screening instrument specific to Manitoba used to determine the level of risk for harm associated with one's gambling (Brown & Smitheringale, 2002). It consists of five items that increase in severity or intensity. The score for this scale is computed by determining the most intense item endorsed regardless of who many items from the scale are endorsed. Five questions are asked, starting with the least intense and ending with the most intense. If a client selects only one item from the scale but it is the most intense, they will be considered at high risk of problem gambling. If a client selects two items that are of a less intensity, they would be placed at a moderate risk. Psychometric properties of the screen, in addition to construct validity, have been tested (Brown & Smitheringale, 2002). The CAGE is a four-question screener for alcohol/drug dependence. Two positive responses out of the four questions is considered positive for an alcohol/drug problem.

TABLE 4: MGIS and CAGE Scores

MGIS score	Frequency	Percent
4 or 5 High Risk	51 (mean 4.9)	94.4
2 or 3 Moderate Risk	2	3.7
0 or 1 Lower Risk	1	1.9
Total	54	100
CAGE score		
2 or more positives (alcohol/drug problem)	30	55.5
1 positive (no alcohol/drug problem)	5	9.3
0 positives	10	18.5
Does not drink/use drugs	9	16.7
Total	54	100

Table 4 shows that 94% of the clients identified themselves as high risk for harm due to their gambling (as measured by the MGIS). In addition, the CAGE screen revealed that over half of the clients were also having problems with their alcohol/drug use. Assessment at intake also revealed that 40% of the clients presented with a dual disorder (gambling and a substance abuse issue). These research findings are not unique, as previous literature indicates that many problem gambling clients have issues with their drinking and/or substance use (Kausch, 2003; Kidman, 2002). The Canadian Community Health Survey: Mental Health and Well-being (CCHS 1.2) in 2003 revealed that the likelihood of alcohol dependence increased as the at-risk gambling level increased. For example, 2% of non-problem gamblers were alcohol dependent compared to 7% and 15% of low-risk and problem gamblers, respectively (Marshall & Wynne, 2004). Table 5 shows the percentage breakdown of MGIS and CAGE question for the PGRRP clients.

“I am now more capable to handle stressful situations. I also have a much better understanding of how the "odds" work with vlt gambling. The program gives a better overall understanding of gambling addiction for gambling addicts”

PGRRP client

TABLE 5: The Frequency & Percent of MGIS and CAGE Questions Endorsed by PGRRP Clients

MGIS	Frequency	Percent
Gambled more than intended	51	98.1
Chasing losses	48	90.6
Hiding losses	46	86.5
Troubled due to gambling	50	94.3
Recurring problems due to gambling	45	84.9
CAGE		
Cut down	32	65.3
Annoyed	23	46.9
Guilty	30	61.2
Eye opener	16	32.7

3. 4. At Intake: Past Help-Seeking Behaviour

Similar to the findings from Statistics Canada, 79% of clients in the PGRRP reported that VLTs were their most problematic form of gambling. In addition, casino tables games and slot machines were problematic for 14% and 7% of clients, respectively. Most clients have had problems with gambling in the past (71%), and almost all reported that their gambling had an impact on their family, friends and employers. Most had gone for help for problems related to their gambling in the past (66%), and of those who had sought out help, the AFM was their most common choice (40%). Gamblers Anonymous (GA) was also a fairly common help-seeking choice with 30% using GA in the past. Clients were also asked if they had ever used the Manitoba Problem Gambling Help-line. Almost half (44%) had called the help-line before seeking residential treatment at AFM. Over half (55%) have attended a rehabilitation program for gambling and of these 26, 42% completed the program. A large majority (74%) indicated that they had attended some type of self-help group (including GA).

3. 5. At Intake: Mental Health

Just under half (43%) of the PGRRP clients report current mental health problems primarily treated by medication and/or counselling. Of those clients with current mental health issues, 81% were affected by depression, 48% reported stress and 43% with anxiety. Most of these clients (with a current history) were on prescription medication for their mental health problems (86%), while 62% also sought help through a counsellor. Over half (53%) of all clients have received treatment for emotional or mental health issues in the past. Past mental health issues mostly included depression (78%), but anxiety (48%) and stress (30%) were also past issues. Likewise, prescribed medication

(59%) and counselling (63%) tended to be the most common form of treatment. The majority (82%) of all clients reported lifetime suicidal ideation, with 9% telling us at intake that they have suicidal thoughts. A more in-depth analysis of the PGRRP clients' clinical files confirmed their mental health self reports. The co-occurring nature of gambling and various mental health issues has been well documented (Getty, Watson & Frisch, 2000), however, it is not clear whether the emotional problems precede gambling problems or are a consequence of the financial and social impacts of pathological gambling.

4. RESULTS

4.1. Short-term Objectives

The short-term objectives were identified as goals that the clients could achieve by the end of the 14-day program. These goals focus mainly on learned knowledge and various skills such as coping and communication. It is anticipated that these objectives will be met and that this knowledge will be applied over-time, leading to more favourable outcomes for the client at 3, 6 and 12 months later. A short knowledge questionnaire was created to evaluate various components of the knowledge transfer that was expected. A copy is included as Appendix A. Table 6 shows the average score for each content area before the program and after the program. Although some of the differences are quite small they are statistically significant because of the ability to pair pre and post test scores.

TABLE 6: Short-term Objectives: Pre and Post Test Results

Content area (n=55 ⁵)	Possible score	Average pre-test score	Average post-test score
General gambling knowledge	4	3.53	3.69*
Impact of gambling on family	3	2.55	2.82*
Mental health issues related to gambling	3	2.64	2.53 NS
Recovery plan	2	1.84	1.89 NS
Life skill capacity	3	1.87	2.27*
Relapse prevention and management	3	1.87	2.55*
Financial aspects	3	1.91	2.36*
Support and community resources	3	1.73	2.22*
Total Knowledge score	24	17.93 (74.7%)	20.33 (84.7%)*

NS = not significant

*p < .05

⁵ There are 56 pre-tests and 55 post-tests (one client had to leave the program one day early and was not able to complete the post-test), therefore, the paired t-tests were performed with a sample size of 55. In addition, group 1 did not complete pre and post-tests because the evaluation plans were not yet complete.

The comparison data presented on Table 6 shows the average score for the 55 clients before and after the program. As can be seen from the table, the clients significantly improved their knowledge levels from pre to post in 75% (6/8 objectives) of the material covered within the 2 weeks. The two short-term objectives that were not met were mental health issues and recovery plan. Although clients did not improve significantly from pre to post on recovery plan indicators, almost all clients had a copy of their recovery plan when they were discharged.

Clients were significantly more likely to show more general gambling knowledge, have a better understanding of the impact of gambling on family, increased life skill capacity, a better understanding of relapse prevention and management, financial aspects and community resources. This quantitative information has been confirmed with anecdotal evidence from clients who have since taken on new jobs/responsibilities and who have put to use financial strategies learned in the program to decrease their debt.

“By being in this program I have learned about the vlts and how they work, they don't pay out like one thought. The program gave me a stepping stone to recovery”

PGRRP client

4. 2. Long-term Objectives

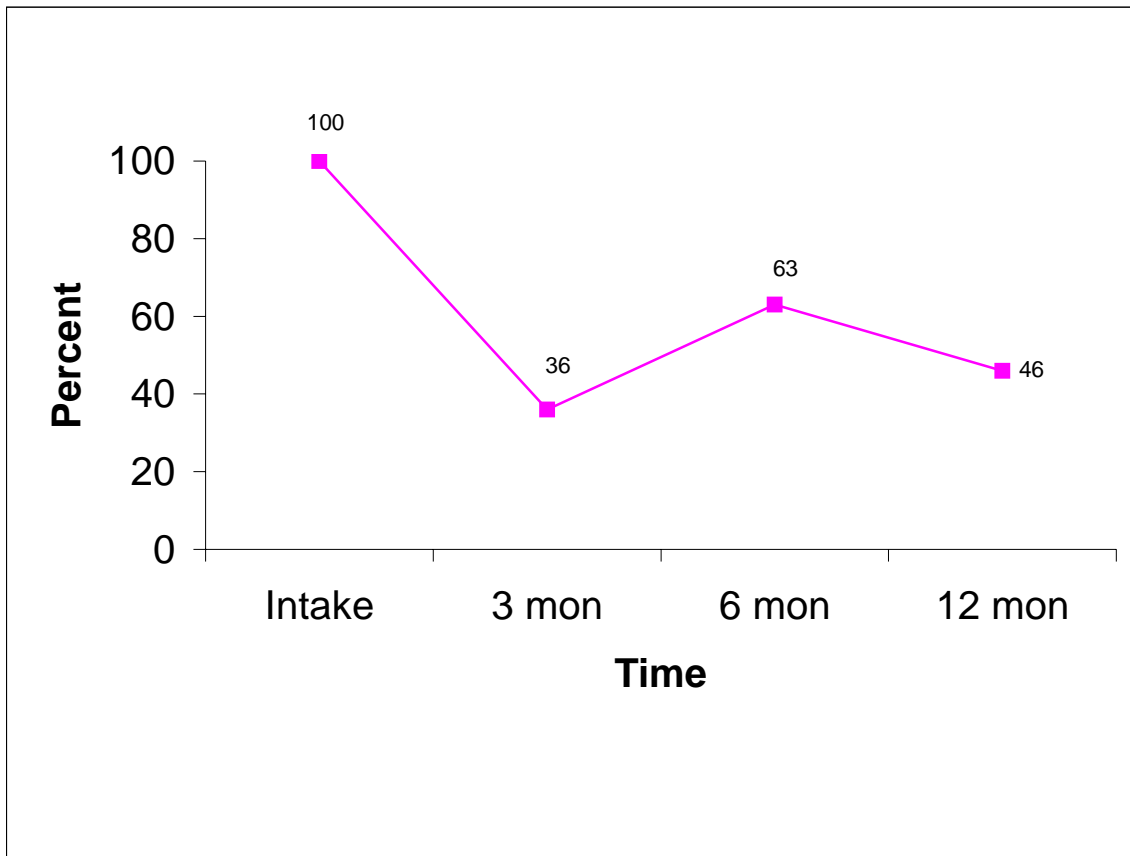
One of the unique aspects of the PGRRP evaluation is the opportunity for longer-term follow-up. In order to demonstrate whether the knowledge they gained during the 14 day program would carry over in to the long-term, clients were contacted at 3, 6, and 12 months from discharge. Eighty clients gave consent to be contacted, however, 12 of these could not be reached. Reasons included invalid contact telephone numbers, refusals once called, disconnected phones and unavailability after many attempts. Only 9 clients dropped out of the program before the end of the two weeks.

The follow-up contacts were conducted by telephone. Consenting clients were contacted by a researcher (Jackie Lemaire) who was not involved in any aspect of their admission and counselling process. These follow-up calls included questions about the extent to which the individual is still gambling and questions about the potential harm from continuing to gamble. A copy of the post-residency questionnaire is included as Appendix B. Follow-up interviews have been conducted to date on 68 clients. The average phone call conversation is 20 minutes, however the interviews ranged from 5 to 45 minutes. Most clients appreciated the follow-up call and felt it contributed to their on-going recovery.

4. 2. 1. Reduce Harm From Gambling

At 3, 6, and 12 months after being discharged from the PGRRP, clients were asked if they had gambled. Between intake and 3 months after discharge, there was a significant decrease in client gambling (100% to 36%). While 63% of clients are gambling at 6 months, 46% are gambling one year later. Figure 1 shows the frequency of gambling after discharge. Some clients relapsed after the first follow-up call resulting in higher rates at 6 months. This trend appears to be decreasing at one year with under half of the clients gambling.

FIGURE 1: Percent of Clients Gambling



Most importantly, as Figure 2 shows, those who have gambled are doing so at a reduced level of harm. Although at intake almost all clients were at a high risk of harm due to their gambling, this proportion decreased to almost 50% at 12 months. One third of clients are at low risk of harm due to their gambling at 12 months.

FIGURE 2: Percent of Clients Reporting Harm from Gambling

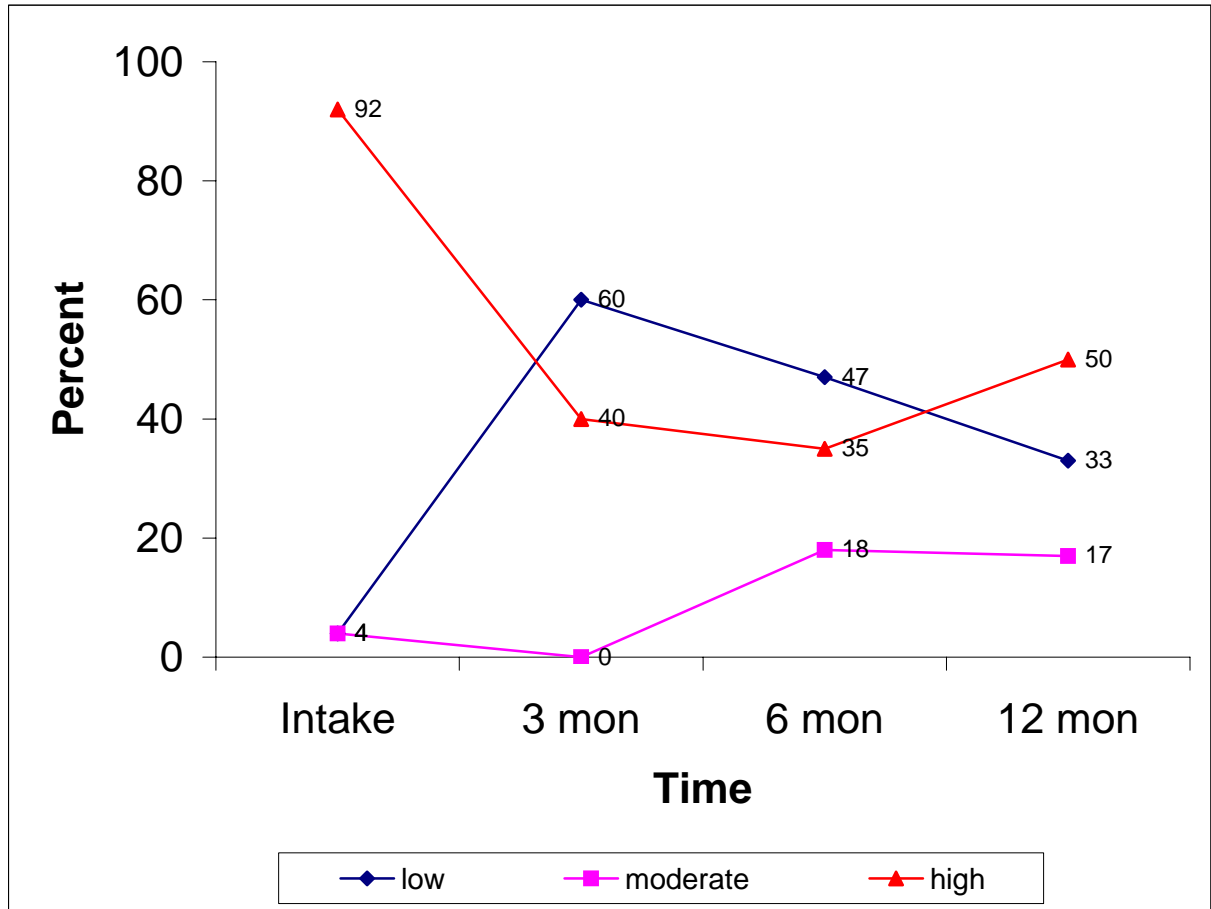


Figure 3 shows significant improvements in the clients' own assessment of their gambling problem and self-reported concern from others. At intake, the majority of clients reported that they had a gambling problem and that they knew of at least one person who was concerned with their gambling. However, at 12 months from discharge only 38% felt they have a problem with gambling and knew of someone who was concerned with their gambling behaviour. The slight increase at 6 months can be explained by the additional 7 clients who relapsed by the second follow-up call.

FIGURE 3: Percent of Client Assessment of Problem & Percent of Others Concerned

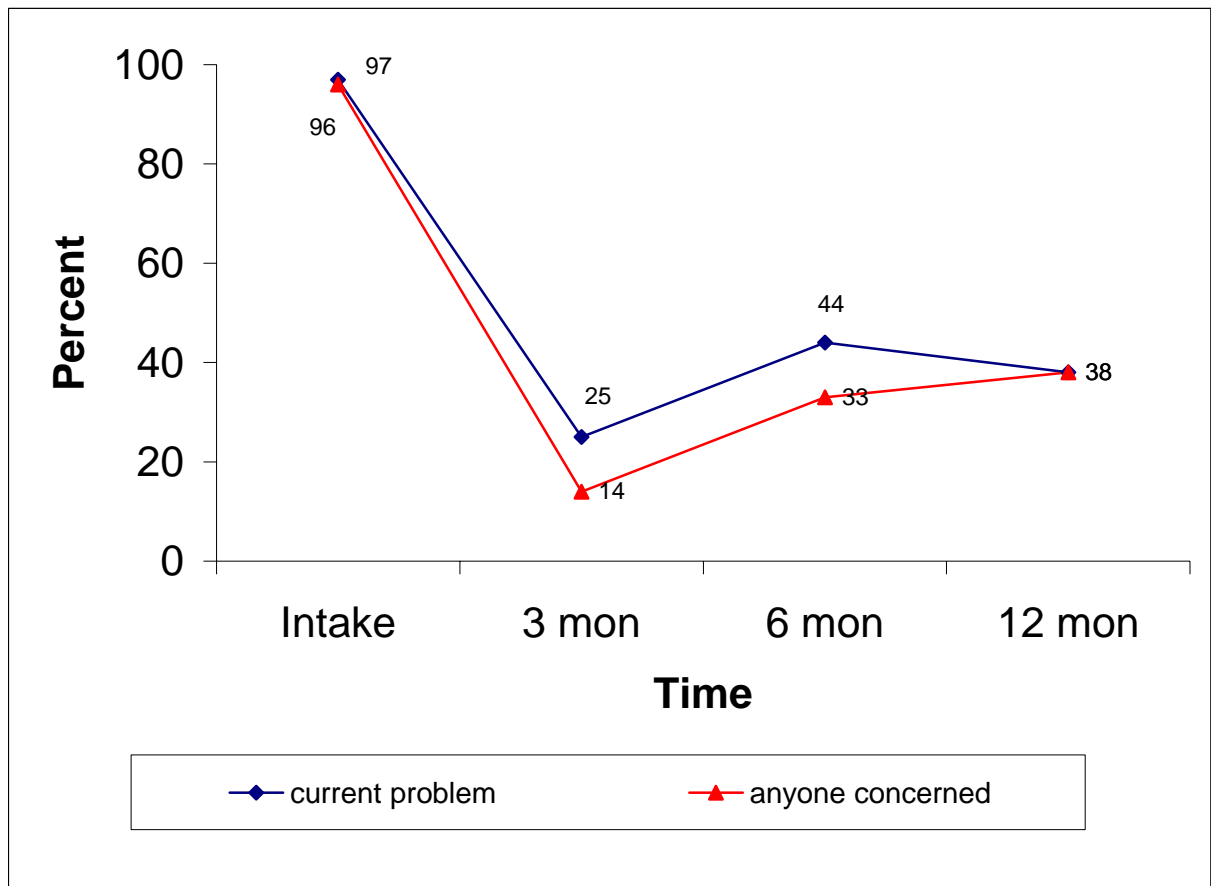
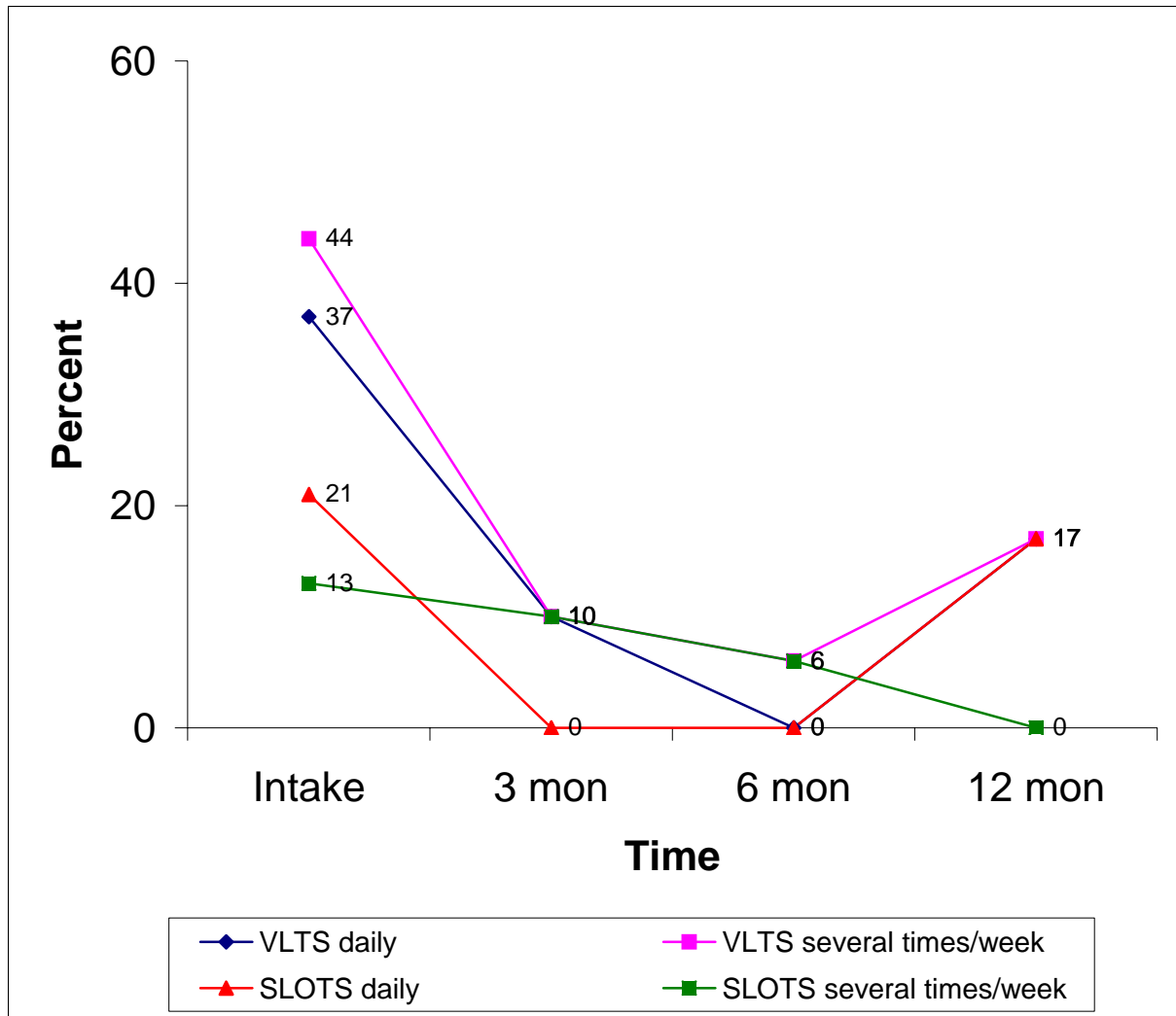


Figure 4 shows that the frequency of VLT and slot machine playing has significantly decreased over time. Although there appears to be a small increase between 6 and 12 months in the proportion of clients playing vlts and slots daily (see discussion for limitations of this report), clients have decreased their frequency of electronic gaming machine playing. Considering that our clients report that VLTs are the main source of their gambling problems, this movement is considered very positive.

FIGURE 4: Frequency of VLT/Slot Gambling



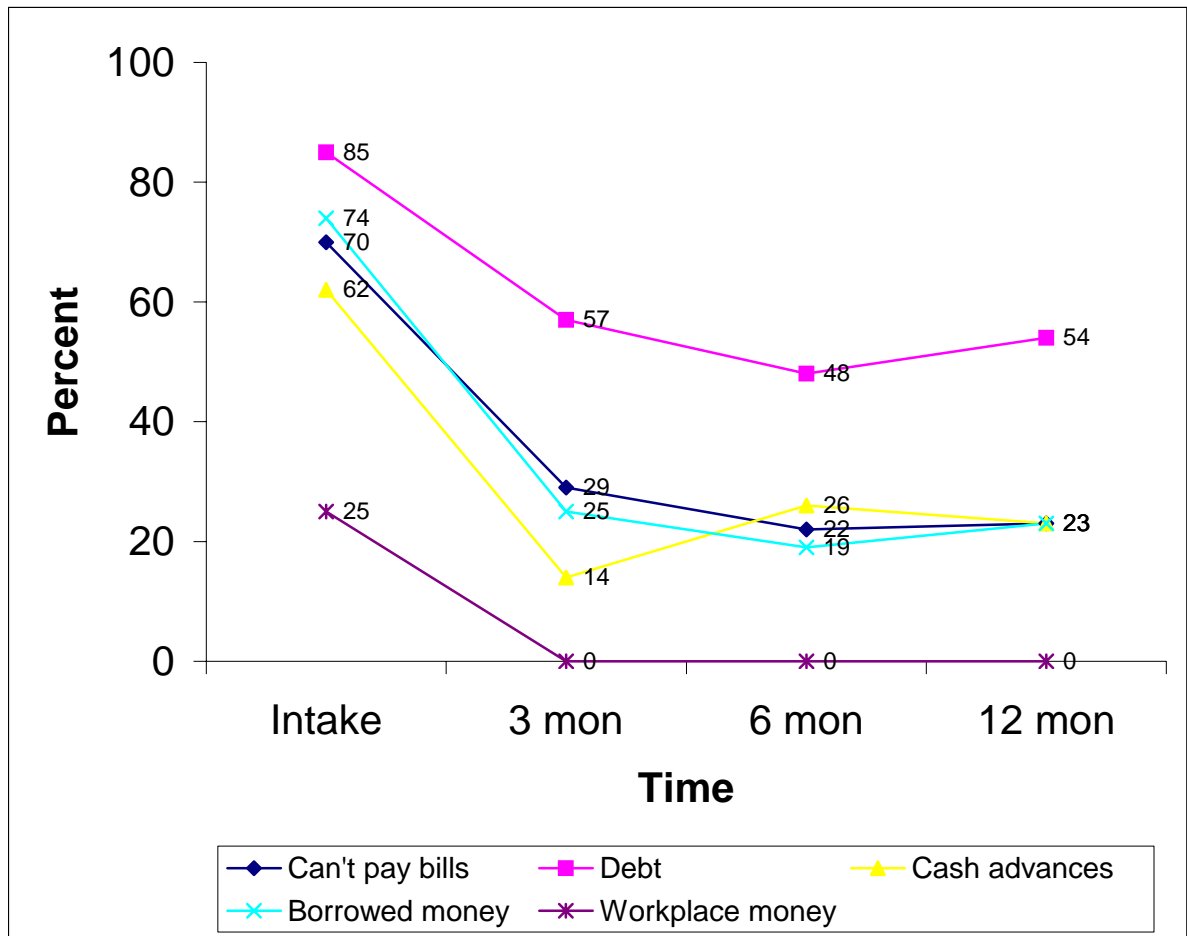
“It has given me the tools to work with to be on the path to recovery. Now I have to put these tools to good use. It has given me positive reinforcement and let me know there is help out there if needed. I am not alone”

PGRRP client

4. 2. 2. Reduce Financial Effects From Gambling

Clients report significantly fewer financial effects at follow-up. Although 85% reported significant debt and 70% had issues with paying their household bills, one year later only 23% have troubles paying their bills and 54% felt the effects of gambling-related debt. This is an amazing reduction in debt considering the financial issues that most of these clients have at intake. Using workplace funds to support gambling can be seen as a desperate attempt on behalf of the gambler. While at intake 25% of clients reported that they had used workplace funds for their gambling, one year later no clients were using money from their work to support gambling. Therefore, it appears that clients' financial situations have significantly improved. They have less trouble paying their bills, and are much less likely to be using workplace funds for gambling.

FIGURE 5: Percent of Clients Reporting Various Financial Effects



“Self discovery; it's more than just the action of gambling. It's emotional, coping, dealing, knowledge, information, and awareness. I am so appreciative of the support of the Brandon AFM staff”

PGRRP client

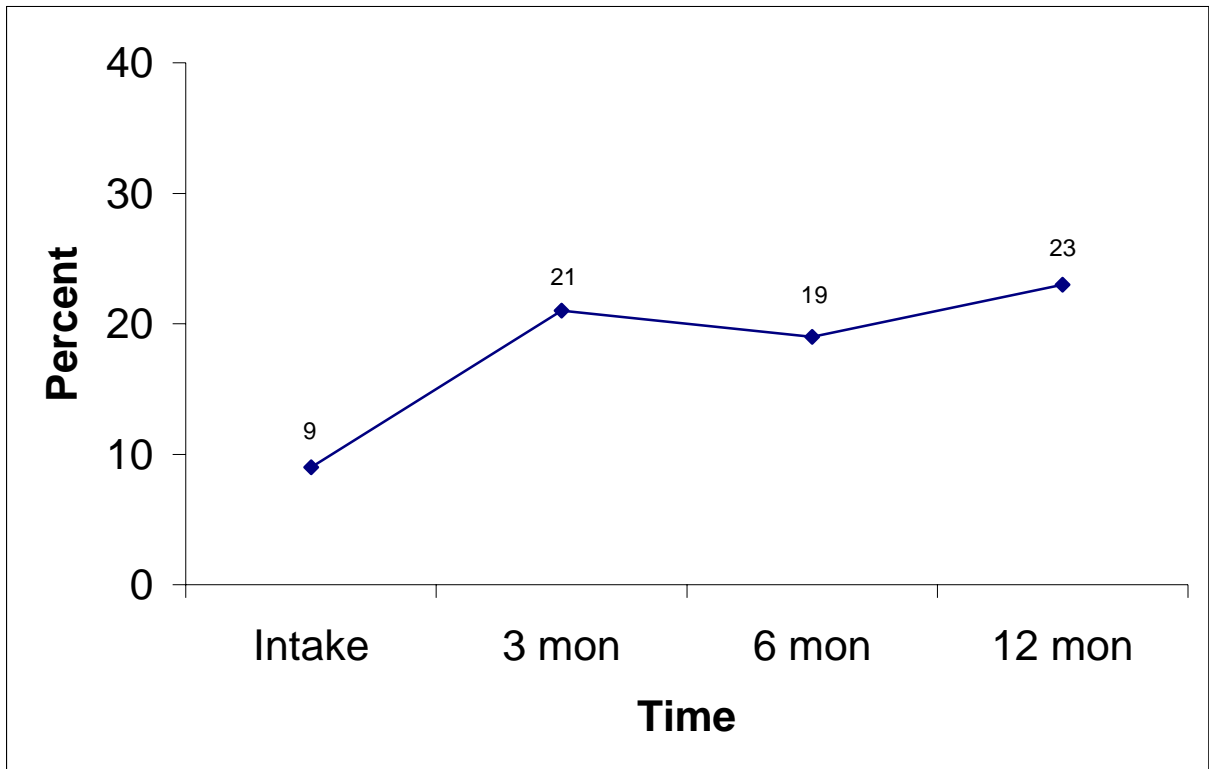
4. 2. 3. Reduce Mental Health Issues

As previously stated, many of the PGRRP clients have past histories of mental health issues and prescription medications for depression. Clients were asked to report on their current suicidal ideation. At intake, only a handful reported feeling suicidal but most of the clients had experienced suicidal thoughts at some point in their lives. Figure 6 shows that the percentage of clients feeling suicidal over time increased after intake. The intake phase of a clients' recovery journey can be seen as a time of safety, security and hope. They may report feeling less suicidal because they have begun the process of making important changes in their lives. In addition, many clients expressed how the journey to recovery (after the gambling program) had been a difficult ride filled with many bouts of depression and anxiety. Future evaluation should aim for a more comprehensive measure of the clients' mental health coupled with a more appropriate intake data collection time (e.g., one week after intake?).

“A feeling of belonging to a support group. The ability to talk about my addiction honestly”

PGRRP client

FIGURE 6: Percent of Clients Reporting Suicidal Ideation



4. 2. 4. Reduce Work-related Issues

Another long-term objective of the PGRRP was to reduce work-related issues. As financial impacts due to gambling can be overwhelming for some clients, it was hoped that the program would provide the clients with enough tools to begin to work on employment issues. Although full-time and part-time employment increased slightly from month 3 to month 6, not a lot of large changes occurred in this area. However, after discharge, significantly fewer clients (17% from 55%) are reporting work problems due to gambling after 12 months. Considering that over half (55%) of the clients had gambling-related work problems at intake, this is a very positive outcome.

FIGURE 7: Percent of Clients Reporting Problems with Employment

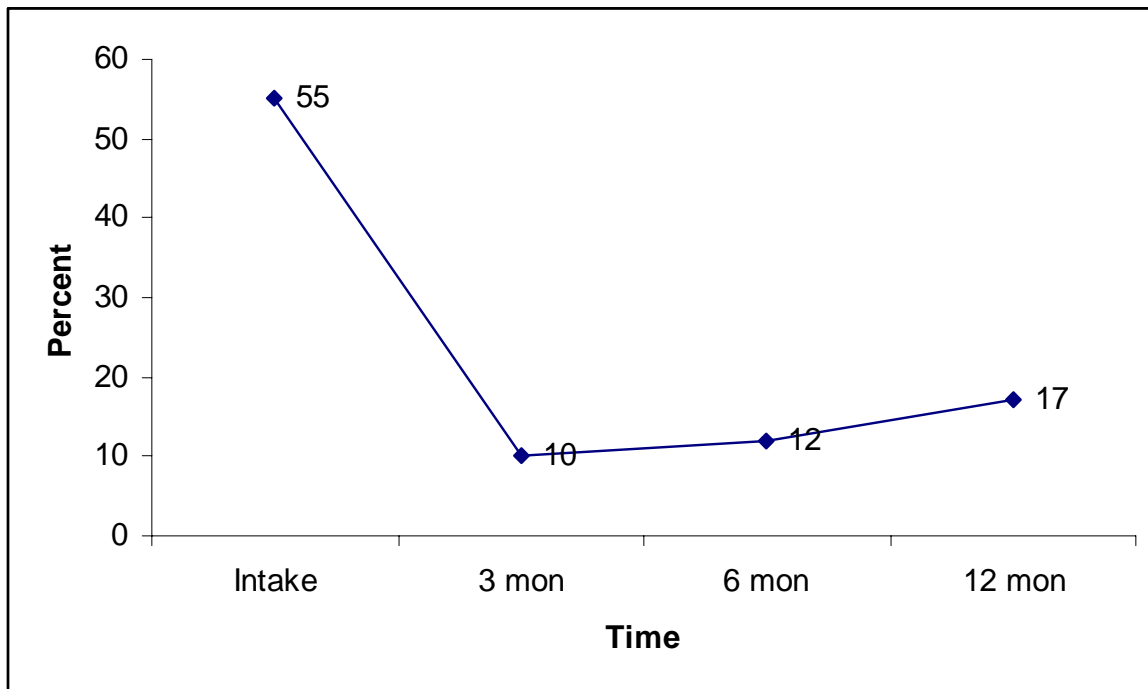
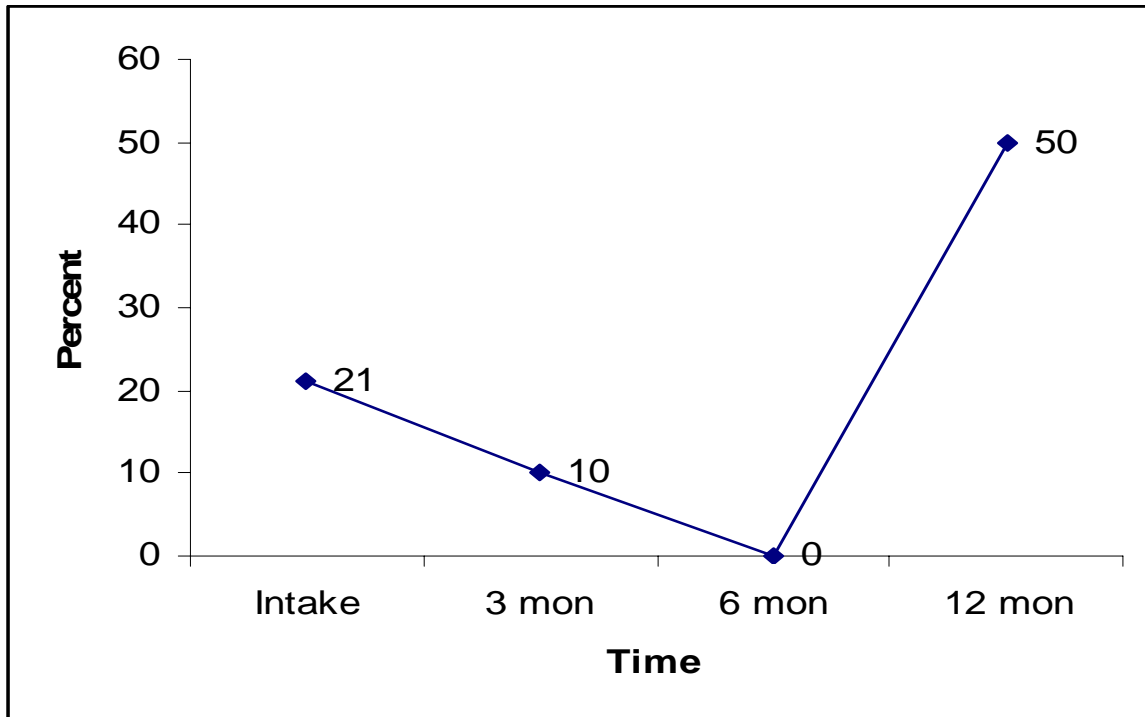


Figure 8 shows the percentage of self-reported employer concern over client gambling. While 21% of clients report that their employer is concerned about their gambling at intake, no clients report employer concerns at 6 months. Although this percentage spikes up to 50% at one year, it is with caution that we interpret these findings as the sample size at 12 months is much smaller than any of the other categories. This means that slight changes in a few clients at 12 months may appear more exaggerated than they really are. Over time, a larger number (and more comparable group) of clients will provide data that will be more representative at 12 months.

FIGURE 8: Percent of Employer Concern for Clients' Gambling



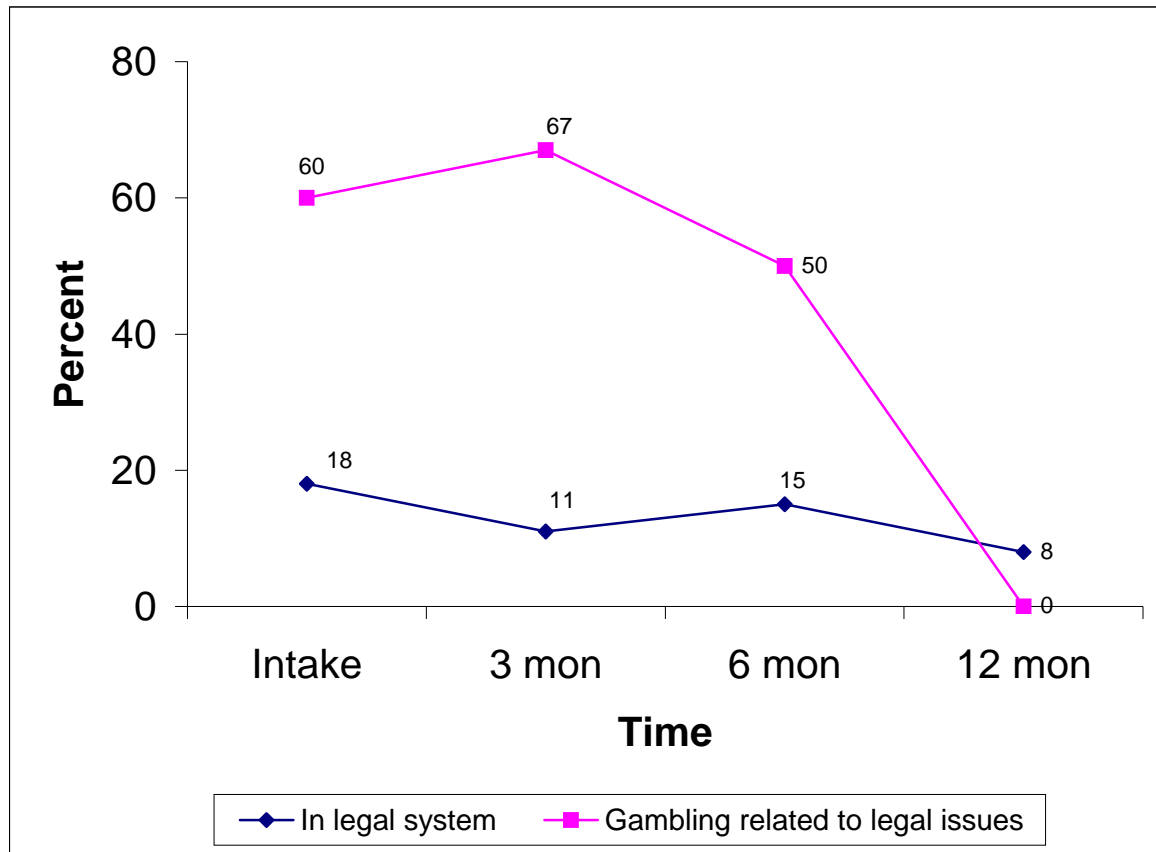
“I've learned to take care of myself; to express myself. To know that it is not likely that you are going to get the 'big win'”

PGRRP client

4. 2. 5. Reduce Legal Issues

A myriad of research linking criminal behaviour and addictions exists. Considering that 25% of PGRRP clients report to have stolen money from their work to finance their gambling, coupled with research linking gambling to crime, it was important to look at decreasing legal issues for our clients over time. At intake, 18% of the PGRRP clients were involved in the legal system with 60% due to gambling. At one year after discharge, these numbers have significantly decreased to 8% involved in the legal system for reasons other than gambling.

FIGURE 9: Percent of Client Legal Issues



“The residential program has given me much more insight and help to determine courses of actions I may use to help me recover from problem gambling. The ability to look at myself and honestly assess my feelings. Don’t stop this service”

PGRRP client

5. DISCUSSION

Problem gamblers usually wait for a long time prior to contacting treatment services. The individuals in the Problem Gambling Residential Rehabilitation Program have tried other programs, and have not been successful in reducing their harm and involvement in gambling. Those who require in-patient or residential programming are the most severely affected individuals suffering from other addictions and frequently co-existing mental health problems.

While in the program the clients were taught factual information about gambling. Comparison of pre and post-test knowledge scores confirm that 6/8 short-term objectives were met. Follow-up response rates were excellent (on average 87%) and suggest that some clients do return to gambling (36%, 63% and 46% report to be gambling at 3, 6, and 12 months, respectively) but at a much safer level. High risk for harm due to gambling decreased from 94% at intake to 42% (on average over 3, 6, and 12 months). In addition, frequency of VLT and slot playing significantly decreased over time. Less clients report gambling-related employment problems. Financial impacts and consequences have improved and at 12 months only 8% of clients are involved in the legal system (compared to 18% at intake).

As with any research evaluation, limitations exist and should be acknowledged. Due to the self-report nature of the data collection, interpretation of the results of this evaluation should be taken with caution. In addition, incomplete client files, missing client file information, and small number of clients may lead to inaccurate results. The number of clients at 12 months is relatively small (only 14 client thus far have been eligible for a 12 month interview) making comparisons with the other groups somewhat invalid.

Overall, the PGRRP evaluation suggests that many of the objectives of the program were met. Above all, clients of the program reported to be very satisfied with their experiences at the PGRRP and recommend that residential services for gamblers be offered permanently. Contingent on existing resources, it is recommended that the PGRRP continue with on-going monitoring and evaluation.

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Appendix A: Knowledge 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.

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

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

25. It is easier to quit gambling when a gambler cannot consistently predict when they will win.

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 B: Follow up Questionnaire

Name _____	Phone Number _____
Client Code _____	Follow-up Number (i.e. 1 st , 2 nd) _____
Date of Program Completion (dd/mm/yyyy) _____	
Date of Follow-up _____	

Thank you for doing this evaluation. 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.

1) Have you gambled in the past three months (VLT, Casino, horses, bingo, slots, table games, etc)?

Yes No **If “No”, go to 12**

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

Yes No

3) 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

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

Yes No

5) In the past three months, 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/school) (MGIS 4)

Yes No

6) In the past three months, have you had recurring 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 spouse or friends) (MGIS 5)

Yes No

7) Do you feel that you currently have a problem with gambling?

Yes No

8) Please indicate, on average, how frequently you have been involved in each of the following gambling activities over the past 3 months.

Type of Gambling	Daily	Several Times Per Week	About Once Per Week	About Once Per Month	Less Than Monthly	Never
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:						

9) In the past 3 months, has gambling caused problems with your employment/schooling?

Yes No

10) In the past 3 months, has anyone been concerned with your gambling?

Yes No **If “No” go to 12**

11) Who has been concerned about your gambling in the past 3 months? (All that apply)

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

12) 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
- Don't know
- Refused

13) Please indicate which of these effects of gambling you have experienced in the past 3 months (indicate all that apply)

- Can't pay household bills (i.e. utilities or rent)
- Being in debt
- Used cash advance from credit card to finance gambling
- Borrowed money from friends and/or family to finance gambling
- Gambled with company/workplace funds

14) What is your present marital status?

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

15) In the past 3 months, have you been concerned that someone in your family has a problem with gambling?

- Yes No **If "No" go to 17**

16) 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) Have you thought about suicide in the past 3 months?

- Yes No

18) 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

19) Do you have any court appearances pending?

- Yes No

20) Are you currently involved in the legal system?

- Yes No **If "No", END**

21) 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: _____

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

- Yes No

23) Are you currently on probation? Yes No

24) Are you currently on parole? Yes No

25) How much money have you spent on gambling in the past month?

\$ _____

26) Has your overall debt due to gambling increased in the past three months?

Yes No

Thank you for helping us by answering these questions...

Appendix C: PGRRP Accountability Model

Gambling Residential Program (Brandon)

Target: Harmfully and dependently involved gamblers

Activities

Short-term goals

Long-term goals

