Gambling: Identification, diagnosis and management

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Gordon Moody	Comments form questions	Q1	1. Are there any cost saving interventions or examples of innovative approaches that should be considered for inclusion in this guideline? Brief Interventions & Motivational Interviewing Online CBT Interventions (with or without therapist assistance) Self-help workbooks and digital support Relapse Prevention SMART Recovery 12 Steps Facilitated Group Therapy Therapeutic Communities Medium- and Long-Term Residential Treatment System Intervention for Addiction Neurofeedback, TMS and Brain stimulation Mindfulness Based CBT Dialectical Behavioural Therapy Integrative Psychotherapy Solution Focused Psychotherapy Acceptance and Commitment Therapy Exposure and Response Prevention Therapy Trauma-Informed Addiction Therapy	Thank you for this information. It will be considered when finalising the review questions and developing the review protocols through discussion with the guideline committee.

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			Gamification Psychotherapy and mHealth Apps & Games More treatment modalities are explored here: https://www.ncbi.nlm.nih.gov/books/NBK230629/ , here: https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(20)30230-9/fulltext and here: https://www.greo.ca/en/resources/GREO_05_2020_TreatmentRER_Final.pdf	
Gordon Moody	Comments form questions	Q2	2. Following the Scoping Stakeholder Workshop NICE is considering changing the title to “Harmful gambling: identification, assessment and management”. We would like your views on this. At moment there is not a unified approach in our field, regarding the definition of issues caused by gambling behaviour. DSM 5 as well as the International Centre for Responsible Gambling in USA use the term Gambling Disorder whilst ICD 11 uses the terms Pathological Gambling or Gambling Addiction. Organisations with a long history in addressing gambling related harm such as The Victorian Responsible Gambling Foundation or the Responsible Gambling Council also seem to use different format for defining the issue with the former leaning towards the	Thank you for your comment, and for this information on the possible ways of describing the topic of this guideline. Based on feedback at the stakeholder workshop and from the consultation comments it has been agreed that the title of the guideline will be: Harmful gambling: identification, assessment and management. The use of the word harmful can apply to the person doing the gambling, but can also include the fact that others can be harmed by that gambling.

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			use of "gambling harm" and the later towards the use of the "problem gambling". The most significant set of guidelines to date, the Monash Guidelines, use the term Problem Gambling. The most important journals in the field (Journal of Gambling Studies, International Gambling Studies and Journal of Gambling Issues) are also divided in their approach and tend to talk about "pathological gambling behaviour", "problem gambling" or "gambling related harm". Whilst we agree with the view expressed by our colleagues in the stakeholder scoping workshop, that the word "harm" should be part of the title of these guidelines, we believe the Harmful gambling puts emphasis on the behaviour, or the act of gambling in itself as being harmful whilst omitting the wider individual or societal harms resulting from the behaviour. As an alternative we would incline towards "Gambling related harm: identification, assessment and management".	
Department of Health and Social Care	Comments form questions	Q2	Supportive of this change as long as a clear definition of 'harmful gambling' is included in the scope	Thank you for your comment. Based on feedback at the stakeholder workshop and from the consultation comments it has been agreed that the title of the guideline will be: Harmful gambling: identification, assessment and management. The definition of harmful gambling included in the scope aligns with that

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				used by Public Health England in their recent evidence review of gambling-related harms, and will be included in the guideline as well.
Royal College of General Practitioners	General	General	The RCGP would like to highlight • That a significant amount of the current and historical evidence available is funded by the gambling industry and we would request that this is fully transparent in the evidence review. That the methods within much of the evidence base has changed over the last 10-15 years and so direct comparisons may be difficult to make.	Thank you for comment and for highlighting these important issues. NICE methods for reviewing evidence to inform recommendations do take account of the kinds of problems you identify through use of the GRADE methodology, including critical appraisal of included studies. This will include transparent information regarding the source of funding (where reported by the authors). This is described in the NICE methods manual for guideline development.
London School of Hygiene and Tropical Medicine	General	General	Language throughout should be mindful to reduce stigma eg use " a person experiencing a gambling disorder" not "disordered gambler". As noted in particular comment, use of the word addiction is potentially very stigmatising.	Thank you for your comment. It is standard NICE style to use terminology in the format 'person experiencing..' or 'people with…' so we will use this in the guideline. We have changed the reference to addiction to clarify that this is people with alcohol or substance use problems.
London School of Hygiene and Tropical Medicine	General	General	The guidelines say nothing about products. While it is understood that the focus of the guideline is on diagnosis and treatment, health professionals are key actors in helping to identify exposure to harmful products. Gambling is a vague and ambiguous term that covers a vast array of products and types of play, and it would be a missed opportunity for this to not be addressed in the guideline and explored in some way.	Thank you for your comment. We recognise that there are a number of ways in which people can gamble and although we have not discussed this in detail in the scope, it may be taken into consideration when developing the review protocols if appropriate.

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NICE Social Care and Leadership Team	General	General	It's very disappointing that the guideline scope is not considering social care or social care interventions to deal with the effects of harmful gambling given that many people who gamble may also be experiencing social care issues or/and their gambling may lead them to have social care needs. This is highlighted in the scope on page 2, lines 1-3.	Thank you for your comment. The Department of Health and Social Care commissioned NICE to develop a clinical guideline on gambling and although the guideline will cover all settings in which harmful gambling may be identified (which will include social work and social care contexts), in terms of management and treatment social care is not in the remit of the current commission. This reflects that the scope covers harmful gambling behaviour, rather than addressing the broader consequences. That said, the guideline will examine the information and support needs of people affected by harmful gambling, for example, family and friends, and these are likely to include services provided by local authorities and the voluntary and community sectors. In addition, the types of interventions delivered by NHS commissioned services for the treatment of harmful gambling do take account of people's wider social contexts and they are also likely to sign post to onward treatment and support, which may include social care interventions and input from social workers.
NICE Social Care and Leadership Team	General	General	It's also surprising that the scope doesn't include a more therapeutic perspective and the social model regarding the causes of the gambling. The guideline seems to be very focused on a medical model.	Thank you for your comment. The Department of Health and Social Care commissioned NICE to develop a clinical guideline on gambling and although the guideline will cover all settings in which harmful gambling may be identified (which will include social work and social care contexts), in terms of management and treatment social care is not in the

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NICE Social Care and Leadership Team	General	General	It would be helpful if the scope could be amended to include a more person-centred perspective so that the person experiencing harmful gambling is asked why they gamble, what support they need and what they want to work towards, such as what outcomes they want to achieve. It would also be helpful if this person-led approach included reference to principles from NICE's Shared decision-making guidance.	Thank you for your comment. Although the draft questions are yet to be finalised, it is anticipated that people's support needs and treatment goals will be covered in qualitative questions within 'Information and support' and 'Experiences of gambling treatment services' key areas. Cross-referral to other NICE guidelines (including shared decision-making) will be made where appropriate.
Department of Health and Social Care	General	General	Link between gambling and health inequalities could be more explicit when referring to groups with specific needs, especially socioeconomic groups.	Thank you for your comment. We have revised the equality considerations text in the guideline, and the equalities impact assessment to reflect the areas where we have identified potential equality issues. This has been done using the latest data on the prevalence

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				of gambling harm (based on the updated Public Health England [PHE] gambling-related harms evidence review quantitative analysis) and the latest data on people accessing treatment (based on the National Gambling Treatment Service annual statistics 2020-21). Unfortunately these sources do not both contain data on harmful gambling and treatment broken down by socioeconomic group, and although the PHE data shows that problem gambling is more common in those from the most deprived group, there are no data to indicate if people from this group are accessing treatment more or less than would be expected.
The Howard League for Penal Reform	General	General	The Commission welcomes NICE's focus on developing a guideline for gambling and the opportunity to respond to the draft scope. We make several observations based on the research we have collated and conducted which we would be happy to share further with NICE as the guidance is developed.	Thank you for your comment and for advising us of the research you have conducted.
London School of Hygiene and Tropical Medicine	1	4	Title is not helpful-either "harmful Gambling' if focusing on the individual, or 'Gambling Harms' if have an all-harms focus to the guideline.	Thank you for your comment. Based on feedback at the stakeholder workshop and from the consultation comments it has been agreed that the title of the guideline will be: Harmful gambling: identification, assessment and management. The use of the word harmful can apply to the person doing the gambling, but can also include the fact that others can be harmed by that gambling.
Department of Health and Social Care	1	6	It's the department of health and social care now	Thank you for your comment. We have changed this to include social care.

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Department of Health and Social Care	1	11 - 13	Those terms are used to refer to individuals experiencing gambling harms and not affected others. However, harmful gambling encompasses the harms experienced by affected others. Would be useful to alter this paragraph to say why Harmful gambling is being used and the types of harm it encompasses. Definition available in glossary: https://www.gov.uk/government/publications/gambling-related-harms-evidence-review/gambling-related-harms-evidence-review-glossary	Thank you for your comment. We based the definition of harmful gambling on the glossary you have referenced to ensure consistency between the public health work on gambling and the NICE documents. Gambling that results in people experiencing harm refers to both the gambler themselves and affected others.
Gordon Moody	1	14	We propose the use of the term "gambling related harm" instead of "harmful gambling. Details on our reasoning can be seen in our response to Q2.	Thank you for your comment. Based on feedback at the stakeholder workshop and from the consultation comments it has been agreed that the title of the guideline and the terminology used in the scope will be: Harmful gambling: identification, assessment and management. The use of the words 'harmful gambling' can apply to the person doing the gambling, but can also include the fact that others can be harmed by that gambling.
Gambling with Lives	1	14	We are wary of this definition because it could lead to defining the condition by the external consequences rather than the internal process or the experience of sufferers. A different definition might emphasise the distress, compulsion or anxiety. Perhaps the words "level or intensity of gambling" might be more helpful than frequency. Frequency of gambling is one aspect of harmful gambling or possibly a cause of developing other symptoms and could lead to	Thank you for your comment. Based on feedback at the stakeholder workshop and from the consultation comments it has been agreed that the title of the guideline and the terminology used in the scope will be 'harmful gambling'. The use of the words 'harmful gambling' can apply to the person doing the gambling, but can also include the fact that others can be harmed by that gambling (and also that harm could include the terms you have mentioned such as distress,

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			the exclusion of the literature on the intermittent aspects of gambling disorder. A further definition might include use of some forms of gambling that are known to be particularly addictive, for example electronic gambling machines or the online equivalent are associated with much higher prevalence of 'problem gambling'. (Ref: NatCen for Gambling Commission, 2018, Gambling behaviour in Gt Britain in 2016). Some forms of gambling, such as 'micro betting', are associated with extremely high levels of 'problem gambling' – with one study indicating that 78% of participants were classified as 'problem gamblers'. (Ref: Russell, A.M.T. et al., 2019, Who bets on micro events (microbets) in sports?)	compulsion and anxiety). The definition is based on that used by Public Health England in their recent evidence review and we have specifically defined it as 'any frequency of gambling' so that would include intermittent gambling. We recognise that there are a number of ways in which people can gamble and although we have not discussed this in detail in the scope, it may be taken into consideration when developing the review protocols if appropriate.
Department of Health and Social Care	1	14 - 15	Is it worth explaining why 'harmful gambling' is preferable to 'problem gambling' i.e. to avoid stigmatisation, and that this term should be adopted as the norm?	Thank you for your comment. We have added that this is a less stigmatising term.
London School of Hygiene and Tropical Medicine	1	15	"that results in people [directly or indirectly] experiencing harm". Need to clarify scope.	Thank you for your comment. The line above clarifies that the harm can be to the individual or those around them ('affected others') so we do not think it is necessary to repeat that the harm can be direct or indirect again here.
Gambling with Lives	1	16-18	Prevalence: the numbers shown include people who have engaged in <u>any</u> gambling activity. If we exclude people who gamble on the National Lottery only, the proportions gambling fall to 46% of men and 38% of women. 'National Lottery only' are unlikely to suffer from gambling disorder.	Thank you for your comment. We have updated the figures in the scope based on the recent gambling-related harms evidence review carried out by Public Health England, and this includes both people at risk of and involved in problem gambling, as well as affected others. We have also included the figures from the National Gambling Treatment Service statistics for

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			The figures on 'harmful' gambling include only those who would be classified as 'problem gamblers'. We believe that it is important to include the wider group of gamblers who would be classified as 'at risk' of gambling harm. Research indicates that there is a considerable 'churn' of individuals between the 'problem gambler' and 'at risk' categories (Ref: Reith & Dobbie, 2013, Gambling careers: a longitudinal, qualitative study of gambling behaviour) and that the vast majority of gambling harms affect those who are not classified as 'problem gamblers' (Refs: Browne et al., 2016, Assessing gambling related harm in Victoria; and Browne et al., 2017, The social cost of gambling to Victoria). Gambling behaviour in Gt Britain in 2016 found that 0.7% of gamblers were classified as 'problem gamblers', with a further 1.1% classified as 'moderate risk' and 4.4% classified as 'low risk', so that the potential population of gamblers who would be eligible for treatment could be over 7 times higher than the figures quoted. We also believe that the figures on 'harmful gambling' should also include 'affected others'. AS noted, the majority of harms are suffered by people other than the gambler themselves. We also note that over 12% of people treated by the GamCare network in 2019/20 were 'affected others' rather than the gambler themselves (Ref: GambleAware: NGTS 2019/20).	2020/21 on the number of affected others who access the services (which is now reported as 15% for England).

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London School of Hygiene and Tropical Medicine	1	18	Are any references for these stats going to be included? Also no mention of range of harm in different products eg up to 50% in EGM according to some evidence	Thank you for your comment. We do not usually include references in this introduction to the scope, but as we have been made aware that there are so many sources of data on gambling we have now added links to the references. We have used the recent Public Health England gambling-related harms evidence review quantitative analysis (2021) and the National Gambling Treatment Service statistics 2020/21. Although we recognise that different gambling products cause different levels of harm and we will consider this when developing the review protocols, we have not included this level of detail in the introduction to the scope.
Gambling Education Network	1	18	The draft scope identifies estimates of the number of people in the UK who are believed to have suffered from gambling disorder level harms in the past year as those participating in harmful gambling. Hence, the current draft scope incorrectly conflates the prevalence of gambling disorder with harmful gambling; this is akin to conflating alcohol use disorder with harmful alcohol consumption. We feel that the draft scope should consider individuals who suffer gambling harm but do not meet the diagnostic thresholds for gambling disorder (Problem Gambling Severity Index: 1-7). We suggest that the omission of sub-gambling disorder level harms is inappropriate because a) harms are on a continuum b) the relative difference in prevalence suggests that sub-threshold gambling	Thank you for your comment. We have updated the figures in the scope based on the recent gambling-related harms evidence review carried out by Public Health England, and this includes both people at risk of problem gambling (PGSI 1-7) and involved in problem gambling (PGSI 8 or above).

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			harm may contribute to more harm than gambling disorder level harm. The prevalence of harmful gambling was measured at 8.5%, and the prevalence of gambling disorder was measured at 1.2% of the population in the British Gambling Prevalence Survey 2010. 1 in 30 adults reported betting more than they could afford to lose in the past year (3.6%, British Gambling Prevalence Survey 2010) 1 in 80 adults reported gambling caused health problems including stress in the past year (1.2%, British Gambling Prevalence Survey 2010) Infographics: https://www.gamblingeducationnetwork.com/post/gambling-harm-in-adults Gambling Explained: Addiction (Prevalence) https://www.gamblingeducationnetwork.com/post/gambling-and-addiction	
Department of Health and Social Care	1	18	Not sure about the 1.4 million estimate, I think NICE should stick with quoting HSE which is the best estimate	Thank you for your comment. We have updated the figures in the scope based on the recent gambling-related harms evidence review carried out by Public Health England and this includes both people at risk of problem gambling (PGSI 1-7) and involved in problem gambling (PGSI 8 or above).

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Department of Health and Social Care	1	19	'Participate' sounds quite blaming of the individual. May be better to go with experience	Thank you for your comment. We have used the terms 'involved in' and 'participate in'. 'Experience' does not make it clear that these figures relate to people who gamble themselves.
Gordon Moody	1	20	Defining what "in treatment" entails would help in better understand the prevalence of those affected by gambling related harm accessing support	Thank you for your comment. We have amended this to clarify that these figures relate to those who have been treated by the National Gambling Treatment Service.
Gambling with Lives	1	20	We believe that it is a much lower proportion of people who would benefit from treatment who actually receive anything. The 3% figure is based upon using both the lower estimate of people diagnosed as 'problem gamblers' (340,000 vs 1.4 million) and also excluding those who are classified as 'moderate/low risk'. We believe that it would be better to state the actual number of people receiving any form of treatment: 9008 clients of which only 7473 were gamblers (Ref: [GambleAware: NGTS 2019/20]). We also note that the vast majority of clients who seek treatment are scoring very high on the PGSI. The NGTS figures are not clear, but analysis of the quoted 'improvement rates' and exit scores indicates that the majority clients must be scoring 20 or more. So that people do not appear to access treatment until their condition is 'severe'.	Thank you for your comment. We agree that the 3% is only those defined as participating in problem gambling with a PSGI score of 8 or more, and that some people at low to moderate risk of gambling (PSGI 1 to 7) may also benefit from treatment. The latest report for 2020/21 from the National Gambling Treatment Service states that the mean PSGI score at start of treatment was 19 (although we have not included this detail in the scope).
Gambling with Lives	1	22	We feel that labelling current treatment as an NHS national system is somewhat misleading. Current provision is partially commissioned by the NHS and partially by GambleAware and the funding source determines the process of commissioning and consequent governance, reporting	Thank you for your comment. We have removed the term 'NHS' from this sentence, as you are correct that the National Gambling Treatment Service includes services that do not fall under the remit of the NHS.

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			and service improvement requirements as well as the use of evidence in determining treatment methods. GambleAware is a gambling industry partner charity funded wholly by the industry and commissions the charity GamCare to provide treatment and the National Gambling Helpline. GamCare also functions as a secondary commissioner of 13 subcontracted counselling providers. GambleAware also commissions residential treatment from the Gordon Moody Association. Therefore, the vast majority of people who receive treatment do not receive treatment commissioned or provided by the NHS and it is not held within NHS governance standards.	
Department of Health and Social Care	1	22	There will be updated figures you can use for those treated by the national problem gambling clinics as GambleAware realised them last week	Thank you for your comment. We have now updated these figures with data from the National Gambling Treatment Service 2020/21 report.
Department of Health and Social Care	1	22	Not sure 'NHS national gambling service' refers to just [redacted] clinic or that and [redacted] clinics in the north? Would be good for this to be clearer	Thank you for your comment. We have removed the term 'NHS' from this sentence, as the National Gambling Treatment Service includes services that do not fall under the remit of the NHS.
Gambling with Lives	1	23 - 26	We welcome the work on a NICE guideline because we feel it is essential that services are commissioned in line with the evidence of best practice. Currently, 96% of people entering the NGTS service receive counselling as a treatment for which there is very limited evidence of efficacy (Ref: GambleAware: NGTS 2019/20). The severity of gambling disorder of people referring is extreme with a mean average PGSI score of 19.5 which for 50% of patients is reduced	Thank you for your comment. We agree that the NICE guideline aims to provide evidence-based recommendations on the most effective treatments for harmful gambling, including for relapse prevention and follow-up.

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			after counselling to 7.9 at the point of discharge. We note that over 40% of clients leaving treatment are still scoring 8+ on the PGSI, which indicates a diagnosis of gambling disorder. Currently there seems to be no follow up measurement of relapse or severity in non-NHS services and there is no indicator of how many people who have received treatment have gone on to take their lives. Gambling with Lives requested a critical incident review on behalf of a bereaved family and this was declined.	
Department of Health and Social Care	1	27	What physical comorbidities do they tend to present with- both depression and suicidal events are psychiatric right?	Thank you for your comment. Although not as well reported as the psychological comorbidities, people participating in harmful gambling can present with a number of physical comorbidities, often linked to stress. These include hypertension, cardiovascular disease, peptic ulcer disease, and sleep deprivation.
Gambling with Lives	1	27 - 28	While the technical definition of comorbidities does not necessarily indicate causality it can misinterpreted as implying that the comorbidity caused the gambling disorder or that gambling does not cause mental health problems. It is worth noting that in 2017 DCMS wrote that "we know that problem gambling can cause physical and mental health problems, including anxiety disorders and depression" (Ref: DCMS, 2017, Consultation on proposals for changes to gaming machines and social responsibility measures) GwL's own collation and summary of international research concluded that even amongst treatment seeking "problem gamblers", around half do not have any comorbid conditions or	Thank you for your comment. We have not implied causation and, as you suggest, comorbidities can be as a result of gambling or can be antecedents. We mention comorbidities in this introductory section to the scope, and have included depression and suicidal ideation as these are well-reported. However, comorbidities will be considered in the evidence reviews and are included in a number of the review questions.

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			that they were probably caused by their gambling disorder. (Ref: GwL, 2020, Gambling and Comorbidity: Interim Paper) While the wording may imply suicide attempts and completed suicides, we believe that it is worth spelling out the high numbers. The recent PHE report (Gambling related harms: evidence review, 2020) estimated that there were 409 gambling related suicides a year in England. These deaths represented over half of the total costs that PHE were able to attempt to quantify. These figures confirm GwL's estimated 250 to 650 deaths each year in the UK (Ref: GwL, 2018, Gambling – Suicidal Ideation, Attempts and Completed Suicides)	
Gordon Moody	1	28	A significant proportion (%34 for Gordon Moody) of those accessing our support present with EUPD diagnosis	Thank you for your comment. We will consider including Emotionally Unstable Personality Disorder in the comorbidities to be considered when we develop our review protocols.
London School of Hygiene and Tropical Medicine	2	7	There is no list of vulnerable groups-the harms are spread unequally across the population.	Thanks for your comment. The groups who are perceived to be more at risk from gambling harms are listed separately in the Equality Impact Assessment (EIA).
Department of Health and Social Care	2	7	For reference annual economic burden of harmful gambling is estimated to be about £1.27 billion: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1022208/Gambling-evidence-review_economic-costs.pdf	Thank you for this useful information. It will be reviewed when developing economic analyses for this guideline

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Department of Health and Social Care	2	9 - 10	The number of NHS gambling clinics will need updating. The 2 clinics noted here are jointly funded by GambleAware and the NHS. The clinics in Manchester and Sunderland are funded by the NHS.	Thank you for your comment. This text has been updated to clarify that there are a currently some NHS-commissioned clinics, in order to ensure that the information in the scope does not become out of date too rapidly.
Gambling with Lives	2	9 - 26	Currently there is little understanding of the need to triage and provide NHS treatment according to severity as well as complexity. We have spoken to many bereaved families and recovering gamblers who speak of extreme severity of gambling disorder and clear causal simplicity. Complexity may arise from legacy harms such as harm to relationships or finances but these are different from treating for severity of gambling disorder.	Thank you for your comment. We will consider including severity and complexity when developing our review protocols on the provision of care and access to treatment, as well as the differential use of interventions.
Department of Health and Social Care	2	14	Treatment services are COMMISSIONED by, not provided by GambleAware	Thank you for your comment. We have amended this text as you suggest.
Department of Health and Social Care	2	14 - 15	Further nuance needed here. GambleAware were set up by the industry initially, are independent of industry in terms of representatives on their board but they are funded by voluntary industry donations. Current wording does not make this clear.	Thank you for your comment. We have amended the text to clarify the status of GambleAware.
London School of Hygiene and Tropical Medicine	2	17	No mention of the Primary Care Gambling Service, Gamblers Anonymous or GamAnon-why?	Thank you for your comment. We are aware of a number of other organisations and charities that provide treatment and support to people involved in gambling causing harm (some of which only cover limited geographical areas) and have not tried to list

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				them all individually but we have added an additional sentence acknowledging these other organisations.
London School of Hygiene and Tropical Medicine	2	21	"do not routine SCREEN, identify or refer gamblers"	Thank you for your comment. We have not added the word 'screen' here as this generally refers to population-wide screening, but have stated that 'there is no coordinated system of early identification'.
Department of Health and Social Care	2	22	Worth mentioning the Primary Care Gambling Service and framework?	Thank you for your comment. We are aware of a number of other organisations and charities that provide treatment and support to people involved in gambling causing harm (some of which only cover limited geographical areas) and have not tried to list them all individually but we have added an additional sentence acknowledging these other organisations.
London School of Hygiene and Tropical Medicine	2	24	"for other addictions" of note this is the first time you frame this as directly comparable addiction-this has significant connotations in terms of stigma and framing.	Thank you for your comment. We have amended the text to refer instead to alcohol or substance use problems, to avoid using the word addictions.
Department of Health and Social Care	2	24 - 25	The NHS Long Term Plan made a commitment to create 15 specialist problem gambling clinics by 2023/24. Not all NEW clinics as the London and Leeds clinic were already in operation.	Thank you for your comment. We have removed the word 'new'.
Gordon Moody	2	28	We also use USA's ICGR and Canadian CCSA guidelines as well as best practice from the wider addiction field.	Thank you for your comment and alerting us to these other guidelines. We have removed the reference to all other existing guidelines in the scope and so have not included these.
Gordon Moody	3	3	There is a significant wider area of treatments and intervention used	Thank you for your comment. We have removed the detail on currently-used interventions from the scope.

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Department of Health and Social Care	3	3	Are pharmacological treatments used alone for gambling in the UK? Find that hard to believe	Thank you for your comment. We have removed the detail on currently-used interventions from the scope.
London School of Hygiene and Tropical Medicine	3	6	This paragraph should end with an explicit comment that research is predominantly funded by the industry and recognition of the implications this has for moving forward. There needs to be more explicit recognition that actions needs to be taken because it is clear that harms are occurring (as shown in the PHE evidence review) but how to address these is less clear give the paucity of independent, robust and/or relevant research. But lack of evidence is not a licence for inaction but instead the premise in which action should be taken using a precautionary approach.	Thank you for your comment. We have not included details in the scope about the evidence base, such as sources of funding and possible limitations in the evidence. This will be identified and reported in the evidence reviews using the NICE manual methods, which includes the use of GRADE. Evidence may therefore be downgraded if sources of bias are identified. We are also aware that there may be a lack of good evidence for some topics but recommendations and research recommendations can also be made based on the knowledge and expertise of the committee.
Department of Health and Social Care	3	7 - 12	Current treatment provision also not informed by need because the evidence base is lacking. Other gaps include no clear treatment pathway between GA commissioned services and NHSE clinics.	Thank you for your comment. This paragraph relates to current gaps in treatment. Deficiencies in identifying need and pathways are covered in earlier paragraphs.
Gordon Moody	3	10	Evidence shows that relapse rate Is no different from substance misuse	Thank you for your comment. We will be looking at interventions to try and reduce relapse rates, as any relapse is not beneficial.
Department of Health and Social Care	3	11	Should perhaps refer to 'family members and close associates.	Thank you for your comment. We have amended the terminology here and elsewhere in the scope to 'family members, friends and others close to the person'.

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London School of Hygiene and Tropical Medicine	3	12	Gambling Commission data states 1 in 20 11-16 significantly harmed by others gambling. ?ADD	Thank you for your comment. We have highlighted the particular impact on families and children in an earlier paragraph and so have not repeated it here.
Department of Health and Social Care	3	12	…who are affected by the gambling of others	Thank you for your comment. We have made this change to the wording.
London School of Hygiene and Tropical Medicine	3	15	Any comment GambleAware manage the industry voluntary contributions?	Thank you for your comment. We have now included details about the funding of GambleAware in an earlier paragraph so have not repeated it here.
London School of Hygiene and Tropical Medicine	3	19	Should comment that Gambling Act currently under review and white paper imminent	Thank you for your comment. We have added that this legislation is currently being updated.
London School of Hygiene and Tropical Medicine	3	20 - 23	Not clear here that GambleAware are managing industry contributions	Thank you for your comment. We have now included details about the funding of GambleAware in an earlier paragraph so have not repeated it here.
Royal College of General Practitioners	3	28	Please consider the addition of community care	Thank you for your comment. We have added community care to the groups for whom the guideline is intended.
Department of Health and Social Care	3	29 - 30	…their families and affected others	Thank you for your comment. We have made this change to the wording.
Royal College of Nursing	3	55	The draft scope currently excludes people who have already been diagnosed. We feel this group should be included because…	Thank you for your comment. There is no line 55 on page 3 so we are unsure exactly what your comment relates to, but the scope does not exclude people who have already been diagnosed. The groups covered include 'Adults (aged 18 and over) who participate in

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				gambling that is causing harm to themselves or to their family, friends, and others close to them.'
London School of Hygiene and Tropical Medicine	4	3	What is a 'social care practitioner'? Does this include Social prescribers in GP? List should also include financial support services eg CAB, drugs and alcohol services and industry OH specifically	Thank you for your question. The term 'social care practitioner' is used here to refer to social workers and others involved in delivering social care. It would not include people in general practice who may undertake ad-hoc social prescribing (and who would be covered under 'healthcare professionals'), but we note that the NHS Long Term Plan now refers to 'trained social prescribing link workers...who will connect people to wider community support' and so we have added this role in addition to social care practitioners. Services providing financial support or drugs and alcohol services are included in the groups of 'healthcare professionals', 'social care practitioners' or 'voluntary, community and social enterprise', depending who delivers the service. Occupational health services (industry or otherwise) are already included separately in this list.
Royal College of General Practitioners	4	6	Please consider adding all educational settings. There are some young people aged 18 who are still in full time education and have not yet moved to higher education institutions. In addition, there are younger children who will be impacted by gambling (affected others) and their needs should be considered as per page 6, line 6. Teachers and school nurses, may look to the guidelines to determine what family help is available and what treatment is expected for the index patient.	Thank you for your comment. We have amended this to state 'education providers' so it will now include schools, as you have suggested.

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Gordon Moody	4	7	Addiction specialists and Employee Assistance Providers can also be included	Thank you for your comment. In order to keep these lists to a manageable size we have used broad categories. Addiction specialists are included in either 'providers of gambling treatment services', 'healthcare professionals' or 'voluntary, community and social enterprise' depending on the exact nature of the service and so we have not included them separately. Employee Assistance Providers are covered under 'occupational health services' and so we have not included them separately.
Gambling Education Network	4	13	The equality impact assessment omits the significant role of race/ethnicity in gambling harm. Individuals from ethnic minority backgrounds are less likely to gamble but yet more likely to experience gambling-harm (according to British Gambling Prevalence Survey 2007, British Gambling Prevalence Survey 2010, National Health Survey 2012, YouGov 2020), and less likely to receive treatment for gambling harm (National Treatment Statistics 2019, 2020). Individuals from ethnic minority backgrounds are also more likely to live in areas which have high densities of betting shop. https://www.gamblingeducationnetwork.com/post/gambling-harm-in-ethnic-minority-populations Individuals from ethnic minority backgrounds are likely to have larger families and as such affected others are disproportionately likely to be from ethnic minority backgrounds.	Thank you for your comment. We have reviewed the most recent data on the prevalence of gambling from Public Health England and the uptake of treatment in different ethnic groups from the National Gambling Treatment Service statistics from 2020/21, and the updated Equality Impact Assessment includes more information on the potential inequalities relating to people from certain ethnic groups.

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Gambling Education Network	4	13	The equality impact assessment omits the significant role of age in gambling harm for both Men and Women. 1. Prevalence of gambling harm is likely to be highest among 16-24 year olds for both Men and Women (according to British Gambling Prevalence Survey 2010). Moreover, the risk of harm in this age group is noteworthy due to gambling harm effects on education and employment and the potential for more prolonged and more profound legacy harm effects.	Thank you for your comment. We have reviewed the most recent data on the prevalence of gambling from Public Health England and the uptake of treatment from the National Gambling Treatment Service statistics from 2020/21, in men and women and people of different ages and the updated Equality Impact Assessment includes more information on the potential inequalities relating to people of different ages and sexes.
Department of Health and Social Care	4	17 - 21	Curious as to why LGBTI+ are included here (didn't come through as a group in our evidence review) and why people from BAME ethnicity are not included here? Should also consider young men, migrants, and veterans.	Thank you for your comment. We have simplified this section of the scope as more detailed information on groups who may face potential inequalities is included in the Equality Impact Assessment document and the 'groups covered' section of the scope. This now provides detail on the groups you have highlighted such as ethnic minorities, young men, migrants and veterans. The LGBT+ group were flagged by stakeholders at the workshop as a group who are, in general, less likely to access healthcare services.
London School of Hygiene and Tropical Medicine	4	21	List has missed out students and workers in the gambling industry-both recognised vulnerable groups	Thank you for your comment. We have simplified this section of the scope as more detailed information on groups who may face potential inequalities is included in the Equality Impact Assessment document and the 'groups covered' section of the scope This now provides detail on the groups you have highlighted

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				such as young people and those working in the gambling industry.
London School of Hygiene and Tropical Medicine	4	27	This suggests the guideline has an 'all-harms' scope-will need to maintain same scope all way through	Thank you for your comment. The guideline will apply to both people participating in harmful gambling and affected others, and this is reflected in the review questions in section 3.5.
Gordon Moody	5	2	In line with comments made by our colleagues during the scoping workshop the problematic of gambling behaviour can be significant starting with the age of 13. There are already interventions aimed at this group category and we believe that it would be beneficial if the current guidelines will address these issues as well.	Thank you for your comment. As the access to treatment and treatment pathways for children and young people under 18 may be different, the focus of the guideline will be people aged 18 and over. However, we recognise, and have stated in the scope, that the guideline may be applicable to services for those under 18.
Department of Health and Social Care	5	2	In the stakeholder meetings we had discussed this also covering younger age groups, seems a shame this is only for 16 up.	Thank you for your comment. As the access to treatment and treatment pathways for children and young people under 18 may be different, the focus of the guideline will be on people aged 18 and over. However, we recognise, and have stated in the scope, that the guideline may be applicable to services for those under 18, and we have removed the age range in this statement.
Department of Health and Social Care	5	13 - 14	How will that be classified e.g. with PGSI? Potentially tricky as even low levels of gambling cause low levels of harm – will only moderate to severe harms be in scope?	Thank you for your comment. All levels of harmful gambling will be covered by the guideline. The gambling that will not be covered is that which does no harm.

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Gordon Moody	5	18	Healthcare for people who participate in harmful gambling is also provided in the charity and private sector alongside the NHS commissioned services.	Thank you for your comment. We recognise that services for harmful gambling are provided by the charity and private sector, but NICE guidance does not have a mandate to advise these sectors how services should be run. However, as indicated in the list of 'who the guideline is for' we hope other sectors will make use of the guideline to guide their service provision.
London School of Hygiene and Tropical Medicine	5	18	Limiting cover to only NHS-commissioned healthcare (eg not considering Gamblers Anonymous or Gordon Moody for example) is a significant limitation of the value of the guideline	Thank you for your comment. We recognise that services for harmful gambling are provided by the charity and private sector, but NICE guidance does not have a mandate to advise these sectors how services should be run. However, as indicated in the list of 'who the guideline is for' we hope other sectors will make use of the guideline to guide their service provision.
Department of Health and Social Care	5	18	So these won't cover GA commissioned services? What about blended GA/NHSE services, such as the London clinic and Northern Clinic? If so this should be mentioned in the areas not covered on page 6	Thank you for your comment. We recognise that services for harmful gambling are provided by the charity and private sector, and are aware that funding arrangements for blended GA/NHSE services will be changing soon. NICE guidance does not have a mandate to advise other sectors how services should be run. However, as indicated in the list of 'who the guideline is for' we hope other sectors will make use of the guideline to guide their service provision.
Gordon Moody	6	1	Measurement tools used for screening, assessment and diagnosis	Thank you for your comment. Under this key area we have already included a question in section 3.5 of the scope about tools used for identifying and assessing harmful gambling.

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Gordon Moody	6	1	Gambling severity screening as part of GP routine screening tools	Thank you for your comment. Under this key area we have already included a question in section 3.5 of the scope about how GPs can identify people who may be involved in harmful gambling, and on tools that can be used to identify and assess the severity of gambling.
Royal College of Nursing	6	1	Following identification and assessment, details will be needed for the professional on referral pathways and signposting. Will this follow a Making Every Contact Count approach?	Thank you for your comment. Under this key area we have already included a question in section 3.5 of the scope about models of care and delivery of services which will encompass referral pathways. We will discuss the potential use of the Making Every Contact Count approach with the committee when considering this section of the guideline to determine whether it should be considered for inclusion.
London School of Hygiene and Tropical Medicine	6	2	Should 'targeted screening' be added here (if population screening is not within remit) as part of identification	Thank you for your comment. The phrase targeted screening or screening are not used in NICE scopes or guidelines due to the potential for confusion with mandated national screening programmes, as set out by the National Screening Committee. Instead we have used the term case identification, but as described in the draft questions this will include pro-active identification of people who may be involved in harmful gambling.
Gordon Moody	6	4	Triage and referral pathway need to play an important role in the development of best practice guidelines	Thank you for your comment. Under this key area we have already included a question in section 3.5 of the scope about models of care and delivery of services which will encompass referral pathways.

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Department of Health and Social Care	6	5	…for people EXPERIENCING harmful gambling	Thank you for your comment. In this context we are referring specifically to people who participate in harmful gambling so have used that terminology, as 'experiencing' could be construed to mean those who gamble and affected others.
Gordon Moody	6	10	Social care interventions, community interventions, mutual aid and self-exclusion to be evaluated as interventions for harmful gambling	Thank you for your comment and highlighting these additional interventions to us. Under this key area we have already included a question in section 3.5 of the scope about the interventions, and more detail on the interventions to be included will be discussed with the committee when developing the protocol for this review question.
Gordon Moody	6	18	Aftercare and long term recovery maintained interventions (especially developed in co-production with lived experience can play a significant role in best practice development)	Thank you for your comment and for highlighting that co-production is best practice. Under this key area we have already included a question in section 3.5 of the scope about the interventions used to prevent relapse and more detail on the interventions to be included will be discussed with the committee when developing the protocol for this review question.
Gordon Moody	6	21	Outcome measurements tool to be evaluated for each of the intervention types	Thank you for your comment. Outcome measures will be chosen by the committee for each review protocol, to ensure they are relevant to the interventions being considered.
London School of Hygiene and Tropical Medicine	6	30	Says social care interventions not considered but the guideline 'may be relevant' for social care practitioners-again this is a significant limitation.	Thank you for your comment. The Department of Health and Social Care commissioned NICE to develop a clinical guideline on the treatment of gambling, and it will focus on NHS commissioned care.

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				However, the guideline will examine the information and support needs of people affected by harmful gambling ('affected others'), interventions to reduce gambling-related harms for affected others, and models of care which will include referral pathways. All these topics may include some gambling-specific social care interventions, but will not include other social care interventions which are not gambling-specific. These are likely to include services provided by local authorities and the voluntary and community sectors. In addition, the types of interventions delivered by NHS commissioned services for the treatment of harmful gambling do take account of people's wider social contexts and they are also likely to signpost to onward treatment and support, which are likely to include social care interventions and input from social workers. For these reasons, the guideline will not make recommendations specifically for action by social care practitioners but it is intended to be relevant to them, hence the description in this section of the scope.
Royal College of Nursing	6	31	If training of healthcare professionals is not covered where will this be examined? Research shows health professionals reporting gaps in their knowledge to identify gambling harms and how to support a person.	Thank you for your comment. It is not within the remit of NICE guidelines to provide specific details on training that should be provided to assist practitioners implement the guidelines. Instead organisations will need to consider the training required for their staff.
Department of Health and Social Care	7	General	I'd add suicide related guidance, anything for co-morbidities or multi-morbidities	Thank you for your comment. We have added the link to the NICE guideline on preventing suicide. We had already included guidelines on mental health, smoking,

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				alcohol and drug misuse and so have not added any other comorbidities.
London School of Hygiene and Tropical Medicine	7	1	If the guideline is to adopt an 'all-harms' approach then a population wide screening programme SHOULD be considered, given 7-10 people affected by one persons harmful gambling	Thank you for your comment. Population-wide screening programmes are not within the remit of NICE guidelines. Instead we have used the term case identification, but as described in the draft questions this will include pro-active identification of people who may be involved in harmful gambling, and we will discuss with the committee when we develop the review protocols whether this should include those affected by harmful gambling.
Department of Health and Social Care	7	1	Clear that this will not include population wide screening. Will targeted screening be looked at? Not sure I can see this in the other categories outlined before this	Thank you for your comment. The phrase targeted screening or screening are not used in NICE scopes or guidelines due to the potential for confusion with mandated national screening programmes, as set out by the National Screening Committee. Instead we have used the term case identification, but as described in the draft questions this will include pro-active identification of people who may be involved in harmful gambling.
Gordon Moody	7	3	Complex needs care and integrative care should play a role in provision of care	Thank you for your comment. We agree that complex needs and integrative care are important and will take this into consideration when developing the review protocols.
Department of Health and Social Care	8	17	Many other factors could be included e.g. debt, relationship breakdown, homelessness.	Thank you for your comment. We are aware that there are a range of potential factors that may lead to harmful gambling, and this list was not intended to be

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				exhaustive. The factors to be included in the review protocol will be discussed and agreed by the guideline committee.
Gordon Moody	8	21	Need to explore and assess the underlying causes of gambling (i.e. trauma-informed), not just symptom management.	Thank you for your comment. The draft question you have referenced is relating to measurement tools to aid the identification and diagnosis of harmful gambling, rather than the treatment. It is anticipated that the exploration of the causes of gambling will be covered in the draft question about risk factors for harmful gambling, and the factors to be included in the review protocol will be discussed and agreed by the guideline committee.
Betknowmore UK	8	23	Barriers to access information and support also need to be identified. These help explain the low numbers of people seeking help, especially from specific groups such as women. Information support needs and barriers will vary per group.	Thank you for your comment. This question is designed to be a review of qualitative evidence, meaning results will be driven by the data identified, but we anticipate that this will include problems that people have identified when accessing support and information. In addition, in response to yours and other stakeholder comments an additional draft question has been added to the final version of the scope, which focusses specifically on the barriers and facilitators to accessing treatment. This review may provide data about availability of information as a means of support or as a means to access treatment.
Department of Health and Social Care	8	23	Potential additional question – What are the information needs of those serving as first points of contact for those experiencing harmful gambling e.g GPs, Debt Advisors, Mental health staff	Thank you for your suggestion. Although there is not a draft question specifically about the information needs of practitioners it is likely that data pertaining to this will be located by the broad qualitative review about

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				people's experiences of treatment services. In addition, a new draft question has been added to the final version of the scope, in light of stakeholder comments, which will examine evidence about perceived barriers to accessing care. Should the issue of practitioners' information needs arise from the findings of either of these reviews the guideline committee will consider whether and how to use them as a basis for recommendations.
Department of Health and Social Care	8	23 - 26	May also be useful to look at where people are accessing information and support- this may not be in traditional places such as GP- may be wider as financial harms can often be the first harms people are experiencing due to their gambling	Thank you for your suggestion. It is possible that this evidence review will capture findings about people's information and support needs, both in terms of where they are accessed as well as what exactly they should cover. If this is the case then the guideline committee will discuss whether and to what extent they use the data to make recommendations about the location and availability of information and support.
Gordon Moody	8	24	Also look at other people (such as health and social care professional, safer gambling representative, probation officers etc) that might come in contact with people who experience gambling related harm.	Thank you for your suggestion. Although there is not a draft question specifically about the information needs of practitioners it is likely that data pertaining to this will be located by the broad qualitative review about people's experiences of treatment services. In addition, a new draft question has been added to the final version of the scope, in light of stakeholder comments, which will examine evidence about perceived barriers to accessing care. Should the issue of practitioners' information needs arise from the findings of either of these reviews the guideline committee will consider

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				whether and how to use them as a basis for recommendations.
Betknowmore UK	9	1	The effectiveness of interventions such as peer support cannot simply be measured using indicators such as PGSI score. Effectiveness needs to be measured across a the range of possible harms and benefits, including social support networks and legacy harms such as guilt and shame.	Thank you for your comment. We agree that the outcomes for people experiencing harmful gambling are varied, and not limited to those measured by standardised measurement tools. The appropriate outcomes and timeframes will be discussed and defined by the guideline committee when finalising the evidence review protocols for each question.
Betknowmore UK	9	1	Peer support founded on the value of lived experience must be included under 'psychosocial' and have equal status with therapeutic interventions.	Thank you for your comment. The interventions listed in the evidence review protocols will be discussed and defined by the committee, and peer support will be considered for inclusion along with other interventions. Psychosocial interventions will be given the same importance as psychological and pharmacological interventions.
Betknowmore UK	9	7	There is very little work going on in this area in the UK. Evidence from other countries will need to be considered.	Thank you for your comment. The committee will discuss which countries should be included in literature reviews when designing the protocols, in order to identify the most relevant and useful evidence on harmful gambling to help the committee make its recommendations.
Betknowmore UK	9	11	Longer-term considerations need to not just focus upon relapse but also legacy harms, such as shame, debt and poor career prospects, over very long time periods.	Thank you for your comment. The question referenced in your comment is specifically about interventions for relapse prevention, and it therefore may not be appropriate to include the legacy harms as outcomes for this particular review. However, it is anticipated that

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				the longer-term support needs for people (currently or previously) participating in harmful gambling and affected others will be covered by qualitative questions in 'Information and support' and 'Experiences of gambling treatment services' areas.
Betknowmore UK	9	16	Barriers need to be considered to understand why these groups do not come forward.	Thank you for your comment. In response to this an additional draft question has been added to the final version of the scope, which focusses specifically on the barriers and facilitators to accessing treatment. This review may provide data about why certain groups of people do not come forward for treatment and if this is the case then the guideline committee will discuss whether and how to use the evidence as a basis for recommendations to improve access and uptake of treatment.
Betknowmore UK	9	21	Throughout a person's journey through a treatment service, there will usually be multiple points at which they need help from other service providers. Having strong referrals pathways in place is essential.	Thank you for your comment. We agree that referral pathways are an important aspect of managing problem gambling. It is anticipated that this will be addressed not only in the qualitative question you referenced, but also by the quantitative question on different models of care and delivery of services.
Betknowmore UK	9 - 10	30 - 14	The impact of new and emerging forms of gambling (e.g. gaming that does not involve money) are not always captured by existing measurement tools. The PGSI is only of use when applied to people who recognise that have a gambling problem; it should not be used alone be in conjunction with other tools. Measurement of impact should centre on the various forms of capital created by treatment and support (see work by David Best).	Thank you for your suggestion. The measurement tools listed in this section of the scope are merely intended as examples but in light of your comment the outcome 'Recovery capital' has been added and the Life In Recovery Scale has been given as an example for measuring this.

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Department of Health and Social Care	10	10	Could include AUDIT here for the screening of alcohol use	Thank you for your comment. We have amended the scope to add AUDIT as an example tool.
Gordon Moody	10	14	As mentioned by our colleagues in the scoping workshop defining and evaluating longitudinal recovery can play a crucial role is shaping best practice.	Thank you for your comment. We agree that the considerations for shorter- and longer-term management of problem gambling are different, and both should be considered. We propose that longitudinal recovery will be captured by using a defined timeframe in the evidence review protocols, which will be developed through discussion with the guideline committee.

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