Consultation on draft guideline - Stakeholder comments table Registered stakeholders
05/10/2023 to 15/11/2023

Stakeholder	Document	Page No	Line No	**Comments** Please insert each new comment in a new row	**Developer's response** Please respond to each comment
NIHR, Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London	Guideline	1	7	Text box - Under heading 'Who is it for' suggest altering wording to include social care professionals – currently indicates only for 'healthcare professionals' which contradicts later guidance (e.g. P4) that social care professionals also have a role to play in identifying and supporting those affected by gambling harms. Suggest 'Health and social care professionals' more appropriate.	Thank you for your comment. Social care practitioners have been added.
Gambling with Lives	Guideline	1	General	Age as a risk factor We are concerned by the failure to address age as a significant risk factor and to include age as a significant indicator in the identification of gambling harms. Evidence indicates that the highest addiction and at-risk rates are within the 35-34 age group, followed by the 16–24 and 18 – 25 (1). Research indicates that young people are most vulnerable to experiencing gambling harm when they achieve independence from their parents and	Thank you for your comment. The committee originally decided not to include demographic factors (age, sex) in the risk factors for gambling, and to focus on more specific non-demographic risk factors. However, the committee later agreed that with the advent of online access to gambling via smartphones and other devices, it was now worth noting that young people leaving home for the first time was a group that was particularly at risk and so added this to the at-risk groups.

				move out of home, often to study at university or college or starting their first job (2). HCPs must be aware that this is a particularly vulnerable time for a young person when assessing their risk or exposure to gambling harm. This is a significant omission and the opportunity to make early identification of harm may be missed resulting in increased severity and possible deaths. References https://assets.ctfassets.net/j16ev64qyf6l/60qlzeoSZIJ2QxByMAGJqz/e3af209d552b08c16566a217ed422e68/Gambling-behaviour-in-Great-Britain-2016.pdf https://www.gamblingcommission.gov.uk/statistics-and-research/publication/exploring-the-gambling-journeys-of-young-people	

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Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	1	General	Although the context for the guideline is detailed on pp 40-42, we think that it would be helpful to set out a clear summary statement at the front that identifies: A whole systems approach. Effective specialist gambling harms services will be integrated and work in partnership at all levels with organisations across health, social and criminal justice systems, and with voluntary, community and neighbourhood based agencies and resources. A Public Health perspective. Although public health interventions lie outside the remit of this guideline, effective specialist gambling harms services will promote awareness of Gambling Industry harms experienced by local populations ('affected others') and individuals, and their impact on identification, treatment and supporting recovery.	Thank you for your comment. It is not usual practice to include a summary at the start of guidelines as it is preferable for people to read the complete recommendations in context in the guideline. The models of care recommendations already provide advice on the integration of care and partnership between services. The recommendations on information and support already include advice on informing people about gambling industry harms.

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Adferiad	Guid eline	3	002 - 004	The absence of evidence would suggest that the Guideline should not yet be recommending NHS treatment for those with a PGSI score of 8 and above until there are sufficient outcomes to support this recommendation.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

Betknowmore UK	Guid eline	4	3	1.1 -Research led by Kings College London, https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcad155/7205469, has shown that there is resistance among social care staff to asking questions on gambling harms. The research shows that considerable training and institutional buy-in are needed to ensure staff ask questions about gambling. Practical barriers also exist such as the contracting out of data management systems, which means recording gambling harms data required time consuming and expensive changes. The Guideline underplays the barriers to change.	Thank you for your comment. The committee recognise that there may be barriers to change and that implementation of these recommendations will require training and buy-in from health, social care and other organisations, but the aim of the guideline is to change practice and increase the identification and successful treatment of gambling-related harms. This will require changes in practice, such as including questions about gambling in core assessment questions, which will, over time, need to be included in individual operational systems.

Betknowmore UK	Guideline	4	3	1.1 - Evidence, e.g. https://doi.org/10.1038/s41562-020-01045-w, suggests that a person's engagement in harmful gambling can fluctuate and worsen rapidly so asking a question about gambling harms, or applying the PGSI, just once, may not capture accurately gambling harms. The PGSI would have to be taken on numerous occasions and median score derived. This is one of the PGSI's weaknesses which explains why NGSN providers do not rely solely upon it to assess client needs and pathways.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. These recommendations include advice on the need to recognise the variable nature of gambling severity.
GamCare	Guideline	4	004 - 006	GamCare welcomes the recognition that the recommendations in this guideline are for 'health and social care practitioners', but notes the distinction drawn within this section between such practitioners and 'people working in the voluntary, community and social enterprise sectors.'	Thank you for your comment. The guideline has been amended to clarify that this applies to health and social care professionals working in all settings.

				Charitable organisations that comprise the National Gambling Support Network (NGSN), including GamCare and Primary Care Gambling Service could under this definition, not be considered 'health and care practitioners' for the purposes of this guideline, while at the same time providing high-quality, evidence-based, and effective treatment and support for all those directly or indirectly affected by gambling related harms.	
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	4	5	Rec 1.1. - The recommendations could have wider application for example across Defence. We are aware that MoF are keen to align their approach to treatment provision.	Thank you for your comment. The guideline has been amended to clarify that this applies to health and social care professionals working in all settings, and that would include defence.
Gambling Harm UK	Guid eline	4	7	We suggest practitioners initially ask about 'gambling harm' instead of 'gambling' to include consideration for affected other harms.	Thank you for your comment. This recommendation sets out the principle of asking about gambling in general. More details about the actual questions to be asked are covered in a later recommendation.

NIHR, Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London	Guideline	4	10	Evidence from our study (https://www.kcl.ac.uk/research/identifying-gambling-harms) suggests that rapport-building is important in enabling disclosure of gambling harms. Would therefore suggest removal of 'first' contact with social services as this suggests it is only suitable to be included in initial assessments whereas annual reviews or similar may also be suitable. Wording could be '…or in contacts with social services.'	Thank you for your comment. This has been changed to 'or in contacts…' as you suggest.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	4	10	Para 1.1.1 Consider adding 'or health checks by occupational health departments, including for NHS and LA employers'.	Thank you for your comment. These are examples only, and there are many situations where health checks are carried out so it is not possible to list them all.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	4	11	We should not exclude asking other groups of people about their gambling behaviour. In a prison setting we are looking to have generic questions that everyone will be asked at different key points e.g. on reception, on release as some people may present with none of these signs or may not be ready to talk about their gambling behaviour at that point in time. Maybe a line should be included that says these groups are not exhaustive and some people may present with none of these signs. HMPPS are looking at ways to introduce screening questions to pick up those in prison and those under probation supervision. This will have a resource implication both in terms of asking the questions, having interventions in place and staff training.	Thank you for your comment. This recommendation relates to risk factors that should heighten concern about gambling, it is not the only situation in which gambling should be asked about. The previous recommendation relates to asking about gambling at any health check or assessment and so this would cover the 'key points' you have mentioned in your comment, and there are therefore no limits to the range of people or circumstances when questions about gambling could be asked. This has been clarified by adding 'even if they have no previous risk factors'. Thank you for informing us about the work happening in the criminal justice system to introduce screening questions as this aligns well with the guideline recommendations. The resource impact of this new recommendation has now been acknowledged by the committee in the impact statement.
Gambling Harm UK	Guid eline	4	11	We suggest practitioners initially ask about 'gambling harm' instead of 'gambling' to include consideration for affected other harms.	Thank you for your comment. This recommendation sets out the principle of asking about gambling in general. More details about the actual questions to be asked are covered in a later recommendation.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	4	011 - 012	1.1.2 - Ask people about gambling in the following situations, because they may be at increased risk of harm: - Not just harm to self but also to others.	Thank you for your comment. The evidence for this review identified these as factors that increase the risk of a person being involved in gambling that harms. It did not identify that these factors increased harm to others so this change has not been made.

GamCare	Guideline	4	011-021	GamCare supports this proposed intervention within the criminal justice system. GamCare's Criminal Justice and Gambling Harm (CJGH) programme is an innovative two-year initiative developing a test and learn approach to improve awareness of gambling harms, access to treatment and support for people across the criminal justice system, while contributing to an emerging evidence base. There are links between harmful gambling and crime, including, for example, crime committed to support gambling or to pay off gambling-related debts. Gambling-related offending may also include fraud, theft, domestic and financial abuse and links into wider criminality or criminal circles.	Thank you for your comment, for sharing details of the work GamCare does with the criminal justice system and for highlighting the need for gambling services to be available to the criminal justice system. The need to include people within the criminal justice system in assessment and treatment is included in the recommendations on models of care and service delivery, and other recommendations on identification, information, access and treatment.

				GamCare's criminal justice programme is working towards ensuring that every person within or having contact with the Criminal Justice System (CJS) is screened for their gambling behaviours or experience of gambling related harms. Every interaction a criminal justice professional has with a potential or actual offender, or their family members is an opportunity to identify gambling harms and offer support or signposting. This should be supported with relevant information, resources, and training at all stages of the CJS from arrest right through to courts, prisons, and probation. Commissioned services should have access to regional gambling treatment services. We look forward to working with criminal justice services to ensure this proposal is implemented effectively in the criminal justice system.	

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	4	13	Para 1.1.2 Consider giving examples of settings where people may present with a mental health problem or concern, such as NHS Talking Therapies / IAPT services; community mental health services; in-patient services; and A&E.	Thank you for your comment. The recommendation includes the wording 'in any setting' and includes a list of example conditions, so a list of example settings has not been added.
His Majesty's Prison and Probation Service (HMPPS)	Guid eline	4	17	We should also be asking people questions about gambling on release from prison too. Often people in prison will have been forced to stop some types of gambling. Going back out into the community with no follow-on support could mean someone relapses and goes straight back to their gambling behaviour prior to prison.	Thank you for your comment. The wording 'new contact' has been changed to 'key contact' to increase the opportunities for asking about gambling in the criminal justice system.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	4	17	Could there be a specific section on working with people in the CJS. The guidelines do mention the CJS but more clarity would be welcomed on and what specific guidelines should be in place for sentencers in court, the probation and prison service and those in police custody & L&D services – are there any specific needs? Could they also be asked if these issues are also affecting their families (paying off debts etc.)	Thank you for your comment. The guideline includes all settings where gambling that harms may be identified, and all settings where NHS-commissioned support and treatment is provided, including the criminal justice system. The need to include people within the criminal justice system in assessment and treatment is included in the recommendations on models of care and service delivery, and other recommendations on identification, information, access and treatment. However, specific procedures relating to implementation within the criminal justice system are not covered as this level of detail is not usually included in NICE guidelines. This comment will be passed on to the NICE team responsible for implementation support.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	4	020 - 021	Rec 1.1.2 - Language should be amended to say 'when they present with issues relating to drinking or drug use' as opposed to using addiction.	Thank you for your comment. The word addiction has been removed and the alternative '…problems relating to alcohol or substance dependence' has been used instead.

Royal College of Psychiatrists	Guideline	4	General	It seems that clinicians should consider asking about gambling in all encounters? If so, the section could state e.g. ask about gambling when taking a psychiatric history and/or assessing mental state.	Thank you for your comment. The first bullet of this recommendation states that people should be asked 'when they present in any setting with a mental health problem or concern...' and the previous recommendation advises to ask in any setting as part of an assessment or health check and so this already covers the scenarios you have suggested.
NIHR, Policy Research Unit in Health and Social Care Workforce, The Policy	Guideline	4	General	Evidence suggests that staff in social care can feel unprepared to ask the question about gambling as this is not in their usual scope of practice (see https://www.tandfonline.com/doi/abs/10.1080/09503153.2018.1545015).	Thank you for your comment. It is recognised that some training may be required for staff to implement the recommendations in this guideline relating to identifying harmful gambling, and the recommendations do not imply otherwise. The committee recognise that implementation of these recommendations will require training and buy-in from health, social care and other organisations, but the

Institute, King's College London				These recommendations imply that staff do not currently need any additional training or support to ask a question about gambling harms. Our recent study (findings in draft awaiting publication) indicates that this is not the case in practice. Staff should receive training to ensure that asking a question is not a 'tick-box' exercise, that they are aware of the impact of stigma and shame on disclosing gambling harms and that they feel confident and comfortable in signposting and supporting people who disclose a concern. An example of this training and additional guidance (aimed at social care staff) can be found: https://www.kcl.ac.uk/research/identifying-gambling-harms . It is also important to be aware that there is risk of triggering those staff who have experienced gambling-related harms themselves and that ongoing support should be provided.	aim of the guideline is to change practice and increase the identification and successful treatment of gambling-related harms. Thank you for sharing the training resources you have developed and this has been passed to the NICE team responsible for implementation. There will be some resource implications in implementing these recommendations and these have now been acknowledged by the committee in the impact statement, but effective early identification and treatment may reduce the number of people experiencing longer term or more serious harm from gambling, which may lead to savings to the NHS and wider public sector.

				Providing staff training around gambling harms would have cost implications, as would altering client management systems to record responses to a gambling harms question. (https://www.kcl.ac.uk/research/identifying-gambling-harms)	
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	004 - 005	General	Case identification, assessment and initial support Asking about gambling We think this is a helpful section. It conforms to the principles underlying 'Making Every Contact Count' [MECC] which enables the delivery of consistent health and wellbeing information and encourages individuals to engage in conversations about their health at scale across organisations and communities.	Thank you for your support of this recommendation.
GamCare	Guideline	5	001 - 006	GamCare welcomes this proposal and look forward to supporting those who are working in the housing sector to appropriately seek opportunities for early intervention. We recommend that housing is also included within the guideline.	Thank you for your comment, support for these recommendations, and for sharing the work GamCare does in this sector. The section of the guideline on asking about gambling applies in all settings and so this would include those working in the housing sector.

				GamCare's GAP programme (in partnership with Breakeven, Aquarius and NECA) provides training both face to face and online, offered across England, Scotland and Wales. It aims to reduce gambling-related harm by enhancing the capability of diverse professionals to undertake early intervention and prevention and raises the awareness of the issues related to housing, homelessness, and gambling harms. This programme has identified housing and homelessness as a key opportunity for early intervention. NGSN providers such as GamCare, embedded in local settings are well placed to work directly with the housing sector, particularly with hostels, supported accommodation, refuges and similar settings.	
Betknowmore UK	Guid eline	5	2	1.1.2 - Use of food banks may be an indicator of financial problems.	Thank you for your comment. The committee discussed that the use of foodbanks may be an indicator of financial concerns, but agreed that a number of other activities would also indicate this and it was not possible to list them all, so they left the recommendation as 'financial concerns'.

Betknowmore UK	Guideline	5	3	1.1.2 - There is considerable research evidence of a relationship between gambling and all forms of domestic abuse, sometimes victimising the person gambling and sometimes affected others. The need for specific questions around financial, economic, physical, emotional abuse and coercive control should be recognised in the Guideline.	Thank you for your comment. This recommendation is designed to encourage use of a simple question which can be used in all settings, and the groups you mention are already highlighted as being at particular risk of gambling harms. Detailed questioning about domestic abuse would form part of the assessment of gambling-related harms or as part of the support for affected others, which are covered in later sections of the guideline.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	5	005 - 006	Rec 1.1.2 – Is there evidence to support the recommendation that anyone with a family history of any addiction should be asked about gambling? Would it be better to focus on anyone with a family history of issues with gambling / harmful gambling / gambling harms?	Thank you for your comment. There was evidence that a family history of alcohol and drug addiction and a family history of gambling were associated with an increased risk of gambling that harms (please see evidence review A) which are both listed in this recommendation, so this has not been amended.
Haringey Public Health Department	Guideline	5	7	1.1.3 - In terms of persons on medications being at risk, the only drugs mentioned are dopamine agonists. Are there other neuro-modulatory drugs which are higher risk? E.g., benzodiazepines, opioid painkillers, etc.	Thank you for your comment. Increased risk of gambling is not reported for benzodiazepines or opioids so these have not been added.

Parkinson's UK	Guid eline	5	7	Pathological gambling is seven times more common in people with Parkinson's than in the general population. It occurs in about 6% of people with Parkinson's on dopamine agonists and 2% of those on other drugs used to treat Parkinson's (mainly Levodopa). Therefore, we are pleased to see that Parkinson's is noted in the guidelines as a risk factor due to the medications that may be prescribed.	Thank you for your comment. As the focus of the guideline is on gambling-related harms the committee decided that it would not be appropriate to extend the recommendations to cover discussions about shopping and hypersexuality. However, a link to the impulse control disorders section of the NICE guideline on Parkinson's disease has been added to provide more information on this topic and this includes information on the temporal relationship between impulse control disorders and dopaminergic agents.

				We recommend the guideline be changed to ask people with Parkinson's on these medications about gambling alongside other impulse control disorders such as shopping habits and hypersexuality at each appointment or review. This is also important as people with Parkinson's who we spoke to mentioned that they had not fully appreciated the link between their medication and the risk of gambling when first prescribed. This is relevant because there can be a considerable delay between starting treatment on these drugs and the onset of gambling. ((Skelly, R. (2020). Gambling Addiction and Parkinson's disease - supporting better patient care. Royal College of Physicians. Accessed online 15 Nov 23 at https://www.rcplondon.ac.uk/news/gambling-addiction-and-parkinson-s-disease-supporting-better-patient-care).	

Haringey Public Health Department	Guideline	5	7	1.1.3 - A group at risk is named as person with “neurological conditions” - does this mean every neurological condition, like epilepsy and stroke, or is this more limited to certain types of frontal strokes and frontal neuro-degenerative conditions which have consequences on impulse behaviour? Would be helpful to clarify.	Thank you for your comment. The committee have expanded this recommendation to clarify that it is neurological conditions which lead to disinhibition or increased impulsivity.
Medicines optimisation team, Centre for Guidelines, NICE	Guideline	5	10	Rec 1.1.3 first bullet point - The Parkinsons disease guideline (NG71) includes a section on recommendations on managing and monitoring impulse control disorders as an adverse effect of dopaminergic therapy. Could a link be included to this to highlight these recommendations.	Thank you for your comment. This link has been added.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	5	010 - 011	Consider insert to include: bipolar affective disorder or dementia	Thank you for your comment. Bipolar disorder has been added to this recommendation. The committee decided that the reduced disinhibition sometimes seen in dementia was now included in the subsequent recommendation on neurological conditions or acquired brain injury.

GambleAware	Guideline	5	012 - 013	People working in emergency services as well as students living away from home for the first time should be included in this list, as these are both groups that frequently access specialist provision.	Thank you for your comment. The committee added an additional bullet point about students living away from home for the first time, but agreed that the professional groups were only examples and that they were not aware of increased risk in emergency services personnel.
Gordon Moody	Guideline	5	18	Recommendation 1.1.5 of using direct questions about people gambling, has two main limitations, one being the stigma that a person affected by gambling harms might associate with those questions and two, that for people who do gamble, but they are not affected by gambling related harm this question would provide no insight.	Thank you for your comment. Use of direct questions about gambling at routine assessments for everybody will hopefully, over time, reduce the stigma associated with this, just as people are now used to being asked about smoking, alcohol and exercise. The questions do not refer to gambling harms, but just refer to 'worry' about gambling as the committee decided this would be more likely to be understood by people.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	5	18	Rec 1.1.5 – Suggest that 'gambling' is clarified when people are asked so they understand how this relates to them. People may use different language and may not consider some products as gambling e.g. online bingo - therefore examples should be given.	Thank you for your comment. These direct questions are designed as a brief, easy to use starting point to identify if people have worries about gambling, so it would complicate the questions to include a list of examples. However, the committee agree that people may not appreciate that some activities are gambling and advised that this increased awareness of what constitutes gambling would be better addressed by public health campaigns and information.
GambleAware	Guid eline	5	18	Asking "Do you gamble?" is a potentially stigmatising question. It focuses on the activity rather than the harms it causes, and ignores affected others. A better option would be: "Do you feel you are affected by gambling, either your own or someone else's?"	Thank you for your comment. Use of direct questions about gambling at routine assessments for everybody will hopefully, over time, reduce the stigma associated with this, just as people are now used to being asked about smoking, alcohol and exercise. Two questions are suggested, the second of which focuses on worries about 'your own or another person's gambling' so this is already included in the guideline.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	5	18	Direct questions can often close people down, it might be better to ask general question about finances first i.e. has money been a concern? Or have you ever had financial difficulties?	Thank you for your comment. These direct questions are designed as a brief, easy to use starting point to identify if people have worries about gambling, and worries about money could be due to a variety of reasons and so will not necessarily identify gambling that harms. These questions are designed to start a conversation and other topics to discuss are covered in subsequent recommendations on initial support.
Gambling Harm UK	Guid eline	5	18	We suggest practitioners initially ask about 'gambling harm' instead of 'gambling' to include consideration for affected other harms.	Thank you for your comment. Two questions are suggested, the second of which focuses on worries about 'your own or another person's gambling' so this is already included in the guideline.
Haringey Public Health Department	Guid eline	5	18	1.1.5 - Good screening questions but perhaps there could be an expansion of other important questions to spin off. Around best practice for wording - KCL are working on which question is best.	Thank you for your comment. The committee were aware of the KCL work and the questions included in the guideline are almost identical to those developed by KCL, but the committee decided that the simple questions they had developed were easier to use and more natural but would elicit exactly the same information. These are designed to start a conversation and other topics to discuss are covered in subsequent recommendations on initial support.

NIHR, Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London	Guideline	5	18	The following two questions were developed for use in adult social care settings and found to be valid and reliable against gold standard measures used for clinical diagnosis of gambling harms. See study details (https://www.kcl.ac.uk/research/identifying-gambling-harms) Is your own gambling or that of someone else causing you any worries? Do you feel you are affected by any gambling, either your own or someone else's?	Thank you for your comment. The committee were aware of the KCL work and the questions included in the guideline are almost identical to those developed by KCL, but the committee decided that the simple questions they had developed were easier to use and more natural but would elicit exactly the same information.
Gambling with Lives	Guideline	5	018 - 020	1.1.5 - Consider different language here: Instead of 'Are you worried about your own or another person's gambling?' how about 'Are you worried you are being harmed by gambling?'	Thank you for your comment. The committee decided that people may not perceive that they are being harmed by gambling and that 'worried about' was a broader term which would be more easily understood.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	5	020 - 021	Although this is elaborated on page 13 Overcoming stigma, consider inserting a statement recognising why people may be hesitant to talk about gambling harms and the shame or stigma they may experience. This requires a non-confrontational, non-judgemental and compassionate approach by others.	Thank you for your comment. The committee have moved a key recommendation about stigma to the front of the guidelines and also added a sentence to this recommendation to raise awareness that there may be reluctance to talk about gambling.

GambleAware	Guideline	5	021-024	The NHS link provided is not a questionnaire that users can complete on the webpage, meaning it has to be printed out or undertaken offline with reference to the webpage. This is likely to impact uptake and potentially limit the number of people struggling with gambling harm who will be identified through this route. In addition, the provision of threshold information alongside scoring guidance means there is a risk users may amend their answers to receive a particular score, further impacting the value of the assessment tool. GambleAware has developed an assessment tool that should be signposted in the final guideline: https://www.begambleaware.org/self-assessment-tool-entry.	Thank you for your comment. The committee advised that the NHS webpages on gambling will need amending as a result of the development of this guideline, and this will ideally include making the NHS PGSI tool interactive. This has also been passed onto the NICE implementation team. Thank you for informing us about the GambleAware interactive tool – the committee expect that this or a similar service will continue to be available as the planned change to NHS-commissioning arrangements are implemented.

				This is an interactive tool that provides a recommendation for what to do next and where to go for help, depending on responses. This includes instant access to a 24/7 online chat run by GamCare if harms are identified. Since its launch in April, the tool has been completed 71,000 times – equivalent to over 11,000 completions per month – with almost 60% of these users taking action afterwards (including calling the National Gambling Helpline or using the online live chat).	

NECA (Charity Number 516516)	Guid eline	5	21	1.1.6 - The recommended use of PGSI as the sole criteria is not sufficient measure or true reflection of beneficiaries' Gambling Related Harm. The PGSI is a snapshot measurement of a very short timeframe. The nature of gambling and the impacts it causes can change significantly and the questionnaire is not the most accurate representation of an individual's full gambling harms journey and presentation when used alone. The questions used within the PGSI are relatively broad and do not capture the full clinical presentation.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has been amended to clarify that treatment services should be commissioned by the NHS (not just the currently available specialist gambling clinics), but they may be provided by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured following the introduction of the statutory levy.

				Seek support ……. Currently the NHS commissioned services are the minority provider of care, though are utilised for complex cases –To solely promote one service is highly likely to engender risk for the individual coupled with the destabilisation of current services causing additional risks to those with Gambling related harm. Individuals should have access to a range of services, with choice, as we must not introduce potential barriers to care in a field where the presentation rate is, sadly, low.	

Parkinson's UK	Guideline	5	21	The questionnaire for impulsive-compulsive disorders in Parkinson's Disease (QUIP) is a validated screening tool for assessing pathological gambling in people with Parkinson's. Discriminant validity is high for gambling (=0.95). Sensitivity, when combined with other impulsive-compulsive behaviours, was 96%. For the shortened version (QUIP-S) sensitivity is 94%. (Weintraub, D., Hoops, S., Shea, J. A., Lyons, K. E., Pahwa, R., Driver-Dunckley, E. D., Adler, C. H., Potenza, M. N., Miyasaki, J., Siderowf, A. D., Duda, J. E., Hurtig, H. I., Colcher, A., Horn, S. S., Stern, M. B., & Voon, V. (2009). Validation of the questionnaire for impulsive-compulsive disorders in Parkinson's disease. Movement disorders : official journal of the Movement Disorder Society, 24(10), 1461–1467. https://doi.org/10.1002/mds.22571). We believe the guideline should recommend the use of the questionnaire for impulsive-compulsive disorders in Parkinson's Disease (QUIP) instead for people with Parkinson's.	Thank you for your comment. The committee recognise that people being treated for Parkinson's disease may be at a higher risk of gambling and have included this in the recommendations on at-risk groups, but did not specifically examine evidence for screening tools in this population and so have not included the QUIP or QUIP-S. However, the use of this tool has been passed to the NICE surveillance team for consideration when the NICE guideline on Parkinson's disease is updated.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	5	21	Rec 1.1.6 - Suggest rephrasing the sentence 'encourage people to assess the severity of their gambling…' with 'Encourage people to assess if their gambling is causing harm (or) potentially harmful'.	Thank you for your comment. The wording has been amended to refer to harms and not severity, as you suggest.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	5	21	Not sure if telling someone that they have a score of 8 or more is going to be helpful, maybe it would be better to introduce them to the tool and have an open discussion about the findings.	Thank you for your comment. This section of the guideline relates to the initial support to be provided in any setting and so the PGSI tool is suggested as a way of encouraging people to identify their gambling-related harms. It is unlikely that all of the people encouraged to ask the initial 'do you gamble' question would be able to have a detailed discussion about the PGSI tool findings so it has not been added to this section of the guideline.

Breakeven (Charity no 1158156)	Guid eline	5	21	1.1.6 The recommended use of PGSI as the sole criteria is not a sufficient measure or true reflection of Gambling Related Harm. The PGSI is a snapshot measurement of a very short timeframe. The nature of gambling and the impacts it causes can change significantly and the questionnaire is not the most accurate representation of an individual's full gambling harms journey and presentation when used alone. The questions used within the PGSI are relatively broad and do not capture the full clinical presentation of the individual and their specific needs. Some of the questions can be answered with a Top score of 3 and still not be regarded as current Problematic Gambler.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

Royal College of General Practitioners	Guid eline	5	21	Rec 1.1.6 - We are concerned that this recommendation suggests that anyone with a PGSI score over 8 should be referred to a specialist NHS-commissioned treatment service. There are a range of factors that determine the most appropriate treatment for people who experience problems with gambling such as comorbid alcohol problems, mental health conditions, social support, treatment history, treatment preference, and self-harm, all of which have been identified as common complications of gambling-related disorders. Therefore, these factors must be considered alongside the level of problem gambling severity when considering the appropriateness of different types of support, or treatment	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

RCA Trust	Guideline	5	21	1.1.6 The recommended use of PGSI as the sole criteria is not sufficient measure or true reflection of a beneficiaries Gambling Related Harm. The PGSI is a snapshot measurement of a very short timeframe. The nature of gambling and the impacts it causes can change significantly and the questionnaire is not the most accurate representation of an individual's full gambling harms journey and presentation when used alone. The questions used within the PGSI are relatively broad and do not capture the full clinical presentation of the individual and their specific needs, which has already been addressed within this response.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.
Haringey Public Health Department	Guideline	5	21	Full PGSI questionnaire not the most accessible for many patients. Consider using the short-form Gast-G form or alternative short form.	Thank you for your comment. The questionnaire on the NHS website is designed for use by people independently, and is accessible by everyone with internet access. The committee advised that the NHS webpages on gambling will need amending as a result of the development of this guideline, and this will ideally include making the NHS PGSI tool interactive. This has therefore not been changed to the Gast-G form.

Haringey Public Health Department	Guid eline	5	21	Referring only to NHS gambling services when they have limited capacity and are not fully embedded may not be the most suitable option – especially given they are in limited geographic areas. Should also refer to lived experience support groups or alternative statutory or voluntary specialist gambling treatment services, especially if they have more local provision.	Thank you for your comment. The recommendations have been amended to differentiate services into gambling support services and gambling treatment services and to clarify what different levels of services will provide. It is specified that treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured following the introduction of the statutory levy.

Ara recovery for all (Addiction Recovery Agency Ltd. Charity Number 1002224)	Guid eline	5	21	1.1.6 The recommended use of PGSI as the sole criteria is not sufficient measure or true reflection of a beneficiaries Gambling Related Harm. The PGSI is a snapshot measurement of a very short timeframe. The nature of gambling and the impacts it causes can change significantly and the questionnaire is not the most accurate representation of an individual's full gambling harms journey and presentation when used alone. The questions used within the PGSI are relatively broad and do not capture the full clinical presentation of the individual and their specific needs, which has already been addressed within this response.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

Betknowmore UK	Guideline	5	021 - 025	The PGSI is used in surveys such as the Health Survey for England, Scottish Health Survey and the Welsh Problem Gambling Survey. The PGSI was specifically developed for use among the general population rather than within a clinical context. The application of the PGSI alone is insufficient to capture gambling harms, and has no applicability to affected others. Evidence Review B acknowledges the absence of a validated short screening tool for gambling harms. The use of the PGSI on the grounds that it is the most commonly used tool is not a sufficient basis for it being the primary means to assess the extent of gambling harms and the appropriate care pathway. The NICE Guideline is supposed to be evidence based, and yet there is no evidence the PGSI is a robust validated tool that should be used in the way the Guideline proposes.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. The committee acknowledged the lack of evidence for PGSI (and other assessment tools) and made a research recommendation.

Gordon Moody	Guid eline	5	021 - 025	Recommendation 1.1.6 and 1.1.7 on using a PGSI threshold of 8 to advise people to seek support for NHS-commissioned specialist gambling treatment services has a series of limitations:	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services (including

				The vast majority (95-90%) of gambling related support is not provided by NHS-commissioned services, but by third-sector charity services. Signposting/referring everyone with the PGSI score higher than 8 to NHS could create a great demand-offer imbalance. We would also like to see a series of recommendations based on different score levels under 8 There is no evidence that people require treatment at PGSI scores higher than 8, but the PGSI tool only indicates that at this score there is a “likelihood of problem gambling”. The PGSI tool fails to capture a number of important dimensions of harm, including those experienced by others than gamblers themselves (affected others), meaning they are potentially underestimating the scale of the problem. There is no evidence for creating different threshold between the score of 8 and the maximum score of 27. This is a wide scoring range which should call for a more stratified approach of tier-level support recommendations.	specialist gambling clinics and community-based gambling treatment services) to clarify what different levels of services will provide. Following the planned reorganisation of gambling treatment services, services will be commissioned by the NHS but are likely to be delivered by a range of providers.

				There is significant criticism against the use of the PGSI tool and caution is often recommended before using the tool as a population wide screening. Research suggested that some of the questions can contain ambiguity and are results are highly dependent on subjective interpretation (Samuelson et al., 2019), the tool is considered weak in assessing low to moderate problem severity (Currie et al.,2013, Miller et al.,2013) and it has very little evidence of clinical utility and of justifying item-level weights. (Browne et al., 2022; Miller et al., 2013) There is also criticism in using PGSI with older adults (Gorenko and Cornet, 2023) and PGSI can exhibit high false-positive and considerable false-negative misclassification errors with a series of different population groups (Otto et al, 2020). We believe that local community recovery and support options and service-user choice should be considered as first lines of support before people would access NHS.	

GamCare	Guideline	5	021 - 025	GamCare recommends that the committee reconsider using PGSI as a tool for determining someone's treatment pathway. The guideline highlights that for PGSI in particular, the Committee's found that 'there was no evidence for the accuracy of the PGSI in people presenting to a gambling treatment service.' GamCare agrees that the PGSI tool in and of itself is not sufficient to determine levels of harm, and a layered and 'stepped' approach is necessary. PGSI is used by the broad range of charities across the NGSN to assess the extent of a person's recovery, not their support pathway. It is therefore not a sufficiently robust clinical means to assess a client's level of gambling harms. A more comprehensive approach to assessing risk of gambling-related harms can be developed through using a range of tools, including the CORE-10, GAD-7 etc., coupled with a clear and patient-centred explanation of the range of support options available, thus respecting client choice. Evidence suggests that a person's engagement in harmful gambling can fluctuate and worsen rapidly so applying the PGSI just once may not accurately capture gambling harms given it represents only a brief measurement. It would need to be taken on numerous occasions and median score derived. This is one weakness in the PGSI which explains why providers of 'specialist' treatment and support across the	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services (including specialist gambling clinics and community-based gambling treatment services) to clarify what different levels of services will provide. Following the planned reorganisation of gambling treatment services, services will be commissioned by the NHS but are likely to be delivered by a range of providers.

				NGSN providers do not rely solely upon it. In fact, the PGSI was developed for use among the general population rather than in a clinical context and is not in and of itself sufficient to capture gambling harms.	

				More appropriate and cost effective is application of a stratified community-based care-coordinated model to determine the pathway, and to facilitate referral to NHS services where possible. This further enables the greater patient choice outlined above. Such an approach more comprehensively identifies individual needs based on an assessment of multiple factors e.g., underlying mechanisms, risk factors, additional needs, previous responses to treatment. Treatment and support charities in the third sector, including through the NGSN, as community leads for Gambling Related Harms, are expertly experienced and strategically placed to deliver this.	

				In this context, rather than direct referral for clinical interventions to the NHS (an absolutely integral component), anyone with an 8+ PGSI score should be referred directly to a practitioner within a local NGSN gambling support provider in the first instance to complete (as is already the case and working effectively) a comprehensive assessment to gain a full understanding of their requirements, support needs, co-morbidities, clinical risk, safeguarding and complexities. This stratified model to assess need before deciding the most appropriate care pathway enables a system that can promote community-based long-term recovery over clinical interventions and treatment, which should not necessarily be the first point of support for everyone experiencing harms (although naturally being the first point of support for some people).	

				This model has a further advantage of being agile to adapting services to the person's expectations and preferences, in line with NICE's existing guidance and recommendations which identify person-centred care as central to good quality health services. It is supportive of the NHS Constitution for England's commitment to support individuals to promote and manage their own health. NHS services should reflect and be tailored to the needs and preferences of service users. As outlined below, in the context of treatment and support for gambling related harms, direct referral into NHS clinical services, should this be the ambition of the guideline, may not best serve the needs of patients/clients, the development of locally integrated services with the NHS, or the NHS itself (in terms of cost-effectiveness or capacity). Whilst Tier 3B and 4 treatment such as NHS clinics can play an important factor in many people's recovery, it is often time-limited and intensive, while existing third sector services already offer meet the clinical, emotional, social, and practical needs of all but the most complex cases. However, providers across the NGSN do also routinely make referrals to NHS gambling clinics and we agree that these referrals are vital. This is why NGSN providers are working alongside GambleAware and the NHS to establish collaborative arrangements that ensure service users are appropriately and effectively transitioned between the NGSN and NHS. Evidence-based recovery before treatment (the support model adopted by other addiction services) incorporates lived experience, best facilitated by community-services, not NHS clinics.	

				It uses community engagement and early intervention, through lived experience and multiple support networks, to facilitate recovery. The power of communities and peers is central to the model adopted in the current drug strategy. Through active community engagement, aftercare blends with prevention and early intervention in a model where recovery is the aim and specialist treatment reserved for the most complex cases.	

GamCare	Guideline	5	021 - 025	GamCare recommends that the guideline removes reference to 'specialist gambling service' and 'specialist treatment' drawing attention to the ambiguity of language in relation to the draft guideline's definition of 'specialist' treatment, and the need for definitional clarity on this. The guideline refers to 'providers of gambling treatment services' in 'specialist settings' (page 7, Lines 12-13), which would appear to include providers across the National Gambling Support Network (NGSN), including GamCare. It further refers throughout to 'an NHS-commissioned specialist gambling treatment service', which would also appear to include the opportunity for NGSN 'specialist' providers to be commissioned by the NHS. However, throughout, for example at page 12, lines 10-12, the guideline appears to define 'specialist gambling treatment services' as services for people experiencing harm from gambling with a PGSI score of 8 or more, or a lower PGSI score but complex harms or comorbidities.	Thank you for your comment. Services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers (which includes the NHS-provided gambling clinics), and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

				In this context, the guideline could potentially be construed to mean that 'specialist' treatment and support falls under NHS clinical practice alone, rather than third sector provision of treatment and support for gambling-related harms which, as this response will outline, is of equivalent efficacy. As outlined within this response, GamCare is keen to work closely with NICE to resolve this definitional uncertainty positively. Given the Committee's own concerns with the PGSI (see below), coupled with that expressed by professionals across the wider gambling treatment and support sector through the NGSN, GamCare expresses concern that the Committee recommends that an 8+ PGSI score indicates that someone 'may need to seek support and treatment from an NHS-commissioned specialist gambling treatment service'. If an 8+ PGSI score does mean that patients/clients should be referred to NHS clinical treatment services, the rationale is unclear and of concern, given the Committee's own finding that there is no evidence that the PGSI is a validated tool (page 29).	

				Building on this, the term 'specialist' is not a phrase used to described addiction services. Putting 'specialist' alongside NHS commissioned services in the context of how the NHS gambling help website is currently worded and positioned could be considered misleading to the public. It emphasises the NHS (which provides less than 10% of treatment and support for gambling related harms) as gambling treatment providers, while not providing clearly and equally represented and signposted information about voluntary or charity sector providers (which provide 90% of that treatment and support). By comparison, the NHS Drug addiction website offers more balance in its wording and representation of services and system.	

Royal College of Psychiatrists	Guid eline	5	021 - 025	1.1.6. No gambling screening tools are yet suitable for use in general population samples (see e.g. Otto et al., A systematic review evaluating screening instruments for gambling disorder finds a lack of adequate evidence, J Clin Epidemiology, 2020). The positive predictive value of the PGSI in identification of gambling disorder used in this way is likely to be 0.15 or even lower (since population prevalence of gambling disorder may well be even lower than in the sample used by Otto et al.). As such recommending it as a screening tool in the general population via an NHS website or primary care will result in many inappropriate referrals to specialist services (e.g. >100,000 inappropriate referrals to NHS gambling services per 1.3 million people who do the screen, based on Otto et al.). We recommend this section on PGSI be deleted due to the absence of any appropriate instruments with sufficiently high positive predictive value in general community settings. Instead this section could simply encourage people to reach out to their local gambling disorder NHS treatment provider if they are experiencing significant gambling related harms and wish to seek evidence based treatment. It could also note, perhaps, that more general (i.e. non-clinical) support may also be available from local independent charities or other independent organisations.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. Following the planned reorganisation of gambling treatment services, services will be commissioned by the NHS but are likely to be delivered by a range of providers.

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	5	021 - 025	This recommendation has been supported by the paper https://osf.io/g5fxr provided by NICE. Selected parts have been seen as relevant by NICE, for example, psychologist-led CBT, however, the evidence for residential stay for those with a high PGSI has not been recommended. There are three main areas of concern that we have with the NICE guidelines, other than a few more minor issues. These will be covered in our response. The first two concerns are linked to the requirement to refer anyone with a PGSI over 8 to a specialist NHS-commissioned treatment service. The third is that NICE ignores models of service delivery, other than those delivered by or located in specialist sector. Whilst the evidence amongst the gambling field might be limited, there is extensive evidence around the value of shared care, integrated working, third sector input and digital enhanced triage, within the addiction and other areas of medical care.	Thank you for your comment. The committee found no evidence at all for residential treatment for gambling-related harms and so was unable to recommend this, whereas there was evidence of benefit from psychologist-led CBT. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services (including specialist gambling clinics and community-based gambling treatment services) to clarify what different levels of services will provide, and to remove the distinction between specialist services and others. The guideline used NICE methodology to carry out systematic reviews of the evidence, based on predefined review protocols agreed by the committee. Where no evidence that met the protocol criteria was available the committee used their knowledge and experience to make recommendations but did not select evidence to consider as this would not be systematic.

				Our concern is that the draft NICE guidelines have selectively interpreted the evidence and ignored other evidence to reach (we believe pre-determined) conclusions that specialist-led NHS-commissioned services should be the main point of call for most, if not all, of those with gambling-related harms. Though we accept and appreciate that the Committee did change the definition of 'specialist' to include 'GP-led', this is not apparent throughout the documentation, and anyone reading the guidelines would reasonably conclude that 'specialist' means consultant addiction psychiatry-led. It is worth before moving on to expand on this issue – that is what does specialist mean? A "specialist gambling treatment service" can have several interpretations. It usually means consultant addiction psychiatrist-led, but it could be defined by the competencies of the leader of	

				the team and its team members, or its site (i.e., within an NHS specialist mental health environment), or the level of treatment provided (for example, dealing with highly complex individuals, issuing complex prescriptions and so on). This needs to be made clearer. We will expand on this issue further when discussing NICE omission around the evidence for alternative models of care. PGSI cut off of 8. It is important to start with the evidence used by NICE to conclude that a PGSI >8 (maximum is 27) should be used as the cut-off, that is, above this number the individual should be referred to a specialist clinic. The paper cited is used to justify the recommendation that anyone with a score of 8 or above indicates that they may need to seek support and treatment from an NHS-commissioned specialist gambling treatment service is not supported by the conclusions of the study used to justify this recommendation and which is based on Delphi derived standard of evidence. The conclusions of this report are a much more nuanced and balanced (and more	

				equivocal) view. The paper says: To quote (and my bold) Results from the second round of the survey identified consensus among participants regarding treatment thresholds for different types of treatment based on scores on the PGSI and other indicators, particularly mental health, high-risk alcohol consumption, and endorsement of some specific items from the PGSI. Recommended treatment thresholds were overlapping, particularly at the lower end of the PGSI distribution indicating that a range of treatments of different intensities were perceived as appropriate for participants with mild to moderate gambling disorder. Content analysis of free text comments from respondents revealed a range of factors that determine what type of treatment is appropriate for people who experience problems with gambling. Many of these factors overlapped with established moderators of treatment engagement and effectiveness in other addictions including social support, treatment history, client preferences, risk of self-harm, and comorbid mental health problems and other addictions.	

				Furthermore, recommended treatment thresholds were overlapping, particularly at the lower end of the PGSI distribution indicating that a range of treatments of different intensities were perceived as appropriate for participants with mild to moderate gambling disorder. The paper goes on to say. It is important to emphasise that the primary and indeed sole purpose of this study was to generate information to inform prevalence estimates of gambling treatment needs, based on national survey data, for England and its regions. These prevalence estimates, in turn, will be used to characterise the need for different types of treatment in England, and how this differs across regions of England. To do this, the results presented here will be used to assign individuals to treatment type based on their PGSI score and other contextual factors highlighted, to inform those estimates. This study was not intended to inform treatment thresholds or clinical decisions for individuals experiencing gambling problems this work is currently being undertaken by the National Institute for Health and	

				Clinical Excellence, and the results presented here should not be used for this purpose. In this context, it is important to highlight that the PGSI was developed for population surveillance, rather than as a clinical screening tool. This should help to contextualise some of the findings, particularly regarding the overlap between different types of treatment and support, many of which were considered appropriate at the lower end of the PGSI score distribution. Therefore, and in the context of this study, it is important to highlight that the PGSI was developed for population surveillance, rather than as a clinical screening tool. This should help to contextualise some of the findings, particularly regarding the overlap between different types of treatment and support, many of which were considered appropriate at the lower end of the PGSI score distribution. This overlap points to the need to consider factors other than problem gambling severity when considering the appropriateness of different types of support or treatment, an observation that is in line with the free text comments from respondents. These factors included comorbid alcohol problems, mental health conditions, social support, treatment history, treatment preference, and self-harm, all of which have been identified as common complications of gambling-related disorders.	

				This study therefore was not intended to inform treatment thresholds or clinical decisions for individuals experiencing gambling harms –this work is currently being undertaken by the National Institute for Health and Clinical Excellence, and the results presented here should not be used for this purpose. The draft NICE guideline does not reflect what the evidence says. There are three main areas of concern that we have with the NICE guidelines, other than a few more minor issues. These will be covered in our response. The first two concerns are linked to the requirement to refer anyone with a PGSI over 8 to a specialist NHS-commissioned treatment service. The third is that NICE ignores models of service delivery, other than those delivered by or located in specialist sector. Whilst the evidence amongst the gambling field might be limited, there is extensive evidence around the value of shared care, integrated working, third sector input and digital enhanced triage, within the addiction and other areas of medical care.	

				Our concern is that the draft NICE guidelines have selectively interpreted the evidence and ignored other evidence to reach (we believe pre-determined) conclusions that specialist-led NHS-commissioned services should be the main point of call for most, if not all, of those with gambling-related harms. Though we accept and appreciate that the Committee did change the definition of 'specialist' to include 'GP-led', this is not apparent throughout the documentation, and anyone reading the guidelines would reasonably conclude that 'specialist' means consultant addiction psychiatry-led. It is worth before moving on to expand on this issue – that is what does specialist mean?	

				A “specialist gambling treatment service” can have several interpretations. It usually means consultant addiction psychiatrist-led, but it could be defined by the competencies of the leader of the team and its team members, or its site (i.e., within an NHS specialist mental health environment), or the level of treatment provided (for example, dealing with highly complex individuals, issuing complex prescriptions and so on). This needs to be made clearer. We will expand on this issue further when discussing NICE omission around the evidence for alternative models of care. PGSI cut off of 8. It is important to start with the evidence used by NICE to conclude that a PGSI >8 (maximum is 27) should be used as the cut-off, that is, above this number the individual should be referred to a specialist clinic.	

				The paper cited is used to justify the recommendation that anyone with a score of 8 or above indicates that they may need to seek support and treatment from an NHS-commissioned specialist gambling treatment service is not supported by the conclusions of the study used to justify this recommendation and which is based on Delphi derived standard of evidence. The conclusions of this report are a much more nuanced and balanced (and more equivocal) view. The paper says: To quote (and my bold) Results from the second round of the survey identified consensus among participants regarding treatment thresholds for different types of treatment based on scores on the PGSI and other indicators, particularly mental health, high-risk alcohol consumption, and endorsement of some specific items from the PGSI.	

				Recommended treatment thresholds were overlapping, particularly at the lower end of the PGSI distribution indicating that a range of treatments of different intensities were perceived as appropriate for participants with mild to moderate gambling disorder. Content analysis of free text comments from respondents revealed a range of factors that determine what type of treatment is appropriate for people who experience problems with gambling. Many of these factors overlapped with established moderators of treatment engagement and effectiveness in other addictions including social support, treatment history, client preferences, risk of self-harm, and comorbid mental health problems and other addictions. Furthermore, recommended treatment thresholds were overlapping, particularly at the lower end of the PGSI distribution indicating that a range of treatments of different intensities were perceived as appropriate for participants with mild to moderate gambling disorder. The paper goes on to say.	

				It is important to emphasise that the primary and indeed sole purpose of this study was to generate information to inform prevalence estimates of gambling treatment needs, based on national survey data, for England and its regions. These prevalence estimates, in turn, will be used to characterise the need for different types of treatment in England, and how this differs across regions of England.	

				To do this, the results presented here will be used to assign individuals to treatment type based on their PGSI score and other contextual factors highlighted, to inform those estimates. This study was not intended to inform treatment thresholds or clinical decisions for individuals experiencing gambling problems this work is currently being undertaken by the National Institute for Health and Clinical Excellence, and the results presented here should not be used for this purpose. In this context, it is important to highlight that the PGSI was developed for population surveillance, rather than as a clinical screening tool. This should help to contextualise some of the findings, particularly regarding the overlap between different types of treatment and support, many of which were considered appropriate at the lower end of the PGSI score distribution.	

				Therefore, and in the context of this study, it is important to highlight that the PGSI was developed for population surveillance, rather than as a clinical screening tool. This should help to contextualise some of the findings, particularly regarding the overlap between different types of treatment and support, many of which were considered appropriate at the lower end of the PGSI score distribution. This overlap points to the need to consider factors other than problem gambling severity when considering the appropriateness of different types of support or treatment, an observation that is in line with the free text comments from respondents. These factors included comorbid alcohol problems, mental health conditions, social support, treatment history, treatment preference, and self-harm, all of which have been identified as common complications of gambling-related disorders.	

				This study therefore was not intended to inform treatment thresholds or clinical decisions for individuals experiencing gambling harms –this work is currently being undertaken by the National Institute for Health and Clinical Excellence, and the results presented here should not be used for this purpose. The draft NICE guideline does not reflect what the evidence says.	
Adferiad	Guid eline	5	23	The guidelines state that a score of 8 or more on the PGSI indicates that the individual may need to seek support and treatment for their gambling. However, for those scoring just below this threshold (e.g. a score of 6-7 is this risk likely to change? Should individuals be reassessed and if so, at what point. Is the PGSI a sufficient tool to assess an individual's level of gambling harms, is it a robust clinical tool? Has there been clear evidence to support the use of the PGSI for the purposes of referring into treatment.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	5	023 - 024	Rec 1.1.6 – To note that those with scores of less than 8 may also benefit from some level of support / treatment to prevent escalation of harm. Potential for the recommending the use of a diary to monitor gambling behaviour. Insight from Yorkshire and Humber region has shown that men who keep a daily diary of this gambling, including and money spent allows them to become more self-aware and understand the true extent of their gambling This may help is reducing the need to gamble and/or encourage them to seek help.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. The committee did not look for evidence of measures which might encourage people to seek help such as gambling diaries so did not make recommendations on this topic. However, gambling history is included in the recommendations on factors used to assess gambling-related harms, and this may require the use of a diary, but this level of detail would be agreed with the therapist as one of the tools to reduce gambling, and so has not been included in the recommendation.

GambleAware	Guideline	5	25	Currently, the only gambling treatment services commissioned by the NHS are its own clinics. As such, the phrase “NHS-commissioned” can only mean those clinics. A reasonable interpretation of this wording is that it will effectively exclude the vast majority of current gambling treatment provision, because that provision is commissioned by the third sector. Doing so will adversely affect access, population outcomes, costs to the statutory system, system capacity and system stability.	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but does not simply replicate the current provision. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such

				This may change should the NHS become the sole commissioner of all treatment (delivered by both the NHS and third sector) as proposed in the current Government consultation on the introduction of a statutory industry levy to fund gambling harms research, treatment and prevention. However, these draft guidelines were published before the consultation, meaning they cannot have been making reference to it when recommending an NHS-first approach. This is a concerning exclusion of third sector provision given it provides the vast majority of services and delivers high quality care and outcomes. Furthermore, the timelines of any new commissioning arrangements are yet to be confirmed and will in any case require a multi-year transition period before they are fully operational.	as the voluntary sector, as they would with any other health condition. You are correct that no cost-effectiveness analysis has been carried out to compare voluntary sector and NHS treatment, and so currently, there is no evidence that NHS-commissioned services would be less cost-effective than existing services.

				As such it is vital that in the meantime the guideline does not only direct people to NHS-delivered services, but also to the wider range of third sector treatment that is available via the NGSN – which includes specialist treatment. Therefore, it would be both accurate and sufficient to simply say "specialist gambling treatment services" – which may or may not be NHS-commissioned at this point in time. Furthermore, if this guidance does exclude third-sector treatment and support provision, this would undermine NICE's own principles – namely principles 4, 6, 7, and 8: Principle 4: the guideline does not account for or respect individual patient choice. Principle 6: the notion that solely NHS treatment should be required or recommended is completely unevidenced. Principle 7: no cost-effectiveness analysis has been produced to compare NHS treatment provision with third sector treatment provision.	

				Principle 8: third sector provision has driven much, if not all, of the innovation in support, including community outreach, peer support and aftercare.	
Breakeven (Charity no 1158156)	Guid eline	5	25	1.1.6 The guidance states that there is only one path for people experiencing gambling related harms and names the NHS as the sole route. There is no evidence for this regarding efficacy, no evidence that this is an affordable/value for money service .	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured.

Breakeven (Charity no 1158156)	Guid eline	5	25	1.1.6 The guidance implies that the NHS is the only specialist Gambling Treatment service. This is not the case. Breakeven has been a specialist treatment provider for over 20 years and has been at the cutting edge of service delivery and community engagement during that time delivering exceptional KPI, S and outcomes.	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured.

RCA Trust	Guid eline	5	25	1.1.6 The guidance states that there is only one path for people experiencing gambling related harms and names the NHS as the sole route. There is no evidence for this regarding efficacy, cost for increasing access to services. There is a central tenet throughout all the NHS systems across the UK and that is the promotion of choice and provision of choice in accessing the appropriate treatment to suit the patient/client. With nearly a 100 years' experience combined within the NGSN in delivering treatment to those both directly and indirectly affected by gambling harms, the NHS is not the sole route for those experiencing gambling related harms.	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured.

RCA Trust	Guid eline	5	25	1.1.6 The guidance implies that the NHS is the only specialist Gambling Treatment service. This is not the case. THE RCA Trust has been a specialist treatment provider for over 20 years and has been at the cutting edge of service delivery and community engagement working with a wide range of partners and stakeholders to deliver early intervention, prevention, education, training, and treatment provision	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured.
Ara recovery for all (Addiction Recovery Agency Ltd. Charity Number 1002224)	Guid eline	5	25	1.1.6 The guidance states that there is only one path for people experiencing gambling related harms and names the NHS as the sole route. There is no evidence for this regarding efficacy, cost for increasing access to services.	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured.

Ara recovery for all (Addiction Recovery Agency Ltd. Charity Number 1002224)	Guid eline	5	25	1.1.6 The guidance implies that the NHS is the only specialist Gambling Treatment service. This is not the case. Ara recovery for all has been a specialist treatment provider for over 15 years and has been at the cutting edge of service delivery and community engagement	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured.
Adferiad	Guid eline	5	25	The treatment and support would be from an NHS commissioned specialist gambling treatment service, there are other providers such as Adferiad who have a complex needs pathway for people experiencing gambling related harms alongside comorbidities. If the sole route is the NHS, how do they propose meeting the needs of those that do not wish to have any interventions on their GP summary/NHS records?	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition.

NHS England	Guideline	5	General	1.1.3 - Final general comment is whether there is an opportunity in our practices / PCNs to use PHM principles to target certain 'high risk' groups that we are seeing anyway (mental health, taking dopamine agonists, neurological conditions, occupation) with a text or opportunistic question when they present to us. These groups are easily identified on the GP system.	Thank you for your comment. The guideline recommends opportunistic questioning about gambling of everyone, including those at high risk. If pro-active identification of high risk groups is feasible within PCNs this would certainly help with the local implementation of this recommendation.

NIHR, Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London	Guideline	5	General	People with lived experience involved in our study identifying gambling harms in local authorities (https://www.kcl.ac.uk/research/identifying-gambling-harms) highlighted they valued receiving support from a range of providers, and what works for one person at a certain time, may not work for them again, or may not work for a different person. Also, people may not want to be in contact with 'official' NHS/ or social services as they might feel ashamed and not want gambling addiction on their notes. It is therefore important to offer people choice in support services.	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The recommendations on models of care have also been amended to ensure people's preferences are taken into consideration. This will therefore provide a range and choice of services for people, and self-referral is also recommended as an option to increase access and choice. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition.

Gambling with Lives	Guid eline	6	3	1.1.7 - There is not enough about gambling harm as a risk to mental health – focus overwhelmingly on financial harm. People need to know the mental health harms/ risks.	Thank you for your comment. This recommendation about initial support has been amended to include information about gambling-related harms. The immediate risks to mental health are already covered in three subsequent recommendations in this section.
His Majesty's Prison and Probation Service (HMPPS)	Guid eline	6	3	More detailed list of support services would be helpful for signposting individuals.	Thank you for your comment. The NHS website and the national telephone helpline will be available to all (it is anticipated that the national telephone helpline will be recommissioned by the NHS as part of the gambling support and treatment service reconfiguration). The remainder of the services will depend on local commissioning arrangements so it is not possible to list them all here, and details will be available via local NHS commissioners and providers.

Gordon Moody	Guideline	6	003-029	Although we welcome the other initial support recommendations listed at points 1.1.7 to 1.1.9, it is not clear who will be delivering those interventions and what would be the resource implications for training people from the mentioned sectors to deliver them and then the resource implications for delivering such advice and interventions. We advise that people should be signposted/referred to local community gambling recovery and support services for advice and early intervention as well. We would also welcome recommendations for best practice for people signposting/referring to follow-up with the person and, where appropriate, and consent is in place with the service as well. The promotion of professional referrals and follow-up to improve engagement and avoid people falling between the gaps and experiencing ongoing harm should play an essential part of the initial support plan.	Thank you for your comment. This initial support will be provided by a wide range of health and social care professionals in all settings and may also be provided by people working in the voluntary, community and social enterprise sectors. It is recognised that there may be training needs to implement this in all settings but the aim of the guideline is to improve practice in identifying those experiencing gambling-related harms and ensuring they receive support and treatment. Some of this initial support may be provided by current gambling treatment or support services and so for these providers there will not necessarily be training implications. In order to ensure people are signposted to appropriate services a new section on referral and triage has been added to the guideline. These recommendations on initial support are designed for any front-line professional (for example someone working in citizen's advice, in A and E or a person's GP) so it is not possible to be prescriptive about follow-up arrangements as this will depend on the setting.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	6	6	Rec 1.1.7 - Remove 'brief' and amend sentence to read 'Using motivational interviewing…' as the following three bullets are actions.	Thank you for your comment. Brief has not been removed from this recommendation as it intentionally refers to brief motivational interviewing, which can be delivered by a wide variety of professionals as initial support to encourage people to seek help. This recommendation is now a stand-alone recommendation so your comment regarding the bullet points is no longer applicable.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	6	6	Rec 1.1.7 – Will everyone reading this guidance know what motivational interviewing is and who can do it?	Thank you for your comment. Brief motivational interviewing is widely used by healthcare professionals and social care practitioners to encourage change, and can be used in a very short appointment.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	6	8	Rec 1.1.7 – similar to the 'unbiased' information, it would be helpful to have information in the guideline with regards to checking that local support services are also unbiased and recommended. Local public health teams could provide local contact lists to support with this.	Thank you for your comment. It would be very difficult for individuals providing initial support to check if local support services are unbiased. However, recommissioning of these services by the NHS as part of the planned gambling support and treatment service reconfiguration will address the issue of services being biased, and so over time this should not be a concern.

GamCare	Guideline	6	008-011	While welcoming the draft guideline recognition of the impact of gambling-related harm on affected others, GamCare emphasises that the PGSI has no suitability or pertinence to affected others. Just as the Committee outlines in this guideline its intention to develop a more sophisticated tool to assess gambling-related harm, it should also build such a tool to screen affected others. GamCare recommends that the Committee review the draft guideline to ensure that it more comprehensively addresses the support required for those affected by someone else's harm, e.g., the specialist legal assistance affected others often need, their support needs when they come into contact with the criminal justice system, or the relationship between gambling and all forms of domestic abuse. Specific questions are required in any tool intended to assess affected others around financial, economic, physical, emotional abuse and coercive control, and this should be recognised in the Guideline.	Thank you for your comment. The committee agree that the PGSI tool is not applicable for affected others were aware that there is currently a tool called the Family Member Questionnaire (FMQ) used in practice. However, the reference to using PGSI to identify need has been removed from this recommendation and so this list of sources of initial help and support are now relevant to both people experiencing gambling that harms and to affected others. The committee wrote the guideline with an 'all-harms' approach so a large number of the recommendations are applicable to affected others, and this is highlighted in the separate section of the guideline on support for affected others. However, there was very little evidence of interventions that were designed specifically for affected others so the committee made a research recommendation.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	6	008 - 013	Rec 1.1.7 - Repetitive language in these 2 bullets. Suggest that 1 bullet is about signposting to advice, 1 signposting to support and a third signposting to treatment.	Thank you for your comment. This recommendation has been reworded to make the possible options for initial support clearer and in a more logical order.
NECA (Charity Number 516516)	Guideline	6	9	1.1.7 - Suggested deletion of "NHS commissioned" or at least a reflection of other services which operate in this space for reasons highlighted in this response and, again, the PGSI score of =8 is not evidence based and would exclude access to many service providers that manage this condition. This is not an adequate method of assessment of need. Relying solely on this to determine referrals for clinical interventions or treatment within the NHS poses the risk of excessively pathologising service-users. This approach could contribute to stigma, given the negative impact of labelling.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has also been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be provided by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition.

				In addition, this may introduce potential barriers to care and limit access. Many individuals do not want to present to the NHS. Referrals from GPs to our service is negligible despite attempts to raise awareness. This pathway will add to a barrier for some people to access interventions and will potentially delay treatment and add more harm to individuals, families and the community.	
GambleAware	Guideline	6	9	The NHS link provided includes a questionnaire to assess harm that users cannot complete on the webpage, meaning it has to be printed out or undertaken offline with reference to the webpage. This is likely to impact uptake – potentially limiting the number of people struggling with gambling harm who will be identified through this route. In addition, the provision of threshold information alongside scoring guidance means there is a risk users may amend their answers to receive a particular score, further impacting the value of the assessment tool.	Thank you for your comment. The committee advised that the NHS webpages on gambling will need amending as a result of the development of this guideline, and this would include making the NHS PGSI tool interactive and removing the alongside threshold information. This has been passed onto the NICE implementation team. Thank you for informing us about the GambleAware interactive tool - the committee expect that this or a similar service will continue to be available as the planned changes to NHS-commissioning arrangements are implemented.

				GambleAware has developed an assessment tool that should be signposted in the final guideline: https://www.begambleaware.org/self-assessment-tool-entry. This is an interactive tool that provides a recommendation for what to do next and where to go for help, depending on responses. This includes instant access to a 24/7 online chat run by GamCare if harms are identified. Since its launch in April, the tool has been completed 71,000 times – equivalent to over 10,000 completions per month – with almost 60% of these users taking action afterwards (including calling the National Gambling Helpline or using the online live chat).	

Breakeven (Charity no 1158156)	Guid eline	6	13	1.1.7 This paragraph reiterates a singular PGSI score to the sole pathway of NHS -commissioned specialist gambling services. This is not an adequate method of assessment of need. This pathway will add to a barrier for some people, especially those who might choose control over abstinence which currently is not an Intervention offered in many NHS Clinics. Entry in to Treatment /support needs to be inclusive not exclusive.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. It is specified that gambling treatment services should be commissioned by the NHS, but they may be provided by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The recommendations in the section on principles of treatment advise that the aim of treatment should be discussed and agreed in all services.
RCA Trust	Guid eline	6	13	1.1.7 This paragraph reiterates a singular PGSI score to the sole pathway of NHS -commissioned specialist gambling services. This is not an adequate method of assessment of need. This pathway will add to a barrier for some people to access interventions and will potentially delay treatment and add more harm to individuals, families, and the community.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

Ara recovery for all (Addiction Recovery Agency Ltd. Charity Number 1002224)	Guideline	6	13	1.1.7 This paragraph reiterates a singular PGSI score to the sole pathway of NHS -commissioned specialist gambling services. This is not an adequate method of assessment of need. This pathway will add to a barrier for some people to access interventions and will potentially delay treatment and add more harm to individuals, families and the community.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.
Adferiad	Guideline	6	013 - 014	Reiterates that a score of 8 or more on the PGSI should result in referring or signposting to a NHS commissioned gambling treatment service. It references comorbidities, however questions asked on the PGSI score would not indicate if there were any mental health/substance use presentations, so how would they gather this information?	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

				As mentioned previously, utilising a single score cut off could create problems. Individuals may under report, due to adverse consequences. For example, a women may fear social services involvement. Stigma is prevalent among those that are experiencing gambling related harms and is does act as a barrier to accessing support. Is there sufficient evidence to support the PGSI is to be used for the specific use of referring into services or given that the questions are framed within a 12-month time frame is it not guidance to provide an overview of an individual's gambling experience. To accurately determine an individual's needs a comprehensive assessment should be completed, which would identify the best treatment option for the individual.	

GambleAware	Guideline	6	14	Currently, the only gambling treatment services commissioned by the NHS are its own clinics. As such, the phrase “NHS-commissioned” can only mean those clinics. A reasonable interpretation of this wording is that it will effectively exclude the vast majority of current gambling treatment provision, because that provision is commissioned by the third sector. Doing so will adversely affect access, population outcomes, costs to the statutory system, system capacity and system stability. This may change should the NHS become the sole commissioner of all treatment (delivered by both the NHS and third sector) as proposed in the current Government consultation on the introduction of a statutory industry levy to fund gambling harms research, treatment and prevention. However, these draft guidelines were published before the consultation, meaning they cannot have been making reference to it when recommending an NHS-first approach. This is a concerning exclusion of third sector provision given it provides the vast majority of services and delivers high quality care and outcomes. Furthermore, the timelines of any new commissioning arrangements are yet to be confirmed and will in any case require a multi-year transition period before they are fully operational. As such it is vital that in the meantime the guideline does not only direct people to NHS-delivered services, but also to the wider range of third sector treatment that is available via the NGSN – which includes specialist treatment. Therefore, it would be both accurate and sufficient to simply say “specialist gambling treatment	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but does not simply replicate the current provision. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition. You are correct that no cost-effectiveness analysis has been carried out to compare voluntary sector and NHS treatment, and so currently, there is no evidence that NHS-commissioned services would be less cost-effective than existing services.

				services" – which may or may not be NHS-commissioned at this point in time. Furthermore, if this guidance does exclude third-sector treatment and support provision, this would undermine NICE's own principles – namely principles 4, 6, 7, and 8: Principle 4: the guideline does not account for or respect individual patient choice. Principle 6: the notion that solely NHS treatment should be required or recommended is completely unevidenced. Principle 7: no cost-effectiveness analysis has been produced to compare NHS treatment provision with third sector treatment provision. Principle 8: third sector provision has driven much, if not all, of the innovation in support, including community outreach, peer support and aftercare.	

Breakeven (Charity no 1158156)	Guid eline	6	14	Although we acknowledge that a PGSI score of 8 or higher should be promptly flagged as an indicator of needing support, relying solely on it to determine referrals for clinical interventions or treatment within the NHS poses the risk of excessively pathologising service-users. The score suggested is often seen in those that have managed to negate their problems and may need ongoing /further support to help them manage/sustain a client journey.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

				Utilising a single score cutoff also creates potential issues. Firstly, there is the risk of "misses" where individuals may under-report due to fear of adverse consequences or stigmatisation. Secondly, there is the risk of "false positives" where people may over-report, due to historical reasons as discussed earlier. Stigma, as we know, is particularly prevalent among those experiencing gambling-related harms, and it often acts as a barrier to accessing support. Additionally, there is no evidence to suggest that the PGSI was originally intended for this specific use, nor have there been pilot studies confirming its adequate predictive validity. Moreover, it is crucial to acknowledge that all PGSI questions are framed within a 12-month timeframe, providing a broad overview of an individual's gambling-related experiences. Consequently, relying solely on the PGSI as the sole access point for referrals to NHS clinics may not be appropriate. To accurately determine someone's complete clinical presentation and the necessity for stepped-up care, a comprehensive assessment of their situation should be required.	

RCA Trust	Guideline	6	14	Although we acknowledge that a PGSI score of 8 or higher should be promptly flagged as an indicator of needing support, relying solely on it to determine referrals for clinical interventions or treatment within the NHS poses the risk of excessively pathologizing service-users. This approach could contribute to stigma, given the negative impact of labelling. It is a key strategy of commissioners to reduce barriers and stigma through stimulating discussion around gambling and its associated harms. Utilising a single score cutoff also creates potential issues. Firstly, there is the risk of "misses" where individuals may under-report due to fear of adverse consequences or stigmatisation. Secondly, there is the risk of "false positives" where people may over-report, due to historical reasons as discussed earlier. Stigma, as we know, is particularly prevalent among those experiencing gambling-related harms, and it often acts as a barrier to accessing support. Additionally, there is no evidence to suggest that the PGSI was originally intended for this specific use, nor have there been pilot studies confirming its adequate predictive validity. Moreover, it is crucial to acknowledge that all PGSI questions are framed within a 12-month period, providing a broad overview of an individual's gambling-related experiences. Consequently, relying solely on the PGSI as the sole access point for referrals to NHS clinics may not be appropriate. To accurately determine someone's complete clinical presentation and the necessity for stepped-up care, a comprehensive assessment of their situation should be required with the service user actively involved in the decision making of their own treatment. Again, the promotion of choice.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

Ara recovery for all (Addiction Recovery Agency Ltd. Charity Number 1002224)	Guid eline	6	14	Although we acknowledge that a PGSI score of 8 or higher should be promptly flagged as an indicator of needing support, relying solely on it to determine referrals for clinical interventions or treatment within the NHS poses the risk of excessively pathologizing service-users. This approach could contribute to stigma, given the negative impact of labelling.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

				Utilising a single score cutoff also creates potential issues. Firstly, there is the risk of "misses" where individuals may under-report due to fear of adverse consequences or stigmatisation. Secondly, there is the risk of "false positives" where people may over-report, due to historical reasons as discussed earlier. Stigma, as we know, is particularly prevalent among those experiencing gambling-related harms, and it often acts as a barrier to accessing support. Additionally, there is no evidence to suggest that the PGSI was originally intended for this specific use, nor have there been pilot studies confirming its adequate predictive validity. Moreover, it is crucial to acknowledge that all PGSI questions are framed within a 12-month period, providing a broad overview of an individual's gambling-related experiences. Consequently, relying solely on the PGSI as the sole access point for referrals to NHS clinics may not be appropriate. To accurately determine someone's complete clinical presentation and the necessity for stepped-up care, a comprehensive assessment of their situation should be required.	

Betknowmore UK	Guid eline	6	014 - 017	A maximum PGSI score is 27. If every person with a PGSI score of 8 and above were directed to any NHS gambling clinic, the clinics would be overwhelmed and waiting times would present unacceptable levels of risk. The NGSN already has considerable experience in treating and supporting people with high PGSI scores and complex co-morbidities. Imposing the threshold of 8 to direct people to NHS gambling clinics removes patient/client choice and risks people underreporting their gambling harms so as to be able to access support from the third sector. One service user told us: “If I was having weekly/monthly sessions and my support worker informed me that my score may trigger a referral to the NHS I think it would concern me and I would probably amend my answer so I fell under the score”. People with lived experience have reported to us that they do not want to be diagnosed as a ‘problem gambler’ and for this to appear on their medical records. To avoid this, they may avoid treatment and support altogether if there is no direct access to third sector services.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but must be fit for purpose in the future and cannot simply replicate the current provision. It is anticipated that the guideline will take a period of time to implement fully.

Gordon Moody	Guideline	6	014 - 017	We are concerned that a PGSI of 8 plus is being cited as a rationale for NHS-commissioned interventions. We think, sadly, this will deter people from moving forward. In particular, thinking about our client group and the level of complexity, other co-occurring needs and multiple deprivation issues, the NHS approach to appointments and DNAs will result in people being closed and failing to engage. We have clients who haven't disclosed their gambling behaviours to their GP/NHS and don't want their GP to know due to concern about gambling addiction being recorded on their file. Current waiting times are lower withing NGSN, and the waiting time for NHS clinics, would increase if all PGSI 8 plus were referred to NHS commissioned services. Integrated place-based systems will better ensure people are coordinated into the right intervention at the right time for them and protect NHS resource for people wanting this and able to access this that is right for their level of need.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on assessing referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. The planned reconfiguration of gambling services following the introduction of the statutory levy will lead to services being commissioned by the NHS but the services will be delivered by a variety of providers, and people will have the option to self-refer. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition.

GambleAware	Guideline	6	014 - 017	We are concerned by use of the PGSI here as it is not a clinical screening tool, does not measure levels of complexity and as such is not an effective sole means of assessing an individual's clinical need. While someone presenting with PGSI 8+ should be flagged as requiring support, there is no evidence that an NHS-first approach is appropriate and to take one forward would risk delayed access to treatment given limited capacity within clinics and longer waiting times. It would also risk over-medicalisation of gambling harms, which can serve as a barrier to access for some people. To determine someone's full clinical presentation, and whether there is a need for stepped-up care, a full assessment of their needs is required. The guideline must set out how this can be accessed and undertaken.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

GamCare	Guideline	6	014 - 017	Please see comment 4 above. The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five days from assessment to the offer of a first support session at GamCare. Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner. GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment.	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but does not simply replicate the current provision. In addition, a new section on referral and triage has been added to the guideline to enable people to reach the most appropriate level of support and treatment, and people will still be able to self-refer, so services will not only be accessible via a GP referral, as a referral could be made by a range of professionals and practitioners, or via self-referral.

Royal College of Psychiatrists	Guideline	6	014 - 017	1.1.7. Again we would strongly advise against using a specific PGSI threshold for onward referral because of the scientific (including psychometric) limitations of available instruments (see earlier point). Instead it would be more appropriate to write e.g. "referring or signposting them to NHS-commissioned specialist gambling treatment services (for example if the person appears to be experiencing significant gambling harms and wishes for evidence based treatment)."	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.
Betknowmore UK	Guideline	6	18	Not all blocking software is free and the Guideline should recognise that people can access Gamban free of charge via the National Gambling Helpline.	Thank you for your comment. The committee decided not to recommend specific tools and agreed that a variety of tools were available and people may need to use more than one.
Haringey Public Health Department	Guideline	6	18	1.1.8 - "...exclusion systems for land-based gambling..." - what systems is this referring to? Would be helpful to include some examples or a link to some.	Thank you for your comment. The committee decided not to recommend specific tools and agreed that a variety of methods were available to block access to land-based gambling such as betting shops, and people may need to use more than one.

Haringey Public Health Department	Guid eline	6	18	1.1.8 - "...methods to limit their access to money" - again what methods is this referring to? Would be helpful to include some examples or a link to some.	Thank you for your comment. An example has been added of a family member helping control access to finances.

GamCare	Guideline	6	018 - 023	GamCare recommend that TalkBanStop (TBS) is specifically mentioned in this guideline. TBS is a partnership that promotes a layered approach, combining practical tools with support to help individuals at risk of gambling related harm stop gambling and kick-start their recovery journey. The process begins with someone getting in touch with a trained Adviser on the National Gambling Helpline. At this point, individuals will be able to access a free Gamban licence and will be told about the benefits of self-excluding with GAMSTOP if they have not done so already. Case study findings shows that TalkBanStop reflects several benefits as a three-tool layered approach. These included: a strengthening of gamblers' perceptions that they could not circumvent the tools, that was more sustained over time; and, due to the bank blocks in place were also restricted from gambling in-person. As a result, no individuals had gambled over the fieldwork period.	Thank you for your comment. The committee decided not to recommend specific tools and agreed that a variety of tools were available and people may need to use more than one.

				A user of Gamban, GAMSTOP and merchant code blocking and therapy said: "The fact that I've used that service [GAMSTOP] with the blocking software and the counselling has given me, like, three big pillars to stand on. Not only can't I use my own name, I can't do it anyway on my phone, and I'm getting it in my mindset through the counselling that I don't want to do it and that I'm changing my behaviours towards it. So, I think, the use of all three together is why I am so positive and why I have had, like, such quick success, well, such better feelings within myself and such positivity in my life."	
GambleAware	Guideline	6	018-029	The actions set out in this section would be readily facilitated by signposting to the NGSN or an NGSN/third sector-first approach. The multidisciplinary approach within the NGSN means all of these measures are covered in one place, thereby working in the best interests of people who need access to all of these types of support.	Thank you for your comment. This section of the guideline already includes a recommendation to refer people for gambling support services, as you suggest. In addition a new section has been added to the guideline on referral and triage and directing people to the correct level of treatment and support.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	6	20	Rec 1.1.8 - Re-word sentence to read ‘blocking software or tools to manage online gambling e.g. time / deposit limits’	Thank you for your comment. The committee did not agree that 'managing' gambling should be advised, as this implied the gambler was at fault for not managing their gambling.
His Majesty’s Prison and Probation Service (HMPPS)	Guid eline	6	20	It would be helpful to provide links to blocking software tools i.e. gamban, gamblock, betfilter, betblocker as some potential links.	Thank you for your comment. The committee decided not to recommend specific tools and agreed that a variety of tools were available and people may need to use more than one.
Gambling with Lives	Guid eline	6	23	1.1.8 - Mention here about blocking gambling transactions through bank.	Thank you for your comment. The recommendation already states 'systems that block gambling payments through the person’s bank account'.

GamCare	Guid eline	6	025 & 019 - 029	GamCare recommends that our Gambling Related Financial Harm and Money Guidance Service programme are specifically signposted to as part of providing advice on how and where to seek help and support with finances. Our Money Guidance Service (launched this year) is in response to the financial difficulties faced by many of our service uses. Our data found that 76% of those who gamble to harmful levels face financial difficulties, 60% are in debt and 47% of affected others face financial difficulties.	Thank you for your comment and telling us about this service. The committee decided not to recommend specific tools or services and agreed that a variety of tools and services were available and people may need to use more than one.

				The Money Guidance Service (MGS) offers one-to-one budgeting and financial support for people who experience gambling harms. Referrals are made via the National Gambling Helpline and GamCare treatment teams, and we have referral pathways in place for clients in need of specialist debt advice. So far, Money Guidance Service have trained over 70 staff in MGS triage and delivered 99 client referrals. A Money Guidance Service client told us “I always saw my budget and finances as something that just happened to me and felt like I had no control. After speaking to the Money Guidance Service, I feel I have control of my spending and my budget”.	
Gambling with Lives	Guid eline	6	26	1.1.9 - This part is overly financially focused – we recommend adding a line about potential specialist mental health referral here.	Thank you for your comment. This section already includes separate recommendations about mental health referral, and these have been moved up in the section to increase the focus on mental health issues.

His Majesty's Prison and Probation Service (HMPPS)	Guideline	6	26	We should explicitly mention providing advice to people who are in debt, especially those in prison as debt is very often linked to bullying and violence. Again, providing an Annex to the Guidelines with links to services that can offer support would be beneficial.	Thank you for your comment. Debt has been added in as an example to this recommendation to provide more detail on the type of financial advice that may be needed. Links to services that offer support may be included as part of the implementation support that accompanies the guideline.
Gambling Harm UK	Guideline	6	26	We suggest the inclusion of domestic abuse as an area for practitioners to give advice on how and where to seek help and support.	Thank you for your comment. Domestic abuse has been added in as another area where people may need help and support, as you suggest.
Royal College of Psychiatrists	Guideline	6	026 - 029	1.1.9. Also support for legal issues.	Thank you for your comment. Legal support has been added in as another area where people may need help and support, as you suggest.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	6	28	Rec 1.1.9 - Add in 'family / relationship breakdown as well as other social support e.g. for families' as other social issues which may require support.	Thank you for your comment. Harms to family relationships has been added in as another area where people may need help and support, as you suggest. Social support for families is already included as the second bullet point in this recommendation.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	6	General	Initial support for people experiencing harm from their own or another's gambling. We strongly endorse the recommendations here and consider that they provide a basis for a helpful toolkit for community, health, social care and criminal justice agencies. In addition, we would suggest that some specialist gambling harms treatment services may offer an assertive outreach function, and use the approach set out by the guideline to work proactively with agencies and settings frequented by people who are likely to be affected by gambling harms.	Thank you for your comment and support for these recommendations. The committee agreed that outreach by gambling treatment services would be a useful addition to local services as a method of implementing these recommendations.
Parkinson's UK	Guideline	7	1	We welcome the inclusion of this guideline. Impulse-control disorders are a potential contributor to suicide (Shepard, M. D., Perepezko, K., Broen, M. P. G., Hinkle, J. T., Butala, A., Mills, K. A., Nanavati, J., Fischer, N. M., Nestadt, P., & Pontone, G. (2019). Suicide in Parkinson's disease. Journal of neurology, neurosurgery, and psychiatry, 90(7), 822–829. https://doi.org/10.1136/jnnp-2018-319815).	Thank you for your comment. The committee recognised the risk of suicide in people with gambling-related harms and included recommendations on this topic, which will apply to people with Parkinson's disease as well.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	7	1	Rec 1.1.10 – Suggest defining up-front what is meant by ‘people experiencing harmful gambling’ and ‘people experiencing gambling-related harms’.	Thank you for your comment, The definitions of gambling that harms and gambling-related harms have now been added to the 'terms used' section of the guideline.
Gambling Harm UK	Guid eline	7	1	We suggest practitioners should ask openly towards risk to and from others as well as risk to self.	Thank you for your comment. Risk to others is already included in the following recommendation.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	7	001 - 011	We agree that it is critical to consider the association between gambling harms and suicide and to ask directly about suicidal ideation and intent and arrange help appropriate to their level of risk and need, as identified by the NICE guideline on self-harm: assessment, management and preventing recurrence and the national suicide prevention strategy Department of Health and Social Care (2023) Suicide prevention in England: 5 year cross sector strategy Our clinical experience reflects the findings of Lee, Kim and Kim (2021) that 'bailouts' (i.e., seeking help for financial problems) are a significant risk factor for suicidal ideation. See: Lee, K; Kim, H; and Kim, YH (2021) Gambling Disorder Symptoms, Suicidal Ideation, and Suicide Attempts. Psychiatry Investigation18 (1) 88-93. Published online January 25, 2021 DOI: https://doi.org/10.30773/pi.2020.0035	Thank you for your comment. The committee recognised the risk of suicide in people with gambling-related harms and included recommendations on this topic, including a link to the NICE guideline on self-harm. The guideline already addresses the fact that people sharing financial concerns are particularly at risk from gambling-related harms but thank you for reinforcing this view

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	7	7	Rec 1.1.10 – Amend sentence to read '… if the situation deteriorates at a future point.'	Thank you for your comment. Leaving this recommendation without a detailed timeframe allows for greater flexibility - the deterioration could be over the course of the next few hours, days, weeks or longer so this addition has not been made.
Parkinson's UK	Guid eline	7	8	We concur that people experiencing gambling-related harms presenting a considerable or immediate risk to themselves or others should be urgently referred to specialist mental health services. However, we also recommend an urgent medication review from the prescribing clinician is included in this guidance. (Skelly, R. (2020). Gambling Addiction and Parkinson's disease - supporting better patient care. Royal college of Physicians. Accessed online 15 Nov 23 at https://www.rcplondon.ac.uk/news/gambling-addiction-and-parkinson-s-disease-supporting-better-patient-care).	Thank you for your comment. The guideline already alerts professionals to the risk of medication for people with Parkinson's disease, and includes a link to the NICE guideline on Parkinson's disease and the management of impulse control, which includes medication review, so this has not been repeated again in this NICE guideline.

Haringey Public Health Department	Guideline	7	8	1.1.11 - This guidance does not mention gambling, and this would be important for clinicians treating patients with self-harm and suicide attempts to be aware of the risk of gambling and ask about it in initial assessments. If this guidance is specifically mentioning the risks of self-harm and suicide, then it seems that the guidance on self-harm and suicide also needs to reflect the risk of gambling. We note that this is a priority area of emerging harms in the new national strategy, alongside areas like domestic violence. Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk)	Thank you for your comment. The committee were aware of the inclusion of gambling in the recent suicide strategy and agreed it should also be considered in relation to the NICE guideline on self-harm, as you suggest. This suggestion has therefore been passed to the NICE surveillance team who are responsible for ensuring guidelines are up to date.
Royal College of Psychiatrists	Guideline	7	008 - 011	1.1.11. It would be worth highlighting that the most appropriate specialist mental health service for acute immediate risk is likely to be other services such as crisis teams rather than NHS gambling treatment services. Of course, gambling services can provide advice to such other services about clinical management in relation to gambling.	Thank you for your comment. The crisis team has been added to this recommendation as you suggest.

NECA (Charity Number 516516)	Guid eline	7	9	1.1.10 - Suggested Replacement of adequate “social support” with adequate “protective factors”. You can have lots of social support, but will they be protective factors for the individual? Perhaps likely but is this an absolute. Checking for protective factors is in essence what is being assessed.	Thank you for your comment. The committee agreed that social support may not always be protective so amended the recommendation to specify that it was 'social support to help protect them'.

GamCare	Guideline	7	010 - 011	GamCare supports the recommendation that if a person experiencing gambling-related harms presents considerable or immediate risk to themselves or others, refer them urgently to specialist mental health services. GamCare's adult safeguarding procedure also highlights the need to the contact emergency services if someone is in immediate danger, which should also be considered in this guideline. Our suicide prevention policy is also based on NICE NG189 Suicide Prevention 2019 NICE NG 105 Preventing Suicide in the community and custodial settings 2018 NICE CG133 Self Harm in over 8s National Confidential Inquiry into Suicide & Safety in Mental Health 2016 Suicide Prevention: Policy & Strategy UK Parliament 2019 Cross Government Suicide Prevention Plan DHSC 2019.	Thank you for your comment. The need to contact the emergency service has now been included as an option in this recommendation.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	7	12	Assessment of gambling related-harms in specialist settings We consider that the recommendations for assessment of gambling related harms are helpful in the main.	Thank you for your comment.
GamCare		7		Please see comment 2 above.	

	Guideline		012 - 013	As mentioned, this section again reinforces the need for definitional clarity in relation to the use of 'specialist' versus use of language that promotes the gambling treatment and support system as a whole and as partners in an integrated pathway of care – including with the NHS. The language may be considered misleading to the public and to imply that any treatment that is not offered directly by the NHS does not provide the same standard of treatment as the NHS. As mentioned above, other addiction services are not referred to in this way. The guideline sets out just one model of care, which will not fit all. It is vital that service-users are given choice in their treatment. Referring those with a PGSI over 8 into one model of 'specialist' treatment, risks over-pathologising their experience, and discourage people for moving forward with treatment. This move could also risk increasing stigma, when we know from our lived experience community how entrenched this issue already is. The guideline should support a 'no wrong door' approach to people wishing to access treatment and support. It is not clear which organisations the NHS will commission to provide treatment services, and the possible exclusion of any organisation that has accessed gambling industry funding implies that this will largely be NHS provider services. A single or predominately NHS model of care could potentially create further barriers to accessing treatment. We hear from our lived experience community that many people simply do not want	Thank you for your comment. The term 'specialist setting' has been removed from this heading as it applies to all gambling treatment services. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but does not simply replicate the current provision.

				to speak to their GP about a gambling problem or have it on their NHS health record. Some people, mentioned within this guideline, such as people experiencing homelessness or in contact with the criminal justice system, may not have a registered GP. We also know that some groups are less likely to access and have lower levels of trust in NHS health and care services.	

Betknowmore UK	Guideline	7	13	1.1.13 - The Guideline should also mention in this section the need to assess any relationship between gambling and all forms of domestic abuse and coercive control.	Thank you for your comment. The committee decided that it was preferable to leave the wider category of 'safeguarding concerns' as this would cover all the examples you have given.
NECA (Charity Number 516516)	Guideline	7	14	1.1.11 - Note this does not state “refer to NHS commissioned specialist mental health services”. As this is an NHS paper that mental health services are generally provided by the NHS this is assumed for urgent issues (as opposed to the like of MIND). Therefore, why stress “NHS commissioned” in other aspects of this draft. Surely it is the specialist service that matters and would allow this document to be more inclusive and foster mutual collaboration.	Thank you for your comment. You are correct that the mental health services are assumed to be NHS-commissioned and so this has not been stated here. However, gambling support and treatment services are currently, in the main, not commissioned or provided by the NHS. Following the planned reconfiguration of gambling support and treatment services it is anticipated that there will be a move to NHS-commissioned gambling services (which may be provided by a range of providers) and so this has been clarified by the wording used in the revised guideline.

Parkinson's UK	Guideline	7	14	The questionnaire for impulsive-compulsive disorders in Parkinson's Disease (QUIP) is a validated screening tool for assessing pathological gambling in people with Parkinson's. Discriminant validity is high for gambling (=0.95). Sensitivity, when combined with other impulsive-compulsive behaviours, was 96%. For the shortened version (QUIP-S) sensitivity is 94%. (Weintraub, D., Hoops, S., Shea, J. A., Lyons, K. E., Pahwa, R., Driver-Dunckley, E. D., Adler, C. H., Potenza, M. N., Miyasaki, J., Siderowf, A. D., Duda, J. E., Hurtig, H. I., Colcher, A., Horn, S. S., Stern, M. B., & Voon, V. (2009). Validation of the questionnaire for impulsive-compulsive disorders in Parkinson's disease. Movement disorders: official journal of the Movement Disorder Society, 24(10), 1461–1467. https://doi.org/10.1002/mds.22571). We believe the guideline should recommend the use of the questionnaire for impulsive-compulsive disorders in Parkinson's Disease (QUIP) instead for people with Parkinson's.	Thank you for your comment. The committee recognise that people being treated for Parkinson's disease may be at a higher risk of gambling and have included this in the recommendations on at-risk groups, but did not specifically examine evidence for screening tools in this population and so have not included the QUIP or QUIP-S. However, the use of this tool has been passed to the NICE surveillance team for consideration when the NICE guideline on Parkinson's disease is updated.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	7	14	A link to PGSI would be beneficial.	Thank you for your comment. The committee were aware that in gambling treatment services, these tools, if used, would be available and so it was not necessary to add a link here. The PGSI tool for people to use themselves is on the NHS website and the link to this had been included earlier in the guideline.

Royal College of General Practitioners	Guid eline	7	14	Rec 1.1.12 – We are concerned the PGSI has not been developed to be used as a clinical tool. Although the PGSI can provide insights into a person's gambling behaviour and the extent of their gambling-related issues, its primary purpose is to screen and assess the risk level rather than directly recommend or direct individuals to treatment services. The PGSI should not be used in isolation as it does not assess the full spectrum of factors that might contribute to a person's gambling problem, as mentioned above. Furthermore, the PGSI is based on self-reported responses, which can be subject to biases and inaccuracies. Mandating that patients exclusively seek assistance from a specialised gambling service poses the potential risk of overlooking GPs who may be better suited to address various facets of the patient's needs. Given that NICE is keen for GPs to screen for gambling disorders it would also mean that GPs will be deterred from managing these patients in-house or using a treatment provider which they might be more familiar with, such as local mental health services. Similarly, the SOGS is considered a screening tool and should not replace a comprehensive clinical assessment by a trained professional. It is primarily used to help identify individuals who may benefit from further evaluation and, if necessary, treatment or support services for gambling-related problems. Furthermore, the SOGS is not up-to-date and is based on DSM-III criteria and therefore often used in North American services.	Thank you for your comment. You are correct that PGSI is a screening tool and not a clinical tool, and the committee recognised and discussed these limitations (see evidence review B). The recommendations elsewhere in the guideline have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The committee advised (and other comments from the RCGP state) that the capacity of GPs to treat people with gambling-related harms is limited, but the recommendations do not preclude this. As there was so little evidence for tools to assess gambling severity and the PGSI is well-known and widely used the committee included it as a weak 'consider' recommendation. There was some limited evidence for SOGS and so the committee included this as an option too. As there was so little evidence on assessment tools the committee made a research recommendation.

Haringey Public Health Department	Guid eline	7	14	1.1.12 - Would be helpful to provide links here to official SOGS and PGSI tools.	Thank you for your comment. The committee were aware that in gambling treatment services, these tools, if used, would be available and so it was not necessary to add a link here. The PGSI tool for people to use themselves is on the NHS website and the link to this had been included earlier in the guideline.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	7	14	Para 1.1.12 Tools to assess gambling related harms. We use the Problem Gambling Severity Index (PGSI) at assessment and at 12 months follow up. It should be noted, though, that both the PGSI and South Oaks Gambling Screen (SOGS) are widely used to measure population prevalence for problem or at risk gambling and have longer time frames associated with them – SOGS is a lifetime measure and the PGSI reflects events over the past 12 months.	Thank you for your comment. You are correct that SOGS and the PGSI are not ideal clinical tools and the committee recognised and discussed these limitations (see evidence review B). The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. As there was so little evidence for tools to assess gambling severity and the PGSI is well-known and widely used the committee included it as a weak 'consider' recommendation. There was some limited evidence for SOGS and so the committee included this as an option too. As there was so little evidence on assessment tools the committee made a research recommendation.

Gordon Moody	Guideline	7	014 - 016	Recommendation 1.1.12 should be given towards which tool to be used for assessment and why (the advice to use one or the other could make further population studies on prevalence difficult). Also, the DSM-5 diagnostic tool was omitted from the list, but DSM diagnostic tools are used for all other mental health conditions.	Thank you for your comment. There was very little evidence for tools to assess gambling severity and the PGSI is well-known and widely used so the committee included it as a weak 'consider' recommendation. There was some limited evidence for SOGS and so the committee included this as an option too. However, the committee recognised the limitations of both of these tools (see discussion in evidence review B) and so could not provide advice on when to use either. As there was so little evidence on assessment tools the committee made a research recommendation. The use of DSM criteria is included in the subsequent recommendation about carrying out detailed assessment.

GambleAware	Guideline	7	014 - 016	Both of the tools referenced are used in gambling treatment services currently, but neither determine treatment needs. Other assessment measures should be included.	Thank you for your comment. There was very little evidence for tools to assess gambling severity and the PGSI is well-known and widely used so the committee included it as a weak 'consider' recommendation. There was some limited evidence for SOGS and so the committee included this as an option too. However, the committee recognised the limitations of both of these tools (see discussion in evidence review B) and agreed that neither determines treatment need. As there was so little evidence on assessment tools the committee made a research recommendation. The PGSI is no longer included in the guideline as a cut-off measure to determine treatment need.
GamCare	Guideline	7	014 - 016	As mentioned, while GamCare uses the PGSI at all first assessment interactions, and measures PGSI at the end of a client's treatment pathway, it is not the sole measurement that GamCare – or the provider organisations across the NGSN (which support 90% of those seeking treatment for gambling-related harms), employ.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The evidence review looked for evidence on tools relating to measuring gambling severity (see evidence review B for more details) and so this was what the committee was able to consider in its recommendations. Other tools which measure wellbeing and mental health may be used by providers but they were not within the scope of this guideline.

				For the reasons set out above, and in agreement with NICE's own findings, GamCare views as insufficient the PGSI as a single reference or access point into NHS clinical treatment following an 8+ PGSI score, in particular since the PGSI offers only a 7-day overview of an individual's relationship with gambling. For these reasons, providers across the NGSN also employ questionnaires including the CORE-10, PHQ-9, and GAD-7, which offer more accurate clinical assessment and avoid over or under treating someone. These questionnaires should be delivered pre-NHS treatment (unless a patient/client request that they enter NHS clinical treatment).	

Royal College of Psychiatrists	Guideline	7	014 - 016	1.1.12. In the context of gambling treatment services, it is important to be clear about instruments that are designed to screen for gambling disorder, those to make a diagnosis, and those used to assess severity. PGSI is a screening tool originally designed for use in non-clinical settings but subsequently found to be unsuitable for this purpose due to low positive predictive power. It could be used in specialist settings (e.g. gambling clinics) that have a high expected prevalence of gambling disorder as a screening tool (predictive power is then likely to be reasonable), but it is not validated as a severity measure nor a diagnostic interview nor an outcome measure. SOGS is mentioned but this was developed and validated as a screening tool many years ago using now outdated diagnostic criteria, and it was not developed/validated as a severity measure. The most validated severity measures include GSAS and PG-YBOCS for example, but these are not mentioned. These are shown to be sensitive to treatment-related change and are designed for this purpose. In specialist settings it would seem most relevant to use (1) validated structured interview (or at least, the formal diagnostic criteria) to make the diagnosis; and (2) validated measures to quantify severity reductions in severity over time. The role for screening instruments in gambling clinics should be clarified/considered more carefully. Resources should ideally be available in specialist gambling services to conduct a full clinical assessment for each person, so screening would not typically be indicated or necessary in this setting. While some services may opt on local	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. You are correct that SOGS and the PGSI are not ideal clinical tools and the committee recognised and discussed these limitations (see evidence review B). No evidence that met the protocol criteria was identified for GSAS or PG-YBOCS. As there was so little evidence for tools to assess gambling severity and the PGSI is well-known and widely used the committee included it as a weak 'consider' recommendation. There was some limited evidence for SOGS and so the committee included this as an option too. As there was so little evidence on assessment tools the committee made a research recommendation. The following recommendation sets out clearly the components of a full assessment in a gambling treatment service.

				pathways to screen people and then not assess some people fully, we do not feel this should be what NICE recommends as it would not be the ideal approach. At the same time, we recognise there can be occasions in particular local services where screening may be necessary – but this should not be applied in a blanket way in the NICE guidelines / across services. Overall we recommend this section is clearer about the roles for different types of instruments and takes account of what the measures are validated for, as well as psychometric and other scientific findings.	

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	7	014 - 016	Concerning the PGSI itself. I have read the helpful document commissioned by Gambleaware: GambleAware report on the evidence underpinning this measure The PGSI is a validated screening tool, widely used, albeit not specifically designed, to estimate the number of people experiencing gambling problems. That is, it is a tool to estimate prevalence, such that at-scale service delivery decisions can be made. The PGSI has not been developed as a clinical tool and there is some debate surrounding how best to use the instrument as a tool for identifying and measuring risk and gambling harms. The PGSI can provide valuable insights into a person's gambling behaviour and the extent of their gambling-related issues, its primary purpose is to screen and assess the risk level rather than directly recommend or direct individuals to treatment services. The evidence as I understand it is that the PGSI is a	Thank you for your comment. You are correct that SOGS and the PGSI are not ideal clinical tools and the committee recognised and discussed these limitations (see evidence review B). The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The committee advised (and other comments from the RCGP state) that the capacity of GPs to treat people with gambling-related harms is limited, but the recommendations do not preclude this. As there was so little evidence for tools to assess gambling severity and the PGSI is well-known and widely used the committee included it as a weak 'consider' recommendation. There was some limited evidence for SOGS and so the committee included this as an option too. As there was so little evidence on assessment tools the committee made a research recommendation

				Screening Tool: The PGSI is primarily a screening tool, and its primary function is to identify individuals who may have gambling-related problems or are at risk of developing such problems. It categorises respondents into different risk levels, such as low-risk, moderate-risk, or problem gambling. While this can be a helpful first step in identifying those needing assistance, a clinical assessment is needed to determine the extent of the problem and any intervention required. Limited Clinical Diagnosis: The PGSI does not provide a clinical diagnosis of gambling-related harms. It provides a general indication of the severity of gambling-related issues but does not assess the full spectrum of factors that might contribute to a person's gambling problem. Further assessment is required. Individual Variation: The PGSI relies on self-reported responses, which can be subject to biases and inaccuracies. It may not capture all the complexities and nuances of an individual's gambling behaviour and its impact on their life. People may underreport or overreport their gambling issues for various reasons. Treatment Recommendations: While the PGSI may suggest the presence of gambling problems, it does not automatically guide individuals to specific treatment services. Recommending treatment should be based on further assessment which can then determine the most appropriate treatment options for the individual, which may include counselling, therapy, support groups, or other interventions. Cultural and Contextual Considerations: The effectiveness of the PGSI in different cultural and contextual settings may vary. Cultural norms can	

				impact how individuals respond to the PGSI and their subsequent access to treatment. Furthermore, even if the PGSI were a tool based on determining at the individual level the harm caused by gambling or the risk to the individual of developing harm, using a number to create cut-off points for treatment is not appropriate, even if the number was much larger than 8. It is akin to using a cut-off of, for example, 3 when a patient completes a PHQ9 (used to screen for depression) to determine that this patient should be seen by a specialist-led NHS-commissioned mental health service. By way of example. All patients with depression seen in specialist services will more than likely have a patient health questionnaire (PHQ9) above 3 but this is NOT the reason that they are seen by this level of expertise. It is because there are a host of other factors which necessitate them being seen by a specialist service. Likely, most patients contacting any service aimed at helping those with gambling harms (or at risk) will have a PGSI above 8, certainly, not one of the 600 patients presenting to our service (Primary Care Gambling Service) has a PGSI lower than 8.	

				Anyone crossing the threshold into admitting they might have a problem with gambling is likely to score 8, but this does not mean that they need to, or should be, seen by a specialist service. Using a number to create cut-off points to assume the high, medium or low risk when used outside the way the tool was designed can cause problems with the individual being seen in the wrong place for their immediate and ongoing issues. Furthermore, the term 'at-risk' can imply that people who are classified into PGSI groups 1-2 or 3-7 are not experiencing harm now but will do so in the future. When in fact they are showing some signs of problematic behaviour now but remain below the 8+ threshold. Additionally, at risk may be interpreted as implying that people who currently fall within the 1-7 classification groups will in the future progress into the 8+ group when not all do so.	

				The conflation of probability vs impact: being 'at-risk' of 'problem gambling', as measured by PGSI, must be distinguished from the impact of 'problem gambling' in terms of harm and well-being, instances of which can occur across different PGSI classification groups. NICE is doing a disservice to, and risks undermining other providers in the gambling care pathway if it continues to have this recommendation within its guidelines. Recommending that all patients with a PGSI score over 8 will inhibit the sort of work many services, especially those in the third sector, are currently doing and will prevent innovative solutions from being found to new and emerging problems. It will constrain the system being led through the specialist sector, which whilst this sector provides excellent care, is not often the place which is most readily adaptable to changing needs. Furthermore, whilst the guidelines are just that, guidelines, not tram lines (to quote a previous Chair of NICE, Sir David Haslam), practitioners will need to justify why they have not followed the guidelines in every case. This puts disproportionate pressure on all providers outside specialist NHS-commissioned services (who will of course meet this requirement as all their patients will have patients with scores above this number). This could end up with these providers risking fitness to practice hearings, complaints, negative CQC inspections, or other disciplinary interventions if they did not refer someone with this arbitrary and cut-off to a specialist service.	

				Given that NICE is keen for GPs to screen for gambling disorders, and therefore improving identification of patients, it would also mean that they (GPs) will be deterred from managing these patients in-house or using a treatment provider which they might be more familiar with, such as local mental health services or social prescribers trained in mental health.	

				Moreover, individuals experiencing gambling-related harms often present with more than just a gambling disorder, as evidenced by our service (Primary Care Gambling Service) where 98% of patients have co-morbidities. Mandating that patients exclusively seek assistance from a specialised gambling service poses the potential risk of overlooking other professionals who may be better suited to address various facets of the patient's needs. In summary, while the PGSI can be a useful initial screening tool for identifying individuals at risk of gambling problems, it should not be the sole basis for directing individuals to treatment services. An assessment is needed to determine the most appropriate treatment options for individuals with gambling-related issues. The PGSI can be a part of that assessment, providing valuable information about a person's gambling behaviour and its impact.	

				As already mentioned, the PGSI should not be used in isolation. Even the evidence cited by NICE encourages the use of other indicators of severity including alcohol use, social situation, presence of other mental health issues and suicidal risk, but it nevertheless gives prominence to the PGSI score. SOGS (South Oaks Gambling Screen) Much the same can be said of the SOGS. As with the PGSI, The SOGS is considered a screening tool, but it is essential to remember that it is not a diagnostic tool and does not replace a comprehensive clinical assessment by a trained professional. Its primary purpose is to help identify individuals who may benefit from further evaluation and, if necessary, treatment or support services for gambling-related problems. Additionally, different regions and organisations may use variations of the SOGS or other screening tools to assess gambling behaviour.	

NECA (Charity Number 516516)	Guid eline	7	15	1.1.12 - As the PGSI has been recommended for use previously in this guideline should this not be mentioned before, rather than after, the SOGS? This is the first time SOGS is mentioned.	Thank you for your comment. This order has been changed as you suggest.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	7	15	Rec 1.1.12 – Is SOGS a tool that practitioners are using regularly in the UK? Is PGSI not more widely used? Whilst we have no issue with it, it may seem odd to recommend its use when it is not already employed in NHS clinics for example. If including here, suggest linking to the tool so people are able to access it quickly.	Thank you for your comment. There was evidence that SOGS was an effective tool to assess the severity of gambling so, although PGSI is more widely used, SOGS was included in the recommendation. These recommendations are for gambling treatment services and so links have not been included as they would be accessed in different ways by different treatment services.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	7	16	We would, therefore, recommend that routine clinical outcome measures are also applied at assessment, throughout treatment and at follow-up. These should be applicable on a sessional basis, and refer, for example, to events during the past week or two weeks. They should also be easy to complete and make sense to the people using them, have positive correlation coefficients for reliability and validity, be sensitive to change and, minimally, include reference to gambling behaviour and associated activities ('symptoms'), levels of emotional / psychological distress or wellbeing, and the impact of gambling harms across other aspects of life. For these purposes we use: The Gambling Symptom Assessment Scale – GSAS. See The Gambling Symptom Assessment Scale (G-SAS): A reliability and validity study - PMC (nih.gov) Clinical Outcomes in Routine Evaluation- CORE-10. See CORE-10 information : Clinical Outcomes in Routine Evaluation (and CST) (coresystemtrust.org.uk) The Work and Social Adjustment Scale - WASAS. See The Work and Social Adjustment Scale: a simple measure of impairment in functioning - PubMed (nih.gov) We can use routine outcome measures to track a person's progress with them, and clarity areas of difficulty and where further interventions may be required. In aggregate, anonymised formats, clinical outcome measures also help with:	Thank you for your comment. There was very little evidence on tools to assess gambling-related harms and so the committee did not recommend their use as routine clinical outcome measures. The committee recognised there were limitations with the tools they have recommended (see evidence review B). The committee made a research recommendation as evidence that met the protocol criteria on the validation of the other tools you have suggested was not available.

				Understanding and managing service quality. Benchmarking against other, similar gambling harms treatment services.	
Parkinson's UK	Guid eline	7	17	Whilst medical history is included in the list of recommended assessments, we recommend including Parkinson's and associated medication to ensure that it is not overlooked as a causal factor in a person's pathological gambling.	Thank you for your comment. The committee decided that a full medical history would include a medication history and that in gambling treatment services the link between Parkinson's medication and gambling would be known and so did not add this level of detail to the recommendation.

Haringey Public Health Department	Guideline	7	17	1.1.13 - May be helpful to specifically refer to loan sharks as a high-risk form of borrowing here. Borrowing is often from friends/family, but loan shark borrowing is much riskier.	Thank you for your comment. The committee decided that borrowing money to fund gambling or gambling debts was an indicator of the financial impact and so did not add this level of detail to the recommendation.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	7	17	Para 1.1.3 Consider assessment of 'pre-disposing factors' or early influences, in the development of gambling harms, such as childhood aversive experiences, family history of gambling, easy availability of gambling opportunities, peer group influence, and neurodiversity. These may help make sense of reasons or motivations for continued gambling, such as 'feeling safe' 'excitement' 'the idea of winning' 'me time' or 'becoming immersed' / 'losing yourself' in a game.	Thank you for your comment. Neurodiversity, childhood development and family history have been added to the recommendations. The committee decided that the other factors you suggest are already included in the gambling history and factors that contribute to gambling.
Gambling with Lives	Guideline	7	017 - 029	1.1.13 - Move mental health questioning up the list here – to above financial risk.	Thank you for your comment. This has been moved higher up the list.

Gambling with Lives	Guideline	7	017 - 029	1.1.13 - Ask about products at either the gambling history or frequency question here – it's a big marker of harm if someone if up all night playing online casino games/ slots, for example. Also line 29, give examples/explain more about "type of gambling activities" – which products, online, high speed products etc.	Thank you for your comment. The committee discussed that the recommendations already included the types of gambling activities, but added 'location' as they agreed this would provide additional useful information about the nature of the gambling.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	7	23	Rec 1.1.13 – Replace the example with 'Spending money on gambling instead of essentials such as food, bills etc.	Thank you for your comment. The committee decided that money spent on gambling as a proportion of income was the best indicator of the financial impact and so did not make this addition.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	7	24	Rec 1.1.13 - Remove 'financial' from the sentence.	Thank you for your comment. This change has been made to reduce duplication.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	7	29	Rec 1.1.13 – Amend sentence to read 'type(s) of gambling activities participated in'. Also suggest that that is moved up to sit alongside 'frequency of gambling' (Page 7 lines 20 / 21)	Thank you for your comment. This line has been placed next to the line on gambling frequency as you suggest. Other edits have been made to this line as well so 'participated in' has not been added.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	7	027 - 028	Rec 1.1.13 – It should be clear this this will focus on the individual's perception of the impact of gambling on their mental health and that their health in general will be covered in separately in medical history questions. It is also important to ask about the perceived impact of gambling on physical health. It may be pertinent to move this point to sit alongside the risk of suicide (detailed on page 8 – line 9)	Thank you for your comment. The committee decided that it is not just the individual's perception, but also the professional's assessment of the impact so they did not make this change. However, the committee did add the impact on physical health. These points have also been reordered as you suggested.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	7	General	Rec 1.1.10 – General comment that any onward referrals to suicide prevention or crisis services should be tailored towards the individual, wherever possible.	Thank you for your comment. The referral would need to be made to the most appropriate service and, as with any clinical decision, this would be individualised, so no changes have been made to the recommendations.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	8	001 - 003	Consider asking about the person's last gambling episode and undertaking with them an initial analysis of factors that contribute to their continued gambling. This might identify situational factors and the availability of gambling opportunities / cues; 'urges', thoughts, emotions and actions before, during and after gambling; loss chasing.	Thank you for your comment. The recommendation already includes asking about gambling history and factors that contribute to continued gambling so no changes have been made to the recommendation.
Royal College of Psychiatrists	Guideline	8	001 - 013	Please include risk of domestic violence see: Intimate partner violence linked to gambling: cohort and period effects on the past experiences of older women | BMC Women's Health | Full Text (biomedcentral.com)	Thank you for your comment. The committee decided that it was preferable to leave the wider category of 'safeguarding concerns' as this would cover all the examples you have given.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	8	3	Rec 1.1.13 – Insert '...role of peers, other environmental factors.' at the end of the sentence.	Thank you for your comment. The committee decided that there were a large number of factors which could contribute to continued gambling, and these are just examples, not an all-inclusive list so they did not add these suggestions.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	8	6	Rec 1.1.13 – Suggest providing an explanation of DSM criteria and providing a link to the criteria.	Thank you for your comment. The committee decided that professionals working in gambling treatment services would be familiar with DSM so it was not necessary to explain this in detail in the guideline, but the latest version of DSM is 5 so this has been added.
Haringey Public Health Department	Guid eline	8	6	1.1.13 - Please refer to the DSM manual here to the specific criteria.	Thank you for your comment. The committee decided that professionals working in gambling treatment services would be familiar with DSM so it was not necessary to explain this in detail in the guideline, but the latest version of DSM is 5 so this has been added.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	8	6	Alignment to DSM criteria for gambling disorder, if appropriate – remembering that the focus is on the experience of gambling harms and that most health systems in the UK refer to ICD-10 coding.	Thank you for your comment. The committee agreed that both DSM and ICD were used so have added ICD-11 as an alternative.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	8	8	(After discussing reasons for seeking support, motivation to change and expectations and goals for treatment), consider including: identifying personal strengths, resources and family and social support that can help, and potential barriers to change and how these can be overcome	Thank you for your comment. The committee discussed this and agreed that all the factors you have listed are included in the original recommendation and so did not add this additional information.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	8	9	We suggest including past attempts at suicide - which contribute to the assessment of current risk of suicide	Thank you for your comment. This has been added.
Royal College of Psychiatrists	Guideline	8	11	Consider mentioning neurodevelopmental history, including neurodivergence/neurodiversity.	Thank you for your comment. This has been added.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	8	11	Medical history. Suggest: This will include physical health issues, such as chronic pain [See Barry D.T; Pilver C.E; Hoff R.A; Potenza M.N. (2013) Pain interference, gambling problem severity, and psychiatric disorders among a nationally representative sample of adults. Journal of Behavioral Addictions. 2 (3):138-44], mental health conditions, and use of alcohol, drugs, and nicotine. Evidence supports an association between problem gambling and use of tobacco - Grant, J.E and Potenza, M.N. (2005) Annals of Clinical Psychiatry 17 (4) 237-24. Consider also identifying other excessive behaviours, such as excessive sexual activity, use of pornography, gaming, and internet shopping.	Thank you for your comment. The committee discussed this and agreed that all the factors you have listed would already be included in the recommendations on assessing physical medical history, comorbidities and other dependencies so did not add this level of detail.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	8	011 - 012	Rec 1.1.13 – Does this refer to medical history prior to the gambling? If not, then it is hard to say what is their medical history in general and what is the impact of gambling on their mental health. Suggest combining with the bullet on page 27 – (lines 27 – 28) or making the distinction clearer.	Thank you for your comment. This bullet point has been expanded to clarify that it aims to identify aspects of their medical history (past or current) that may be contributing to the gambling that harms. The other bullet on mental health has also been expanded, so these two bullet points have not been combined.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	8	014 - 016	Para 1.1.14 We especially welcome the emphasis on collaborative case formulation to inform the person's care and safety plan.	Thank you for your comment.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	8	017 –	1.2 Information and support We found the recommendations in this section helpful and strongly endorse the need for unbiased information and support for individuals, affected others and wider community. We also recognise the developmental and organisational challenges in achieving a clear, shared understanding of the threats to public and individual health and wellbeing posed by the Gambling Industry	Thank you for your comment.

			general		
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	8	20	Consider current frequency, intensity and length of time (approximately number of years) pattern of gambling has continued.	Thank you for your comment. The recommendation already includes frequency and duration of gambling and gambling history, so no further changes have been made.
Parkinson's UK	Guideline	9	1	The provision of unbiased information to aid treatment and recovery is welcome. We recommend the addition of information provided that explains the link between Parkinson's, Parkinson's medications and gambling.	Thank you for your comment. The committee were aware that patient information supplied by Parkinson's treatment services and with Parkinson's medication already included information about an increased likelihood of gambling so this was not added to the specific information to be supplied by gambling services.

Haringey Public Health Department	Guideline	9	1	1.2.1 - Consider signposting here to alcohol and substance misuse services ("...what services are available...")	Thank you for your comment. The committee decided that some people would need signposting to services for other conditions not related to gambling but that this section was focused on gambling information only, so did not add this. Consideration of the need for drug and alcohol services are covered in the later section on principles of treatment.
Gambling with Lives	Guideline	9	001 - 028	1.2.1 - This section should include information about the impact on the brain – this is not a lifestyle choice, but a physiological change in the brain.	Thank you for your comment. The impact on the reward system in the brain has been added.
GambleAware	Guideline	9	2	GambleAware has long recognised the importance of early intervention and education to prevent gambling harms from becoming problematic. As such we have developed early signs information materials for affected others and those at risk of experiencing harms, and commission education and workforce training in England, Wales and Scotland as part of our prevention strategy.	Thank you for your comment and for telling us about the early signs materials you have developed and training you commission.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	9	3	Rec 1.2.1 – Can you qualify who you mean by 'others close to them'?	Thank you for your comment. The wording of this recommendation has been changed as it applies to all people who are experiencing gambling-related harms, including affected others.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	9	007 – 008	Rec 1.2.1 – Suggest rewording '…how the gambling industry may impact gambling behaviour' and framing as 'the practices of the gambling industry' or 'how the gambling industry / operators may incentivise, encourage and promote gambling behaviour.' Would also suggest that this section includes the need for the following information to be shared: 'Why is it common for people to feel unable to disclose their gambling or be afraid to ask for help due to the stigma and fear of repercussions. This can often be exacerbated by advertising which promotes the idea of 'responsible gambling', placing responsibility with individuals and increasing the sham when people begin to experience harm.'	Thank you for your comment. These changes have been made to include information on the practices of the gambling industry and the stigma and shame that may accompany seeking help.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	9	9	Rec 1.2.1 – Suggest the sentence reads '…types of gambling activities…'	Thank you for your comment. This change has been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	9	11	Rec 1.2.1 – Replace 'promoted' with 'predominantly'	Thank you for your comment. Changing 'promoted' to 'predominantly' would not make sense so this change has not been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	9	014 – 017	Rec 1.2.1 – This para focuses on a fairly narrow set of harms. Is there a rationale for including only these?	Thank you for your comment. The paragraph states that harms 'include' these ones so are only given as examples. These are the harms that the committee discussed as the ones people may be unaware of, and so highlighted them in their recommendation.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	9	016 – 017	Rec 1.2.1 – The existing evidence suggest that it is the debt caused by the gambling that leads to involvement in crime, not the gambling directly. This may appear to be semantics. But to avoid stigmatising the issue it might be useful to clarify this.	Thank you for your comment. The recommendation has been amended to state that gambling can lead to debt, and to crimes, as the theft or fraud may be to fund gambling and not just to pay off gambling debts.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	9	18	Rec 1.2.1 – Suggest re-wording to say 'how to recognise that potential harms associated with gambling.'	Thank you for your comment. This change has been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	9	26	Rec 1.2.1 – May want to consider an additional bullet point in this section to cover 'providing information on how gambling can interact with co-occurring MH and substance misuse conditions. Sometimes gambling will not have been the cause of these issues and may then have an impact on them.	Thank you for your comment. This link between gambling and mental health and alcohol and substance dependence has been added to the recommendation.
His Majesty's Prison and Probation Service (HMPPS)	Guid eline	9	42	Family support link should be included i.e. Gamfam and other family organisations/services.	Thank you for your comment. The committee decided to provide information on the type of services but not to recommend individual services by name as these may vary in availability across the country, or may be delivered by other providers under different names.
Gambling with Lives	Guid eline	10	1	1.2.2 - This second bullet point here should say "Recovery is achievable through treatment."	Thank you for your comment. This change has not been made as the committee were aware that some people were able to stop gambling on their own or with minimal support, so it was not true that all people needed treatment.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	10	4	Rec 1.2.3 – As per notes for Rec 1.2.1 (pg 9 lines 7-8) This information should also be shared with 'affected others to support their understanding and help them effectively support someone experiencing harmful gambling.	Thank you for your comment. This recommendation is about providing information to 'affected others' (this is in its stem) and so it has not been changed.
Gambling Harm UK	Guideline	10	4	We suggest the inclusion of domestic abuse as an area for practitioners to give advice on how and where to seek help and support.	Thank you for your comment. The committee decided that the recommendations already provided advice on a wide range of sources of help, and these sources would be able to provide advice on domestic abuse, so this has not been added separately.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	10	7	Rec 1.2.3 – Amend the sentence to read '…how those experiencing harmful gambling can be supported….'	Thank you for your comment. This recommendation is about providing information to 'affected others' (this is in its stem) and so the wording 'how they can support the person…' is what is intended.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	10	11	Should we be saying something about support for families who are or are being forced to pay off gambling debts?	Thank you for your comment. This recommendation already covers 'financial support' so the additional detail about gambling debts would be included here, and has not been added separately.

Royal College of Psychiatrists	Guid eline	10	12	1.2.4 “Provide information and support in ways that the person prefers, for example, at face-to-face consultations or online, such as through apps or social media”. This should be clarified as passive information can practically be offered via all these methods but support should not routinely be offered via social media or apps. This is setting an unrealistic and unsafe expectation for services and would potentially be contrary to law and/or professional guidelines.	Thank you for your comment. The committee were aware of a number of situations where support is provided via commercially available apps such as those for depression and anxiety (a number of which have been approved for use by NICE), and that these may be promoted via social media including NICE's own X (formerly Twitter) communications so apps and social media have not been removed from this recommendation.

Adferiad	Guideline	10	12	The guidelines mention the use of both face-to-face consultations and online consultations (through apps or social media). This is positive in terms of increasing accessibility, there is no consideration of how information and support would be tailored to different populations. There is no mention of tailored support for the LGBTQ+ community despite evidence suggesting that individuals with minority sexual orientations may be at higher risk of experiencing problem gambling and associated factors (Grant & Chamberlain, 2023).	Thank you for your comment. Information may often need to be tailored to the needs of different people, and this is explained in the NICE guideline on patient experience, which is cross-referenced from this section, so this is not repeated in all other NICE guidelines. Likewise, the section of the guideline on improving access already states that services should take into account the needs of different groups and so no change has been made. The committee looked for evidence on methods to improve access for under-represented and marginalised groups such as those you mention but found no evidence and so made a research recommendation. Further information on equality issues are included in the Equality Impact Assessment that accompanies the guideline.

Parkinson's UK	Guideline	10	15	We recommend that information about gambling-related harms is clearly highlighted in Parkinson's clinics and also included in medication information leaflets. (Skelly, R. (2020). Gambling Addiction and Parkinson's disease - supporting better patient care. Royal College of Physicians. Accessed online 15 Nov 23 at https://www.rcplondon.ac.uk/news/gambling-addiction-and-parkinson-s-disease-supporting-better-patient-care). People with Parkinson's who we spoke to also recommended the need for clear signposting on the front of drug boxes to highlight the risks posed to people with Parkinson's taking certain medications.	Thank you for your comment. The recommendation states that information should be promoted and signposted in all health services, so Parkinson's clinics have not been added specifically as they would already be included. Likewise, the risks of excessive gambling are already included in the patient information leaflets provided with Parkinson's medication so this has not been added to the recommendations. The decision on information to include on medicines' packaging is made by the MHRA and so has not been included in the recommendation.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	10	015 – 016	Rec 1.2.5 – Amend the sentence to read '…information about the risks and harms associated with gambling:'	Thank you for your comment. The information will cover a wider range of issues than just the risks and harms (as detailed in the previous recommendations) so this change has not been made.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	10	017 – 019	Rec 1.2.5 – Lots of 'ands' in the sentence. Suggest rewording to say 'is well promoted and signposted in local and national health and social care services, as well as in the wider community, including in the criminal justice system.'	Thank you for your comment. This rewording has been done.

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	10	General	Although there may not be evidence for the role of digital in promoting the dissemination of information in this area - it would be forward-thinking to acknowledge the use of digital tools in this section. Innovative digital tools have a role in prevention and support especially for those who may wish to keep anonymity. They offer a way of accessing support for different languages. The guideline does not include connecting up services through online digital multidisciplinary meetings or sharing of learning and information between the providers in the system. This would have a direct benefit to the users of this guideline. There is no mention of remote consultations or digital triage. Innovative digital tools have a role in prevention and support especially for those who may wish to keep anonymity.	Thank you for your comment. The fourth recommendation in this section advises that information should be available in the way the person prefers, including online and though apps or social media. Remote consultations are covered in the section of the guideline on principles of treatment. The committee discussed digital triage and agreed it was a useful tool, and the revised guideline now contains recommendations on referral and triage.

				They offer a way of accessing support for different languages. The guideline does not include connecting up services through online digital multidisciplinary meetings or sharing of learning and information between the providers in the system. This would have a direct benefit to the users of this guideline. There is no mention of remote consultations or digital triage.	
Gambling with Lives	Guid eline	11	001 – 030	1.3.2 - Aftercare should be mentioned here.	Thank you for your comment. Aftercare has been added to this recommendation.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	11	001 - general	Models of care and service delivery. We consider these to be helpful recommendations for commissioners and providers of services.	Thank you for your comment.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	11	2	Rec 1.3 – Suggest rewording the sentence to read '… and providers of gambling treatment, including specialist and third sector services.'	Thank you for your comment. Gambling treatment services and gambling support services have now been differentiated and defined in the guideline so the specialist and third sector services are all now all included in these recommendations.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	11	4	1.3.1 - It should be made clear that money from the industry (levy) is being used to fund some services for transparency.	Thank you for your comment. When the planned change to a compulsory levy is made, the money will be used to fund NHS-commissioned services directly, and the industry will therefore no longer have any influence over the commissioning and provision of services or research.

Betknowmore UK	Guideline	11	004 - 007	To date all gambling support and treatment services have been established with funds from the gambling industry, including some NHS gambling clinics, via funds from GambleAware or RET. The NGSN has also been forced to rely upon this funding structure which was established by government and which has multiple levels of oversight and governance to ensure that NGSN providers are entirely independent from industry influence. Even after the mandatory levy has been introduced, the source of the funds will remain the gambling industry. The NGSN (and previously NGTS) is a client focused network of experienced specialist service providers and there is no evidence of its activities having been influenced by industry. Regardless of the funding structures put in place, this will continue to be the case. The NHS continues to benefit from the proceeds of gambling activities and indeed sanctions such activities for fund-raising purposes e.g. https://www.uhdcharitylottery.co.uk/home/howitworks and https://healthservicediscounts.com/nhs-offer?offer=health-service-charity-lottery-support-health-service-staff-win-up-to-ps10000-6373	Thank you for your comment. The current system using a voluntary levy has been assessed as requiring change to remove any potential conflicts of interest. When the planned change to a compulsory levy is made, the money will be used to fund NHS-commissioned services directly, and the industry will therefore no longer have any influence over the commissioning and provision of services or research. It is likely that the planned future services that you describe provided by a number of organisations will be recommissioned by the NHS, with a clinical governance structure. You are correct that some lotteries are used to provide money to the NHS but this money is provided directly to the NHS and is not subject to commissioning by an organisation with direct links to the gambling industry.

Gordon Moody	Guideline	11	004-007	At the moment there is no framework for the integration of NHS, third sectors services and private gambling treatment services, no clinical modelling, no evaluation of the long-term impact of the current treatment system and no independent regulation via the Care Quality Commission. Which is why the commissioning recommendations for developing a coherent model of care of gambling related harms is very welcomed.	Thank you for your comment and support for these recommendations.

GambleAware	Guideline	11	004-007	We are in total agreement that industry should have no influence over treatment services. However, it is misleading and inaccurate to imply that treatment services that are industry funded are less effective - there has been no evidence to suggest that industry funding reduces quality or equates influence. The services provided through the NGSN have no industry influence. This statement may discourage healthcare professionals from referring to these services, and may also turn people experiencing harms away from self-referring.	Thank you for your comment. This recommendation does not suggest that current services are less effective because they are industry funded, but the current system using a voluntary levy has been assessed as requiring change to remove any potential conflicts of interest. When the planned change to a compulsory levy is made, the money will be used to fund NHS-commissioned services directly, and the industry will therefore no longer have any influence over the commissioning and provision of services or research

His Majesty's Prison and Probation Service (HMPPS)	Guideline	11	004-007	1.3.1 - Strongly support the recommendation to provide gambling services free from involvement by the gambling industry within HMPPS. Any investment in HMPPS resource, in the broadest sense of resource (e.g. time, staff, physical space) should be approved by the National Framework for Interventions. HMPPS is currently carrying out a needs analysis in England and Wales to determine the level of need and support required with recognised care pathways.	Thank you for your comment and support for this recommendation. Thank you for telling us about the HMPPS needs assessment.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	11	004-007	1.31 - Gambling treatment services should be commissioned and provided without influence or involvement from the gambling industry, ensuring there are no conflicts of interest between the commissioners and providers of services and the gambling industry - What are or should be the assurance/governance mechanisms for this?	Thank you for your comment. The NHS commissioners (who, in accordance with Nolan principles, do not have links with the gambling industry) would include the need for no conflicts as part of the requirements for provision of a gambling treatment or support service by providers in the future.

GamCare	Guideline	11	004-007	GamCare's overall mission is to support those affected by problem gambling and to minimise gambling-related harm. As a trusted and valued organisation in charity sector, GamCare recognises that, in pursuit of this goal, we will encounter conflicts of interest which have the potential to impact on the ability of our trustees and staff to act, and to be seen to act, only in the best interests of the charity and our beneficiaries. The gambling industry has absolutely no input, influence, or authority over any of our activity, and DCMS, DHSC, OHID and the Gambling Commission all recognise our integrity and independence and work closely with us.	Thank you for your comment. The current system using a voluntary levy has been assessed as requiring change to remove any potential conflicts of interest. When the planned change to a compulsory levy is made (which it is noted that you support), the money will be used to fund NHS-commissioned services directly, and the industry will therefore no longer have any potential influence over the commissioning and provision of services or research.

				The Government's White Paper explicitly acknowledges that the gambling industry has no influence on GambleAware's (our commissioner) commissioning decisions. We also draw the Committee's attention to the recent, and very positive joint statement that Professor Henrietta Bowden-Jones OBE, National Clinical Director on Gambling Harms for NHS England, made alongside GambleAware on the GambleAware website, reiterating the NHS's commitment to working in partnership with GambleAware. GamCare draws attention to recently published statistics for Tier 3 and 4 treatment (which includes gambling treatment therapy and residential treatment), which show that 92% of people who completed their treatment showed improvement on their Problem Gambling Severity Index (PGSI) score. It also shows that 86% of people who completed their treatment also reduced their psychological distress around their gambling behaviour. The most recent statistics show that the rate of 'problem gambling' among service users fell from 90% to 28% between their first and last appointments. Furthermore, among users who completed treatment, the rate of 'problem gambling' was 13% by the end of treatment. Most users begin treatment with very severe gambling problems, often with a PGSI score of 27 – the highest possible severity of gambling problems.	

				Notwithstanding the critique made of the PGSI within this response, most users see considerable improvements on their PGSI scores with, on average, a 15-point reduction in PGSI among those completing treatment. A more accurate assessment of effectiveness would bear in mind where people start from and the progress they make throughout treatment. NGSN providers are required to deliver several quality standards regularly monitored and aligned to the CQC checklist. Additionally, in partnership with the Gambling Commission, we note that GambleAware have commissioned the CQC to deliver an inspection regime for the sector, not previously available.	

				GamCare is highly alert to the risk of undue influence, and we are proactive in identifying and addressing any threat to the independence and impact of our work, including specific consideration of our work with service users, contracted delivery partners and gambling operators. GamCare therefore draws the Committee's attention to its publicly available Conflict of Interest Policy, most recently updated in October 2023, which you can read here Conflict of Interest Policy (d1ygf46rsya1tb.cloudfront.net).	

				To date, all gambling support and treatment services have been established using funds that to a greater or lesser extent are derived from the gambling industry, this includes some NHS gambling clinics, via funds from GambleAware or voluntary operator Research, Education and Treatment funding. The NGSN, for which GamCare is System Coordinator, has multiple levels of oversight and governance that ensure providers working within it are independent of industry influence. The NGSN is a client focused network of experienced specialist service providers. There is no evidence of its work being influenced by industry. The current voluntary funding arrangement was determined by Government and there is no other source of funding for gambling harm treatment and research. Receipt of funding from gambling operators does not in any way enable any influence or control from the industry over how funding is used. GamCare fully supports the introduction of a statutory levy as a means of further cementing this position.	

				Swift development and implementation of the levy model will be vital. The statutory levy will enable proper funding oversight, avoid duplication of work, and provide a sustainable, transparent, and long-term funding model to ensure the successful delivery of vital research, treatment, and prevention services.	
Royal College of Psychiatrists	Guideline	11	004-007	1.3.1. We agree on the importance of protecting patients as well as policy/research/practice/education from industry influence (our paraphrasing) both in the future and also from the effects of past influences. The college would support a statement being added which states that “Measures should be in place to ensure that organisations that have previously been industry funded become completely free of these influences as soon as possible and that these influences are properly declared in any commissioning processes.”	Thank you for your comment. The current system using a voluntary levy has been assessed as requiring change to remove any potential conflicts of interest. When the planned change to a compulsory levy is made (which it is noted that you support), the money will be used to fund NHS-commissioned services directly, and the industry will therefore no longer have any potential influence over the commissioning and provision of services or research. This recommendation already states that commissioners and gambling treatment and support services must not be involved with or influenced by the gambling industry but the exact mechanisms for ensuring any conflicts are managed would be for individual organisations to implement so this recommendation has not been further amended.

				Processes should also be in place to ensure that individuals and organisations with conflicts of interest in relation to the gambling industry are not involved in any funding decisions relating to care provision (or indeed any other elements such as policy, research, education, and public health). Processes and panels making decisions about funding need to be completely independent from the gambling industry. We request that these points be included more explicitly.	

Adferiad	Guideline	11	004-007	Previously NHS clinics were set up with funds received from Gamble Aware, which has come from industry. The levy will be funds that come from the gambling industry. The NHS continue to benefit from the proceeds of gambling activities - https://healthservicediscounts.com/nhs-offer?offer=health-service-charity-lottery-support-health-service-staff-win-up-to-ps10000-6373	Thank you for your comment. The current system using a voluntary levy has been assessed as requiring change to remove any potential conflicts of interest. When the planned change to a compulsory levy is made, the money will be used to fund NHS-commissioned services directly, and the industry will therefore no longer have any influence over the commissioning and provision of services or research. You are correct that some lotteries are used to provide money to the NHS but this money is provided directly to the NHS to use as it wishes and is not subject to the control of organisation with direct links to the gambling industry.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	11	004 – 007	Rec 1.3.1 (and 1.3.2) – Would suggest the inclusion of the following (or something similar) given that industry influence may extend beyond commissioning and perpetuate unhelpful narratives of gambling harm which the service provider should avoid: The provider of treatment services should also demonstrate independence of industry in their description of harmful gambling and gambling-related harms. This may be demonstrated in their service description, but will also apply to their ongoing communications with the public, service users and wider stakeholders. The provider should have a clear understanding of all influences to gambling, knowledge of gambling products and how these relate to harmful gambling The provider should not use narratives which promote gambling culture or imply that gambling has ‘safe’ levels (as we know that there is variation n addictiveness of products / product design) The provider should ensure that any communication do not imply that ‘most people’ are able to gamble ‘safely’ as this services to increase stigma by asserting that only ‘certain individuals will be subject to harm.	Thank you for your comment. The committee were very careful in writing the guideline to ensure that their recommendations did not perpetuate unhelpful narratives about gambling-related harms. The recommendation already states that services should be commissioned and provided without gambling industry influence or involvement. The section on information also states that all information must be unbiased, defined as '... produced without input or influence from organisations with a conflict of interest, such as the gambling industry...' and so these additions have not been made.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	11	6	Rec 1.3.1 – People can have conflicts of interest but don't usually refer to this as conflicts of interest between people. Suggest that this could be edited to say ' no connections (financial or otherwise) between commissioners, service providers and the gambling industry that would impact the independence and impartiality of service provision.'	Thank you for your comment. The recommendation refers to conflicts between organisations, not between people. The committee decided that there should be no conflicts of interest, and that putting caveats on the 'connections' would dilute the strength of this recommendation, so did not make the change you have suggested.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	11	006 – 007	Rec 1.3.1- In respect of conflicts of interest, given the space we operate in and tensions across NHS and non-NHS commissioned services, it may be worth defining exactly what this is, e.g. have received no direct funding for industry in the last x years or have received no funding from industry either directly or indirectly.	Thank you for your comment. Following the planned introduction of the statutory levy, the money for treatment will still come from the gambling industry, it is just the control of how that money is used will be changed, and therefore the committee decided that it would be confusing to create definitions in this way, and that conflicts of interest was a clearer way of ensuring there was no influence from the gambling industry.

His Majesty's Prison and Probation Service (HMPPS)	Guideline	11	008-026	1.32 - Commissioners and service providers should ensure that services: are multidisciplinary and provide coordinated support for people experiencing gambling-related harms across health services and local authorities, including social care, with agreed protocols for sharing information between providers – Add '…and criminal justice system agencies'	Thank you for your comment. This has been added.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	11	9	Rec 1.3.2 – Reword the sentence to read '…assessment of the risk and severity of gambling-related harms, …' Important as would assess the risk before the severity.	Thank you for your comment. This change has been made.
Adferiad	Guideline	11	009-010	The wait time that is being feed back between current providers for referrals into the NHS clinics would suggest that the NHS is not best placed to provide prompt and ongoing assessment needs.	Thank you for your comment. The recommendations have been amended to clarify that gambling treatment services will be NHS-commissioned but are likely to include a range of providers, following the planned reconfiguration of treatment services when the compulsory levy is introduced. Thus waiting times will not necessarily be a problem as you suggest.

Betknowmore UK	Guideline	11	009 - 010 & 017	1.3.2 - The NHS is not best placed to provide prompt and ongoing assessment of needs, given the pressures the service is under and the current average waiting time of 15 days to see a GP. The NGSN currently has a target waiting time of no more than 2 days. Betknowmore UK consistently meets this target or improves upon it.	Thank you for your comment. The recommendations have been amended to clarify that gambling treatment services will be NHS-commissioned but are likely to include a range of providers, following the planned reconfiguration of treatment services when the compulsory levy is introduced. Thus waiting times will not necessarily be a problem as you suggest.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	11	10	Rec 1.3.2 - When referring to '…risk of suicide...' should expand to include suicidal actions or suicidality.	Thank you for your comment. An assessment of the risk of suicide would include these factors, and this is explained in the separate recommendations on the assessment and action to be taken regarding the risk of suicide (in the recommendations on initial assessment), so this has not been changed.
Adferiad	Guideline	11	011 - 012	The National Gambling support helpline should remain an entry point and be included within the guidelines.	Thank you for your comment. The committee agreed that a national telephone helpline was useful to encourage access and so included this in their recommendations on supporting and encouraging access. The committee discussed that in future, with the planned reconfiguration of gambling treatment services, this service may be commissioned by the NHS.

Betknowmore UK	Guideline	11	011 - 012	The National Gambling Helpline should remain a central entry point and should be included within the Guideline.	Thank you for your comment. The committee agreed that a national telephone helpline was useful to encourage access and so included this in their recommendations on supporting and encouraging access. The committee discussed that in future, with the planned reconfiguration of gambling treatment services, this service may be commissioned by the NHS.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	11	12	Rec 1.3.2 – Expand sentence to '…including self-referral, in-person and online support and treatment options.'	Thank you for your comment. The detail of how services should be delivered (for example the options of in-person and remote support) is covered in later recommendations on principles of treatment and so has not been repeated here.
The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	11	14	There is again undue emphasis on the PGSI score.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

Gordon Moody	Guid eline	11	013 - 015	Although we agree with recommendation 1.3.2 to "have clear criteria for entry to all levels of the service" there is no recommendation as to what those "levels of service might be" and how a clear assessment framework could be integrated at a national level.	Thank you for your comment. The recommendations have been amended to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support, as you suggest. The services have also been differentiated into treatment services and support services, and these have been defined, and these include the community-based and peer-led interventions you mention.

				Currently, there is no triage and referral system at a national level, and we would welcome recommendations regarding the development of such a system. We believe that there is value in implementing the current tiered system used in the addiction and mental health model of care. We recommend the development of a national triage service, who would support with the implementation of the assessment and support recommendations and will be best suited to work together with the service users, to understand their strengths and needs and decide the most appropriate care pathway. Individuals with lower severity could commence with less intensive interventions and step-up to intensive interventions and Individuals with higher severity may be better suited to more intensive interventions.	

				Also, early community-based and peer led interventions, which are evidence-based interventions embedded in every substance misuse treatment system, would be able to reduce the need for structured treatment for a considerable number of people.	
NECA (Charity Number 516516)	Guideline	11	013 - 016	1.3.2 - Suggest removal of “NHS commissioned” and the service should accept all who have a perceived or measured risk. Where is the evidence to set this at 8 with a direct referral to NHS? Particularly as some including those with lived experience feel PGSI is a poor tool to assess individual need. NICE's stated aims emphasis the importance of evidence-based recommendations that provide high-quality care and produce the best outcomes within the available budget. Therefore, is the PGSI scoring a valid tool to use in a NICE document?	Thank you for your comment. The recommendations have been amended to remove the PGSI criteria of 8, to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced.

GamCare	Guideline	11	013 - 016	Please see comment 4 above The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five days from assessment to the offer of a first support session at GamCare. Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner. GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment.	Thank you for your comment. There is no suggestion in the guideline that access to services will only be via a GP referral as a referral could be made by a range of professionals and practitioners, or via self-referral. A new section has been added to the guideline on referral and triage and directing people to the correct level of service. The recommendations have been amended to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced.

Royal College of Psychiatrists	Guideline	11	013 - 017	1.3.2. Again example of PGSI should be deleted as it is not sufficiently validated for the proposed purpose. Instead we would suggest simply stating that individual services need to have clear referral criteria, taking into account local needs. In making this recommendation we are mindful that different services may have different approaches to screening and entry, depending on local needs, as well as different opinions based on reading of the available evidence (which is often limited for gambling disorder).	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

GambleAware	Guideline	11	015 - 016	Currently, the only gambling treatment services commissioned by the NHS are its own clinics. As such, the phrase “NHS-commissioned” can only mean those clinics. A reasonable interpretation of this wording is that it will effectively exclude the vast majority of current gambling treatment provision, because that provision is commissioned by the third sector. Doing so will adversely affect access, population outcomes, costs to the statutory system, system capacity and system stability.	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but does not simply replicate the current provision. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such

				This may change should the NHS become the sole commissioner of all treatment (delivered by both the NHS and third sector) as proposed in the current Government consultation on the introduction of a statutory industry levy to fund gambling harms research, treatment and prevention. However, these draft guidelines were published before the consultation, meaning they cannot have been making reference to it when recommending an NHS-first approach. This is a concerning exclusion of third sector provision given it provides the vast majority of services and delivers high quality care and outcomes. Furthermore, the timelines of any new commissioning arrangements are yet to be confirmed and will in any case require a multi-year transition period before they are fully operational. As such it is vital that in the meantime the guideline does not only direct people to NHS-delivered services, but also to the wider range of third sector treatment that is available via the NGSN – which includes specialist treatment. Therefore, it would be both accurate and sufficient to simply say “specialist gambling treatment services” – which may or may not be NHS-commissioned at this point in time.	as the voluntary sector, as they would with any other health condition. You are correct that no cost-effectiveness analysis has been carried out to compare voluntary sector and NHS treatment, and so currently, there is no evidence that NHS-commissioned services would be less cost-effective than existing services.

				Furthermore, if this guidance does exclude third-sector treatment and support provision, this would undermine NICE's own principles – namely principles 4, 6, 7, and 8: Principle 4: the guideline does not account for or respect individual patient choice. Principle 6: the notion that solely NHS treatment should be required or recommended is completely unevidenced. Principle 7: no cost-effectiveness analysis has been produced to compare NHS treatment provision with third sector treatment provision. Principle 8: third sector provision has driven much, if not all, of the innovation in support, including community outreach, peer support and aftercare.	

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	11	16	Consider insert: ensure that gambling harms is not used as a reason to exclude or delay access to other services, for example, NHS Talking therapies.	Thank you for your comment. The need to consider treatment for other comorbidities in relation to the treatment of harmful gambling is already included in the recommendations on the principles of treatment and so has not been repeated here.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	11	17	Para 1.3.2 should read ‘deliver timely support so that treatment can start as soon as possible after assessment and formulation (not diagnosis)’.	Thank you for your comment. This has been changed to 'after assessment', as formulation may not always be necessary for some people with lower levels of harm.
Adferiad	Guideline	11	017 - 018	What exactly is meant by “timely support”? This is vague and open to interpretation. More specificity is needed here. Recent referrals into current NHS clinics have wait times of 6 weeks for an assessment and then a further 5-6 weeks for treatment to start. Is this classed as timely support?	Thank you for your comment. It is not possible to set a finite figure for this as it will depend on the level of risk, need and type of service. The planned reconfiguration of gambling treatment and support services when the compulsory levy is introduced will increase the capacity of NHS-commissioned treatment and support services.

Gordon Moody	Guid eline	11	017 - 018	The recommendation 1.3.2 of delivery of timely support is vague and should be made clearer and differentiate between the various levels of support needed as well.	Thank you for your comment. It is not possible to set a finite figure for this as it will depend on the level of risk, need and type of service. The planned reconfiguration of gambling treatment and support services when the compulsory levy is introduced will increase the capacity of NHS-commissioned treatment and support services.
GamCare	Guid eline	11	017 - 018	GamCare wishes to draw attention to the importance of ensuring that the treatment system is equipped with the capacity, capability and infrastructure to deliver low wait times and easy access to treatment. GamCare and other voluntary sector providers have been delivering treatment for people with PGSI >8 with good outcomes for many years. These organisations have been successfully working with this group of clients for a prolonged period and have developed the skills and knowledge to do so in a safe and effective way that meets the needs of service users, whilst also knowing when to refer high complexity, high risk presentations to NHS partners.	Thank you for your comment. The recommendations have been amended to remove the PGSI criteria of 8, to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced. The resource implications of reconfiguring the service and the need to train additional staff will be considered by the NICE resource impact team when considering the resource impact of this guideline. In addition, a new section on referral and triage has been added to the guideline to enable people to reach the most appropriate level of support and treatment, and people will still be able to self-refer, so services will not only be accessible via a GP referral, as a referral could be made by a range of professionals and practitioners, or via self-referral.

				The Proposed Guideline ignores existing waiting times to access NHS gambling services and an average 2 week wait for a GP. Wait times across the NGSN are low compared to those of NHS services, and the NGSN currently has a target waiting time of no more than 2 days. The guideline would cause NHS specialist clinic waiting times will grow rapidly and levels of risk will become unacceptable. The Guideline also ignores that the NHS is widely recognised to be in crisis with long waiting times for GPs, at A&E, for ambulances, tests, results, surgical procedures etc. The Proposed Guideline therefore risks people avoiding seeking support for fear of putting more pressure on NHS services, as well as fearing long waiting times.	

				In particular, with a maximum score of 27, if every person with an above 8 PGSI score were directed to NHS gambling clinics, the clinics would be overwhelmed by demand and waiting times would present unacceptable levels of risk. The NGSN has considerable experience supporting PGSI scores and complex co-morbidities. The proposed threshold removes patient/client choice and risks people underreporting harms in order to access third sector. In addition, people with lived experience have reported that they do not want to be diagnosed as a 'problem gambler' and for this to appear on their medical records.	

				Resourcing for the proposed guideline also need to be carefully considered. Introducing a new responsibility for health and care staff to ask about gambling harms requires resource, e.g., training, time for difficult conversations, and changes to client management systems. The NGSN already exists as an integrated network covering all GB regions, with existing referral pathways between providers and a strong record of partnership working, demonstrating the ways in which there is already capacity in the system. In addition, the time primary care and social services staff can spend with clients is also limited. An over reliance on PGSI may therefore mean poorly tailored treatment and support, risking increased drop-out rates and relapse.	

				Finally, we require further evidence on the NHS' capacity to treat this number of people in the NHS gambling services, if GamCare is included as an NHS-commissioned specialist gambling service. The NHS plans to treat up to 3,000 patients a year across its 15 new clinics. While these additional clinics are welcomed, the capacity available will result in delays and substantial waiting lists for people experiencing gambling harm. Based on the number of people contacting GamCare with a PGSI score above 8(4,006 for 2022/23), these proposals are likely to lead to a significant increase in referrals to NHS-commissioned specialist treatment. GamCare draws attention to the importance of ensuring that the NHS is equipped with the full capacity, infrastructure and staffing to manage such an in influx with just NHS services, and as such we look forward to ensuring needs are met by GamCare as an NHS-commissioned specialist.	

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	11	18	Rec 1.3.2 – Given that an affected other s unlikely to have a formal ‘diagnosis’ this sentence should be re-phrased to read ‘after assessment.’	Thank you for your comment. This has been changed to 'after assessment'.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	11	21	Rec 1.3.2 – Should also include homeless and those who have co-occurring conditions as co-horts who may find it difficult to access services.	Thank you for your comment. People experiencing homelessness have been added to this recommendation, but the link to the recommendations on access to treatment, which is already included, provides detailed advice on improving access for people with other conditions so this has not been added to the list of examples.

Adferiad	Guideline	11	019-020	Similarly, the term “easy access” is too broad and will differ from person to person. How does this apply for an individual in Wales wishing to access treatment when there are no commissioned NHS services.	Thank you for your comment. Easy access will vary from person to person and so the system will need to be adaptable to overcome barriers to access depending on local needs and so this has not been defined further here. However, a later section of the guideline includes separate recommendations on improving access. NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive
Betknowmore UK	Guideline	11	019-021	A mixture of in-person and remote digital support and treatment services should be offered in order to improve accessibility.	Thank you for your comment. Details of how services should be delivered to improve access are already included in the section on improving access, which is hyperlinked from this recommendation, and so have not been repeated here.

GamCare	Guideline	11	023 - 026	Please see comment 4 above. The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five days from assessment to the offer of a first support session at GamCare. Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner. GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment.	Thank you for your comment. There is no suggestion in the guideline that access to services will only be via a GP referral as a referral could be made by a range of professionals and practitioners, or via self-referral, and a new section has been added to the guideline on referral and triage and directing people to the correct level of service. The recommendations have been amended to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced

Royal College of Psychiatrists	Guideline	11	027 - 030	1.3.2. Final part - consider also mentioning physical health conditions. This is mentioned later but may also be relevant here.	Thank you for your comment. 'Physical and mental' have been added here.
Royal College of Psychiatrists	Guideline	11	027 - 030	“coordinate with services for people with learning disabilities, mental health conditions (such as PTSD or severe ADHD), alcohol or substance misuse, or acquired cognitive impairments (see recommendation 1.5.7)” Recommend change to “coordinate with and where appropriate undertake joint work with services…”	Thank you for your comment. 'Work with' has been added to this recommendation.

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	011 - 012	004 - 020	Models of care and service delivery The NICE committee heard evidence about the Primary Care Gambling Service but has failed to mention this new and highly effective model of care. Whilst the service might be new, there is already considerable evidence of its effectiveness following detailed independent research. In late 2022, GambleAware commissioned an evaluation independent of the service by IFF Research (available here). The evidence of the effectiveness of this service should have been included alongside the evidence provided by others with personal experience of services, it was not. This evaluation found PCGS provided the provision of rapid access to support and treatment, and that patients welcomed the service's personalised approach. The evaluation revealed positive feedback on the service from patients. It concluded that PCGS provided accessible, consistent, and whole-patient support for people experiencing gambling harms by integrating primary care and third-sector support. All the 600 patients currently seen by our service (we have only been fully operational for 2 years due to delays caused by the pandemic) have a PGSI over 8. All have a multiplicity of needs and all bar two whom we have referred to an NHS specialist clinic have been managed by our joint working. We monitor PGSI scores (as well as other indicators) and submit our outcome measures quarterly to our commissioners (Gamble Aware). We submitted evidence to the Health Select Committee about our service.	Thank you for your comment. The committee did not find any published evidence that met the protocol criteria to support any models of care or service delivery methods, including the Primary Care Gambling Service (PCGS) and so did not recommend this (or any other named services). However, the committee were aware that the PCGS is likely to come under the umbrella of 'gambling treatment services' which are now defined in the guideline. Following the planned reconfiguration of gambling treatment service when the compulsory levy is introduced a range of treatment providers are likely to be commissioned by the NHS to provide a comprehensive range of treatment services. Likewise, the guideline does not preclude continued working with third sector providers (now defined as gambling support services). The development of the GP competency framework would be included in the recommendation that practitioners should use an agreed competency framework. The guideline also now includes a new section on referral and triage which will support the development of triage services as you describe. No evidence was found that met the protocol criteria for the effectiveness of online therapies such as computerised CBT (which was classified as supported self-help), but the guideline does recommend that therapies (for example CBT) should be available remotely via a video call.

				The direction of travel for many NHS services is for integration, that is joint working across professional (medical and non-medical) providers. Integrating clinically led (as with PCGS) health care using the third sector is a safe, cost-effective option to efficiently coordinate and support continuity of care for those suffering from gambling harm. The development of this shared care model is patient-centred, establishing collaborative goals between the patient, health provider and third sector. Clinical handover between health providers and the third sector is crucial for the safety and success of the model. Well-coordinated and timely care with formalised agreements, such as shared care protocols, provide evidence-based, safe and efficient patient care. These arrangements and evidence for their effectiveness are extensive. I urge the NICE committee to look for example at the Publication "Teams without Walls" a joint RCGP, RCP, and RCPCH publication written in 2009. PCGS has also developed a competency framework and is working with the Royal College	

				of General Practitioners to create a curriculum and training for GPs and others within primary care (including social prescribers). This work is ground-breaking, yet NICE has not chosen to refer to it. The RCGP is the professional home for more than 55,000 GPs across the UK. For them to be involved at this level is very positive as it means that through them, and through the work they are doing, GPs will be better placed to identify, treat, and engage with those with gambling harms. Our work with the third sector we believe is unique in the gambling field and possibly within the NHS. The Primary Care Gambling Service is a GP-led multidisciplinary, community-based service, which 'faces' around a dozen third-sector organisations as well as general practice across England. This means that we work collaboratively, and using a jointly developed memorandum of understanding, robust policies and practices share the care of those with gambling-related problems. We have	

				also demonstrated the benefit of joint working, within needing to involve specialist-led clinics, meaning that patients with complex needs can benefit from being part of the new integrated way of working. In 2022, the Service was recognised for its innovative approach to improving patient care and won the GP Mental Health Service of the Year award. The PCGS adds to the current provision in the following ways: General practice-led: ensuring we bring an understanding of general practice and the wider primary care team to the heart of the service. This includes using GP electronic records, the ability to prescribe NHS medication directly to pharmacies and using all the governance, policies and practices currently operating in primary care. We are CQC registered.	

				Multidisciplinary team: in-house mental health nurses; therapists (behavioural, analytical, group, individual); consultant addiction psychiatrist; patient expert (expert by experience); general practitioners with clinical interest; generalist practitioners. Links to the third sector: Use of digital front end; we have incorporated a screening question for all eConsults completed nationwide to improve responsiveness and reach. Multiple routes of referral, including self-referral Holistic care: we provide care across the physical, psychological, and social domains. We can offer pharmacological interventions. A broad range of evidence-based psychotherapeutic treatment options: Our therapists (all from different therapeutic disciplines) work together as a single coherent team. Personalised care based on individual assessment and treatment planning. Establishment of an Advisory Group. Expert by experience. We have engaged a patient advocate as a core member of our team. The advocate attends our weekly MDT and helps	

				contribute to all aspects of our service, from treatment to policy development. The Service is part of a network of organisations working together to provide confidential treatment and support for anyone experiencing gambling harm. We offer evidence-based interventions to individuals experiencing gambling harm in a timely and accessible manner. Our services include assessment, treatment, case management, crisis management and prescribing. PCGS was designed to have a few exclusion criteria (the only one is that the patient is not currently an in-patient) and to provide a range of care and support services. Recognising that problem gambling often accompanies other mental, physical, and social issues, we felt it essential to take a holistic approach to patient care. As such, we provide interventions to patients with a range of harms, including physical issues such as diabetes, hypertension, and chronic pain; psychological issues such as depression, ADHD, and learning difficulties; social issues such as homelessness and domestic violence; complex addiction harms, including co-existing substance addictions; and serious safeguarding matters including those involving child and adult sex workers and those with a forensic history.	

				Overall, our findings are that very few patients have an isolated gambling addiction. As such, our holistic approach to patients, recognises the importance of supporting and empowering them to address co-addiction, manage other mental illnesses and improve their social support. We have acknowledged that these factors are crucial to prevent relapse. Three-quarters of the 600 patients we have seen have comorbidity, demonstrating the irrelevance of the PGSI score: 74% with additional mental illness (depression, anxiety, bipolar, schizophrenia), including drug or alcohol misuse; 12% of patients have problems with neurodiversity. We ensure contact with patients within two working days. The service achieves significant reductions in harm. The average starting Problem Gambling Severity Index (PGSI) score is 22.6, with an average score of 4.66 at discharge. The average CORE 10 score at registration is 21.7; this has been reduced to 4.77 at discharge. Even if NICE did not want to include PGCS due to it being new, there is considerable evidence as to the effectiveness of shared care, GP-led, third sector-led, services in the field of addiction, with	

				or without the inclusion of specialists within the service. Indeed, the field of drug misuse is now predominately delivered through the third sector provision. There is no mention of new delivery models such as digital services, digital triage, and online therapies. Again, whilst the evidence in the field of gambling might be lacking, it is not in the rest of mental and physical health and should have been included for completeness. Related to new models of service delivery. NICE appears to have ignored the impact and positive benefit that the third sector has had in delivering more care to more than 80% of individuals with gambling harms over the last two decades. NICE must understand that where the funding comes from (that is via the industry, either directly or indirectly) is not up to these providers. All providers, including those such as the National Problem Gambling Clinic, the initial NHS clinics and the lobby group Gambling with Lives, have now and in the recent past been funded from industry. It appears that NICE recommendations have been swayed according to the source of funding rather than the effectiveness of the interventions provided.	

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	011 - 012	General	How the recommendations might affect services. This is perhaps the most important question posed by NICE. It is our view, from reading the guidelines that they are set in the past. They reflect a model of service delivery that the NHS is trying to move away from, that is top-down, specialist-led, stand-alone services. Instead, as this response has illustrated, the direction is about starting with the patient at the centre, and designing services around them, minimising transition points (though the term 'seamless' is a non sequitur as no service can be without transitions, and the skill is to 'mind-the-gap' with the use of shared care/liaison or link workers). Ideally therefore the direction of travel must be shared care, which goes beyond the simple exchange of letters, ideally with services sharing patient records, shared learning and good communication. Underpinning all of this should be the use of digital and data, neither of which are mentioned other than that NICE will require services which can provide data. There appears to be a real gap in knowledge around the use of modern digital systems, the use of digital triage, digital consultations and AI to assist quality and outcomes. Whilst this is all new it is rapidly developing. NICE also undermine the roles of general practitioners (GPs) and the third sector. For example Overemphasis on Specialist Services: The guidelines may place too much emphasis on specialised gambling services, potentially side-lining the crucial role that GPs can play in early identification and intervention. GPs often have a holistic view of patients' health and well-being, and by focusing primarily on specialist services, the guidelines might overlook the broader context of an individual's health. This	Thank you for your comment. The guideline has been amended to clarify that gambling treatment services and gambling support services are likely, following the planned reconfiguration of gambling treatment services, to encompass a wide range of providers, including the third sector/voluntary services, and not just gambling clinics provided by the NHS. Following this planned reconfiguration of services when the compulsory levy is introduced it is expected that more services will be commissioned by the NHS but from a wide range of providers. This also addresses your concern about resources being allocated only to gambling clinics. A new section has also now been added to the guideline on referral and triage. You are correct that AI is not included in the guideline as this was not included in the scope. However remote consultations are included in the recommendations to improve access. The committee agreed that while GPs do have a holistic view of people's healthcare the role of the GP in most practices that do not operate as a primary care gambling service could not be extended beyond identification, signposting, initial support and referring on due to a lack of GP capacity.

				could result in a disconnect between the guidelines and the day-to-day activities of GPs, who often serve as the first point of contact for individuals with various health concerns. Limited Integration with Primary Care: There might be a need for more integration between the NICE guidelines and primary care practices, especially with the development of intermediate services which 'sit' between generalist primary care, and third and specialist sector providers. Underutilisation of Third Sector Organisations: The third sector plays a crucial role in providing community-based support for individuals with gambling issues. The guidelines do not adequately recognise and support these organisations. Potential Stigmatisation: A focus on specialised services might inadvertently contribute to the stigmatisation of individuals with gambling harms. GPs and third-sector organisations contribute to reducing stigma by integrating gambling support into routine healthcare and community services. Resource Allocation Concerns: The guidelines suggest a disproportionate allocation of resources to specialist services. In this case, it might divert resources away from developing and enhancing services provided by GPs and the third sector, which are often more accessible at the community level. Limited Training for GPs:GPs may only be adequately trained to identify and address gambling-related issues if the guidelines include competency	

				frameworks written by the profession. Patient-centred Approach: The guidelines do not sufficiently provide a patient-centred approach. Involving GPs and third-sector organizations in a collaborative effort ensures a more comprehensive and patient-focused strategy for addressing gambling-related harms. In summary, a balanced and integrated approach that recognises the crucial roles of GPs and the third sector, alongside specialised services, is essential for effectively addressing gambling-related issues within the broader healthcare framework. The NICE reflection is that these recommendations will increase the number of people identified as experiencing gambling-related harms increasing the number that may need treatment and resource use of the NHS. We believe it will reduce the numbers due to Reluctance to attend specialist services. Loss of third-sector involvement Inability to engage primary care effectively (specialist service have little knowledge of primary care organisations or of GPs) Silting up of specialist services due to lack of consultant-level addiction providers Insistence on two practitioners for every group will not be feasible given workforce pressures. The guidelines ignore primary care's involvement.	

				The guidelines place undue reliance on specialist-led services across the NHS. These providers cannot and should not be the main point of care. Not only are there not enough specialist addiction consultants available to lead these services, but it is not appropriate to have the care delivered through them. Specialist-led services should be reserved for complex patients, in-reach to hospitals or secure environments and where other sectors lack the experience. NHS specialist services are also not best placed to do prevention work, tackle hard-to-reach groups, offer wrap-around care or low-threshold support. This strategy will ultimately silt up specialist services and inhibit prevention work – the vast majority of which is currently done in the third Sector. The NICE guidelines make no reference to services such as the Primary Care Gambling Service – an Intermediate Service which 'sits' between GPs and the third sector. It is the direction of travel of most NHS services and also for better-shared care between all providers – the sum addition to more than their parts. In all areas of health care, reaching a specialist service must be seen as a failure – as it means	

				someone has 'the disease or condition'. This does not mean that specialist services cannot play a valuable role – especially when they provide community-based services, just that they should not be the only care provider. Third sector The direction of travel essentially negates the importance of the third sector in providing treatment. The definition of treatment should include any intervention delivered to a person who crosses the threshold into seeking help. Treatment starts with engagement, 'What can it do for you'. Within the NICE guidelines, we are not sure what the definition of 'treatment' is. I fear, having read the documentation that has been provided, that it is a bio-medical definition, completely ignoring the treatment being provided by the third sector in	

				terms of low threshold care, attracting and retaining people in care long enough for more complex interventions such as psychological therapies or prescribing to be delivered, offering harm reduction, and other treatments which are the space of the third sector. PGCS's work with now more than a dozen third-sector organisations tells us that without their input, there would not be the throughput of patients to other parts of the gambling treatment pathway. Their importance must be reflected in these guidelines. This is perhaps the most important question posed by NICE. It is our view, from reading the guidelines that they are set in the past. They reflect a model of service delivery that the NHS is trying to move away from, that is top-down, specialist-led, stand-alone services. Instead, as this response has illustrated, the direction is about starting with the patient at the centre, and designing services around them, minimising transition points (though the term 'seamless' is a non sequitur as no service can be without transitions, and the skill is to 'mind-the-gap' with the use of shared care/liaison or link workers).	

				Ideally therefore the direction of travel must be shared care, which goes beyond the simple exchange of letters, ideally with services sharing patient records, shared learning and good communication.	

				Underpinning all of this should be the use of digital and data, neither of which are mentioned other than that NICE will require services which can provide data. There appears to be a real gap in knowledge around the use of modern digital systems, the use of digital triage, digital consultations and AI to assist quality and outcomes. Whilst this is all new it is rapidly developing. NICE also undermine the roles of general practitioners (GPs) and the third sector. For example Overemphasis on Specialist Services: The guidelines may place too much emphasis on specialised gambling services, potentially side-lining the crucial role that GPs can play in early identification and intervention.	

				GPs often have a holistic view of patients' health and well-being, and by focusing primarily on specialist services, the guidelines might overlook the broader context of an individual's health. This could result in a disconnect between the guidelines and the day-to-day activities of GPs, who often serve as the first point of contact for individuals with various health concerns. Limited Integration with Primary Care:	

				There might be a need for more integration between the NICE guidelines and primary care practices, especially with the development of intermediate services which 'sit' between generalist primary care, and third and specialist sector providers. Underutilisation of Third Sector Organisations: The third sector plays a crucial role in providing community-based support for individuals with gambling issues. The guidelines do not adequately recognise and support these organisations. Potential Stigmatisation: A focus on specialised services might inadvertently contribute to the stigmatisation of individuals with gambling harms. GPs and third-sector organisations contribute to reducing stigma by integrating gambling support into routine healthcare and community services. Resource Allocation Concerns:	

				The guidelines suggest a disproportionate allocation of resources to specialist services. In this case, it might divert resources away from developing and enhancing services provided by GPs and the third sector, which are often more accessible at the community level. Limited Training for GPs: GPs may only be adequately trained to identify and address gambling-related issues if the guidelines include competency frameworks written by the profession. Patient-centred Approach: The guidelines do not sufficiently provide a patient-centred approach. Involving GPs and third-sector organizations in a collaborative effort ensures a more comprehensive and patient-focused strategy for addressing gambling-related harms.	

				In summary, a balanced and integrated approach that recognises the crucial roles of GPs and the third sector, alongside specialised services, is essential for effectively addressing gambling-related issues within the broader healthcare framework. The NICE reflection is that these recommendations will increase the number of people identified as experiencing gambling-related harms increasing the number that may need treatment and resource use of the NHS. We believe it will reduce the numbers due to Reluctance to attend specialist services. Loss of third-sector involvement Inability to engage primary care effectively (specialist service have little knowledge of primary care organisations or of GPs)	

				Silting up of specialist services due to lack of consultant-level addiction providers Insistence on two practitioners for every group will not be feasible given workforce pressures. The guidelines ignore primary care's involvement. The guidelines place undue reliance on specialist-led services across the NHS. These providers cannot and should not be the main point of care. Not only are there not enough specialist addiction consultants available to lead these services, but it is not appropriate to have the care delivered through them. Specialist-led services should be reserved for complex patients, in-reach to hospitals or secure environments and where other sectors lack the experience. NHS specialist services are also not best placed to do prevention work, tackle hard-to-reach groups, offer wrap-around care or low-threshold support. This strategy will ultimately silt up specialist services and inhibit prevention work – the vast majority of which is currently done in the third Sector.	

				The NICE guidelines make no reference to services such as the Primary Care Gambling Service – an Intermediate Service which 'sits' between GPs and the third sector. It is the direction of travel of most NHS services and also for better-shared care between all providers – the sum addition to more than their parts. In all areas of health care, reaching a specialist service must be seen as a failure – as it means someone has 'the disease or condition'. This does not mean that specialist services cannot play a valuable role – especially when they provide community-based services, just that they should not be the only care provider. Third sector The direction of travel essentially negates the importance of the third sector in providing treatment. The definition of treatment should include any intervention delivered to a person who crosses the threshold into seeking help. Treatment starts with engagement, 'What can it do for you'.	

				Within the NICE guidelines, we are not sure what the definition of 'treatment' is. I fear, having read the documentation that has been provided, that it is a bio-medical definition, completely ignoring the treatment being provided by the third sector in terms of low threshold care, attracting and retaining people in care long enough for more complex interventions such as psychological therapies or prescribing to be delivered, offering harm reduction, and other treatments which are the space of the third sector. PGCS's work with now more than a dozen third-sector organisations tells us that without their input, there would not be the throughput of patients to other parts of the gambling treatment pathway. Their importance must be reflected in these guidelines.	

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	12	1	We should also mention that where appropriate working with people in visitors' centres to support families of prisoners and significant others can really help with offering support and rebuilding relationships.	Thank you for your comment. Considering access needs specifically for people in the criminal justice system is included in another recommendation in this section of the guideline, but the committee decided that including specific information about implementation within the criminal justice system was too much detail and so visitors' centres have not been listed as a separate setting.

GamCare	Guideline	12	001-004	Please see comment 6 above. GamCare welcomes the recognition that the recommendations in this guideline are for 'health and social care practitioners', but notes the distinction drawn within this section between such practitioners and 'people working in the voluntary, community and social enterprise sectors.' Charitable organisations that comprise the National Gambling Support Network (NGSN), including GamCare and Primary Care Gambling Service could under this definition, not be considered 'health and care practitioners' for the purposes of this guideline, while at the same time providing high-quality, evidence-based, and effective treatment and support for all those directly or indirectly affected by gambling related harms.	Thank you for your comment. This recommendation has been removed so the distinction between people working in different settings is no longer present.

His Majesty's Prison and Probation Service (HMPPS)	Guideline	12	001 - 014	1.3.3 - Consider using a range of providers to deliver services for people experiencing harmful gambling and those affected by gambling-related harms (such as family members, friends or others close to them). This could include: • individual practitioners in primary care and social care asking people about gambling-related harms, providing initial support, signposting and referring. Appreciate this is a recommendation for commissioners and providers of gambling treatment services but it seems to me that this is a reasonable expectation of criminal justice practitioners also whilst recognising current capacity and workforce constraints.	Thank you for your comment. This recommendation has been removed so the wording of this sentence is no longer applicable.
The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	12	001 - 014	Practitioners in primary care can and do more than ask about gambling, provide initial support, and refer. GPs provide holistic care to their patients, across the physical, psychological, and social domains.	Thank you for your comment. This recommendation advising the role of GPs has been removed. While the committee recognised that GPs working in services such as the Primary Care Gambling Service will have additional expertise, most GPs will not have the capacity or expertise in the treatment of harmful gambling to provide more than identification, initial support and referral. The role of the GP in providing holistic care overall is not diminished by this, but they would not be expected, for example, to provide CBT. The recommendations

				General practitioners with special clinical interests lead services, including gambling-related services, they interact with third-sector organisations to help their patients access care, support the commissioning of local services and participate in education and training across the primary care professionals. The Third Sector do more than provide support as this response has already elucidated.	have been revised to differentiate between gambling support services and gambling treatment services and the third sector may continue to play a role in these services following the planned reconfiguration of services.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	12	2	Rec 1.3.3 – Suggest rewording '…those affected by gambling-related harms' to 'those affected by someone else's gambling (such as family members…)' This is because there aren't affected by GRH they are affected by gambling and may be experiencing harms as a result.	Thank you for your comment. This recommendation has been removed so the wording of this sentence is no longer applicable.

Royal College of General Practitioners	Guid eline	12	5	Rec 1.3.3 – We are concerned that this may imply that a GPs role is limited to asking about gambling activities, providing initial support, and referring. GPs provide holistic care to their patients, across the physical, psychological, and social domains.	Thank you for your comment. This recommendation advising the role of GPs has been removed. While the committee recognised that GPs working in services such as the Primary Care Gambling Service will have additional expertise, most GPs will not have the capacity or expertise in the treatment of harmful gambling to provide more than identification, initial support and referral. The role of the GP in providing holistic care overall is not diminished by this, but they would not be expected, for example, to provide CBT.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	12	005 - 006	Rec 1.3.3 - Suggest re-wording the sentence to say '…about gambling then providing initial support, signposting and onward referral, if required.' Important to ask about gambling to be consistent with the beginning of the document.	Thank you for your comment. This recommendation has been removed so the wording of this sentence is no longer applicable.
Betknowmore UK	Guid eline	12	005 - 007	Research has shown that introducing a new responsibility to health and social care staff to ask about gambling harms requires considerable resource, including training, time for staff to have difficult conversations and changes to client management systems.	Thank you for your comment. It is appreciated that implementation of the guideline recommendations is likely to require training and time, but the aim of the guideline is to increase the identification, support and treatment for people experiencing gambling-related harms. This will be considered by the resource impact and implementation teams when considering the resource impact of the guideline and when considering implementation support.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	12	005 – 007	Rec 1.3.3 – Is there something the guideline can say about ensuring these practitioners know where to signpost and refer to? CONFIDENTIAL COMMENT REDACTED FROM HERE	Thank you for your comment. Details of signposting and referral routes are provided in the new section of the guideline on referral and triage and so have not been repeated here.
Royal College of Psychiatrists	Guideline	12	008 - 009	1.3.3 "the voluntary sector" - suggest change to "the independent voluntary sector.." to highlight NICE is not promoting gambling industry organisations.	Thank you for your comment. This recommendation has been removed and replaced with definitions of gambling support services. The use of the term independent voluntary sector is unlikely to be understood as you suggest, but the guideline does recommend that all providers should be free of gambling industry influence of involvement, so this change has not been made.

Betknowmore UK	Guid eline	12	008 - 012	The voluntary sector also provides specialist gambling treatment services, as well as brief interventions and peer support, through the NGSN. The current provision of specialist gambling treatment services by the NGSN outstrips that provided by NHS gambling clinics.	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that in the future these services will be commissioned by the NHS, but they may be provided by a number of different providers, including the voluntary sector, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but must be fit for purpose in the future and cannot simply replicate the current provision. It is anticipated that the guideline will take a period of time to implement fully.

GambleAware	Guideline	12	008-012	The current wording risks giving the impression that the voluntary sector only provides advice, brief interventions and peer support, and that these are non-specialist services. In reality the voluntary sector is an experienced provider of specialist treatment across Great Britain. As such, the phrase "gambling support services such as the voluntary sector" should be replaced with "specialist support including voluntary and community sector groups".	Thank you for your comment. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be provided by a number of different providers, including the voluntary sector, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but must be fit for purpose in the future and cannot simply replicate the current provision. It is anticipated that the guideline will take a period of time to implement fully.

Adferiad	Guid eline	12	10	Adferiad challenge the proposal that suggest that all individual's with a PGSI of 8 or more should be referred to NHS clinics, the rationale for this relates to the NICE aims and Principles which places emphasise on the importance of evidence-based recommendations that provide high-quality care and produce the best outcomes within the available budget. It is crucial to consider this framework when discussing the proposed referral guidelines. There are numerous studies that indicate that treatment for problem gambling should not be the initial response for all individuals based solely on their PGSI score. Instead, treatment should be seen as a safety net for those most severely affected by gambling harms. Consideration should be given other support options as well as preference of the individual as to what treatment they wish to receive. Referring all cases to the NHS would exhaust resources and add to current waiting times to access treatment, levels of risk for people experiencing harms could increase while they wait for treatment.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will be provided. It is specified that in the future these services will be commissioned by the NHS, but they may be provided by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but must be fit for purpose in the future and cannot simply replicate the current provision. The aim of NICE guidelines is not to recommend the least costly service, but services that are value for money, where additional benefits (and potential future cost-savings) outweigh additional provision costs, compared with current care, according to NICE cost-effectiveness thresholds. Currently, there is no evidence that NHS-commissioned services would be less cost-effective than existing NGSN services and cost-effectiveness cannot be established by solely comparing provision costs. The figure of £2,000 per referral has been an estimate calculated by dividing the current annual funding of £6 million allocated to the NHS specialist gambling clinics by the number of 3,000 patients a year that are planned by NHS to be treated across these clinics. However, the comparison between NHS clinics and the NGSN provider costs do not take into account what type of care is provided in each setting (including assessment, support, treatment and aftercare), by whom (specialist or not), and the outcomes expected to be achieved in each setting. Moreover, the cost estimate of £2000 per referral is based on current NHS provision of 15 specialist gambling clinics and does not

				Its widely reported that the NHS is in crisis with long waiting lists for surgery, appointments, people may avoid coming forward for support in fear or adding pressure to the NHS and the stigma around gambling. With less than 3% of the target population seeking treatment, the concern would be that the proposed referral pathway would likely create new barriers to treatment engagement, which in turn could lead to fewer individuals seeking help for gambling harms. As previously mentioned, there are some individuals that do not want treatment and support on their records, due to wanting to apply for jobs in the future that may require GP/NHS records. By specifically naming the NHS as the sole provider of treatment, this would exclude locally based 3rd sector services. Organisations that are well established in the treatment of gambling related harms.	take into account the fact that the NHS commissioned gambling treatment and gambling support services, may be provided by a range of providers, including the NHS or the voluntary and charity sector. The introduction of the statutory levy (which is expected to raise approximately £90-100 million annually by 2027 – see Government response to the consultation on the structure, distribution and governance of the statutory levy on gambling operators - GOV.UK) is likely to increase the funding available to spend on gambling support and treatment services commissioned by the NHS and a significant reconfiguration of services is expected, as discussed above, to meet different levels of need. It is anticipated that the guideline will take a period of time to implement fully. As there is currently largely unmet need for these services (according to OHID figures on treatment needs: https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates/gambling-treatment-need-and-support-in-england-main-findings-and-methodology) and the financial and social costs associated with gambling-related harms are very high (according to OHID figures https://assets.publishing.service.gov.uk/media/63bc25b4d3bf7f262c5ad31f/The-economic-cost-of-gambling-related-harm-in-England_evidence-update-2023.pdf and NIESR figures https://www.niesr.ac.uk/wp-content/uploads/2023/04/The-Fiscal-Costs-and-Benefits-of-Problem-Gambling.pdf), it is anticipated that expanded, NHS commissioned, gambling treatment and gambling support services will gradually cover a larger part of the population needs, resulting in benefits and cost-savings that are likely to offset, at least partially, the high costs associated with gambling-related harms. The resource implications of the guideline are being considered, and are likely to be substantial, involving setting up new services, reconfiguring existing services and transferring current staff or services from other providers into NHS-commissioned services.

				The current model of gambling harms support across the country engages with thousands of individuals with treatment and support available from Tier 1 – Tier 4, disregarding this model in favour of draft guidelines would risk exacerbating harms in an addiction where self- injury and suicide are significantly higher than other addictions. The proposal lacks robust clinical, financial and outcome-based evidence, it fails to consider systems and approaches that are already in place supporting people with gambling related harms. NICE is required to ensure that all its guidelines consider value for money, this has not been considered within the guidelines and the recommendations are not evidence based. The NHS clinics are due to cost approx. £2,000 per referral, with running costs per clinic estimated at £6million. In comparison NGSN provider costs are much lower.	The guideline advises partnership working across other services for comorbidities and other dependencies.

				Would it not be more cost effective and appropriate to adopt the already existing National Gambling Support Network (NGSN). The model focuses on stepped care, which is person centred and takes into consideration risk, previous treatment and any additional needs. The NGSN providers are experienced and strategically placed to lead in this proposed model, where NHS services would play and integral goal. It should not be that one size fits all. By adopting a person-centred care model, individuals have choices, avoiding an automatic referral to the NHS. Comprehensive assessments are completed which looks at risk, any safeguarding, complexities and comorbidities to best determine the most appropriate treatment for the individuals which would best support their needs. Adferiad have received 240 referrals into the complex needs pathway, with most individuals needing a period in detox, where would the NHS refer these individuals to? NHS drug and alcohol and mental health services are already experiencing long waiting list, would these individuals have to wait on numerous waiting list to access care and treatment?	

Breakeven (Charity no 1158156)	Guid eline	12	10	We strongly oppose the draft guideline proposal that suggests referring all individuals with a PGSI threshold of 8 or above directly to NHS clinics. Our rationale for taking this stance is detailed below. NICE's stated aims and principles emphasise the importance of evidence-based recommendations that provide high-quality care and produce the best outcomes within the available budget. It is crucial to consider this framework when discussing the proposed referral guidelines. Numerous robust international studies indicate that treatment for "Problem Gambling" should not be the initial response for all individuals based solely on their PGSI score. Instead, treatment should be seen as a safety net for those most severely affected by gambling-related harms. It is essential to consider local community recovery and support options, as well as the preference of the service user, before resorting to NHS treatment. Referring all cases to the NHS would not only exhaust limited resources but also fail to serve the best interests of this specific patient group.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that in the future these services should be commissioned by the NHS, but they may be provided by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but must be fit for purpose in the future and cannot simply replicate the current provision. It is anticipated that the guideline will take a period of time to implement fully.

				This field presents its own unique challenges, with less than 3% of the target population seeking treatment. Our concern is that the proposed referral guidelines would likely create new barriers to treatment engagement, leading to even fewer individuals seeking help. By specifically naming the NHS as the sole provider of treatment, the guidelines would exclude other locally based 3rd sector services, such as culturally appropriate and trusted organisations. Engaging with these services may be less intimidating for individuals and promote earlier intervention. The limitations of online screening, the obstacles in establishing a timely pathway from screening to NHS services, and the lack of patient choice and involvement in the process further compound this issue.	

				The current model of gambling harms support in our country engages thousands of service users. Disregarding this model in favour of the draft guidelines would risk exacerbating harms in an addiction area where self-harm and suicide are significant risks. Breakeven has evidence of the outstanding outcomes over the years whilst treating thousands of Clients and to adopt a NHS only model could see too many experts in this field disappear at a time when they are needed most. We propose an alternative model that integrates Stepped care with a "recovery before treatment" approach. This community-based model would involve substantial peer input and offer a stronger argument for patient-centred outcomes. We believe that the current NICE proposal to refer all individuals with a PGSI score of 8 or higher to NHS services lacks robust clinical, financial, and outcome-based evidence. Moreover, it fails to consider alternative approaches and overlooks the optimal use of available resources. We also have concerns regarding the sensitivity and specificity of the PGSI, the appropriateness of the cutoff score of 8, and the lack of pilot data and patient consultation for this model, which makes it high-risk and potentially counterproductive. Breakeven proposes a Stepped National Gambling Support Network (NGSN) community-based care-coordinated model as the preferred pathway, instead of an NHS-first approach. This model focuses on Stepped care, which involves identifying the individual needs of each person based on various factors such as risk factors, previous responses to treatment, and additional needs. The NGSN providers, as	

				community leads for Gambling Related Harms (GRH), are experienced and strategically placed to lead in this model, where NHS services play an integral role. Under this approach, if an individual presents with a PGSI score of 8 or above at a community-based service, they would be referred to a gambling harms practitioner within a local NGSN support provider. Through a positive therapeutic alliance, the practitioner and service-user negotiate the needs and urgency of the situation. Appropriate interventions can be provided, or local support can be offered while referral to specialist care is managed.	

				Once engaged, the individual completes a comprehensive assessment to understand their presentation fully. This assessment considers potential support needs, co-morbidities, clinical risks, safeguarding, and other complexities. The NGSN providers, who have established pathways to local services, can then determine the best support pathway based on the person's needs. By adopting this person-centred Stepped care model, individuals have choices and support within their local community, avoiding a disempowering automatic referral to the NHS. It emphasises relationship building, trust, and engagement, which is crucial for a group often experiencing high levels of stigma, shame, and distress. Peer coaching and recovery-oriented support are also prioritised, leading to improved retention and engagement.	

				This approach not only meets the clinical, emotional, social, and practical needs of individuals accessing the services but also enables collaboration and adherence to treatment and support plans. Implementing the Stepped model through the NGSN community-based approach ensures that third sector and community-based services are fully utilised, preserving their local knowledge and expertise. Overall, this model aims for a comprehensive and integrated approach to gambling support, leveraging community resources and expertise while ensuring personalised care that meets the unique needs of everyone.	

				The NGSN (National Gambling Support Network) providers possess extensive experience, expertise, and knowledge in the field of gambling harm treatment and recovery support. They offer holistic support programs that encompass various interventions, provided by mental health practitioners, support workers, counsellors, and psychotherapists. Large numbers working in the Network have Lived Experience which is invaluable and Breakeven staff Team has over a third of the Team with that Lived experience. Many of these professionals are CBT (Cognitive Behavioural Therapy) qualified, which is a core component of the care model provided within the network. It's worth noting that CBT-led therapy is not exclusive to psychologists in the NHS and can be delivered by trained therapists as well.	

				Therefore, the CBT offered within the NHS is comparable to the counselling and therapeutic services available within the NGSN. To ensure effective support for individuals with a PGSI score of 8 or above seeking help for gambling related harms through community-based services like those in the NGSN, it is crucial to provide appropriate therapeutic interventions. These services should be able to offer clinically robust support unless the individuals have additional mental health issues or present clinical risk/safeguarding concerns, in which case further referrals can be discussed.	

				Moreover, community based services are well positioned to facilitate the reintegration of service-users back into their communities and society at large, which is a crucial aspect of long-term recovery. This challenges the notion presented in the draft that NHS clinics are the sole "gambling specialist service." In an ideal system, the local NGSN provider should offer both front-end and back-end support for high-needs clinical cases, as well as ongoing case management and recovery support for all other service users. An existing example of this approach and the optimal model is a Recovery-Oriented System of Care (ROSC, SAMHSA (Substance Abuse and Mental Health Services Administration), 2009) that combines specialist care with 3rd sector and community provision to meet the personalised, cultural, and familial needs of individuals seeking help. It is doubtful that the proposed model will achieve this comprehensive approach.	

RCA Trust	Guideline	12	10	We strongly oppose the draft guideline proposal that suggests referring all individuals with a PGSI threshold of 8 or above directly to NHS clinics. Our rationale for taking this stance is detailed below. NICE's stated aims and principles emphasise the importance of evidence-based recommendations that provide high-quality care and produce the best outcomes within the available budget. It is crucial to consider this framework when discussing the proposed referral guidelines. Numerous robust international studies indicate that treatment for "Problem Gambling" should not be the initial response for all individuals based solely on their PGSI score. Instead, treatment should be seen as a safety net for those most	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that in the future these services should be commissioned by the NHS, but they may be provided by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but must be fit for purpose in the future and cannot simply replicate the current provision. It is anticipated that the guideline will take a period of time to implement fully.

severely affected by gambling-related harms. It is essential to consider local community recovery and support options, as well as the preference of the service user, before resorting to NHS treatment. Referring all cases to the NHS would not be in the best interest of those who may not serve the best interests of this vulnerable group.
This field presents its own unique challenges, with less than 3% of the target population seeking treatment. Our concern is that the proposed referral guidelines would likely create new barriers to treatment engagement, leading to even fewer individuals seeking help. By specifically naming the NHS as the sole provider of treatment, the guidelines would exclude other locally based 3rd sector services, such as culturally appropriate and trusted organisations. Engaging with these services may be less intimidating for individuals and promote earlier intervention. The limitations of online screening, the obstacles in establishing a timely pathway from screening to NHS services, and the lack of patient choice and involvement in the process further compound this issue.

The current model of gambling harms support in our country engages thousands of service users. Disregarding this model in favour of the draft guidelines would risk exacerbating harms in an addiction area where self-harm and suicide are significant risks.

RCA Trust proposes a Stepped National Gambling Support Network (NGSN) community-based care-coordinated model as the preferred pathway, instead of an NHS-first approach. We have local evidence where the stepped approach works well within other areas of problematic lifestyle choices such as drugs and alcohol. This allows for the promotion of choice and appropriate care being given when required.

This model focuses on Stepped care, which involves identifying the individual needs of each person based on various factors such as risk factors, previous responses to treatment, and additional needs. The NGSN providers, as

				prioritised, leading to improved retention and engagement. This approach not only meets the clinical, emotional, social, and practical needs of individuals accessing the services but also enables collaboration and adherence to treatment and support plans. Implementing the Stepped model through the NGSN community-based approach ensures that third sector and community-based services are fully utilised, preserving their local knowledge and expertise. Overall, this model aims for a comprehensive and integrated approach to gambling support, leveraging community resources and expertise while ensuring personalised care that meets the unique needs of everyone. The NGSN (National Gambling Support Network) providers possess extensive experience, expertise, and knowledge in the field of gambling harm treatment and recovery support. They offer holistic support programs that encompass various	

				interventions, provided by mental health practitioners, support workers, counsellors, and psychotherapists.		
				Many of these professionals are CBT (Cognitive Behavioural Therapy) qualified, which is a core component of the care model provided within the network. It's worth noting that CBT-led therapy is not exclusive to psychologists in the NHS and can be delivered by trained therapists as well. In addition to CBT all the professionals have training in motivational enhancement techniques, solution focussed interventions, critical thinking management and relapse prevention techniques. Therefore, the CBT offered within the NHS is comparable to the counselling and therapeutic services available within the NGSN. To ensure effective support for individuals with a PGSI score of 8 or above seeking help for gambling related harms through community-based services like those in the NGSN, it is crucial to provide appropriate therapeutic interventions. These services should be able to offer clinically robust support unless the individuals have additional mental health issues or present clinical risk/safeguarding concerns, in which case further referrals can be discussed. Moreover, community-based services are well positioned to facilitate the reintegration of service-users back into their communities and society at large, which is a crucial aspect of long-term recovery. This challenges the notion presented in the draft that NHS clinics are the sole "gambling specialist service." In an ideal system, the local NGSN provider should offer both front-end and back-end support for high-needs clinical cases, as well as ongoing case management and recovery support for all other service users.		

Ara recovery for all (Addiction Recovery Agency Ltd. Charity Number 1002224)	Guid eline	12	10	We strongly oppose the draft guideline proposal that suggests referring all individuals with a PGSI threshold of 8 or above directly to NHS clinics. Our rationale for taking this stance is detailed below. NICE's stated aims and principles emphasise the importance of evidence-based recommendations that provide high-quality care and produce the best outcomes within the available budget. It is crucial to consider this framework when discussing the proposed referral guidelines. Numerous robust international studies indicate that treatment for "Problem Gambling" should not be the initial response for all individuals based solely on their PGSI score. Instead, treatment should be seen as a safety net for those most severely affected by gambling-related harms. It is essential to consider local community recovery and support options, as well as the preference of the service user, before resorting to NHS treatment. Referring all cases to the NHS would not only exhaust limited resources but also fail to serve the best interests of this specific patient group.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that in the future these services should be commissioned by the NHS, but they may be provided by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but must be fit for purpose in the future and cannot simply replicate the current provision. It is anticipated that the guideline will take a period of time to implement fully.

				This field presents its own unique challenges, with less than 3% of the target population seeking treatment. Our concern is that the proposed referral guidelines would likely create new barriers to treatment engagement, leading to even fewer individuals seeking help. By specifically naming the NHS as the sole provider of treatment, the guidelines would exclude other locally based 3rd sector services, such as culturally appropriate and trusted organisations. Engaging with these services may be less intimidating for individuals and promote earlier intervention. The limitations of online screening, the obstacles in establishing a timely pathway from screening to NHS services, and the lack of patient choice and involvement in the process further compound this issue.	

				The current model of gambling harms support in our country engages thousands of service users. Disregarding this model in favour of the draft guidelines would risk exacerbating harms in an addiction area where self-harm and suicide are significant risks. We propose an alternative model that integrates Stepped care with a "recovery before treatment" approach. This community-based model would involve substantial peer input and offer a stronger argument for patient-centred outcomes. We believe that the current NICE proposal to refer all individuals with a PGSI score of 8 or higher to NHS services lacks robust clinical, financial, and outcome-based evidence.	

				Moreover, it fails to consider alternative approaches and overlooks the optimal use of available resources. We also have concerns regarding the sensitivity and specificity of the PGSI, the appropriateness of the cutoff score of 8, and the lack of pilot data and patient consultation for this particular model, which makes it high-risk and potentially counterproductive. Ara proposes a Stepped National Gambling Support Network (NGSN) community-based care-coordinated model as the preferred pathway, instead of an NHS-first approach.	

				This model focuses on Stepped care, which involves identifying the individual needs of each person based on various factors such as risk factors, previous responses to treatment, and additional needs. The NGSN providers, as community leads for Gambling Related Harms (GRH), are experienced and strategically placed to lead in this model, where NHS services play an integral role. Under this approach, if an individual presents with a PGSI score of 8 or above at a community-based service, they would be referred to a gambling harms practitioner within a local NGSN support provider. Through a positive therapeutic alliance, the practitioner and service-user negotiate the needs and urgency of the situation. Appropriate interventions can be provided, or local support can be offered while referral to specialist care is managed.	

				Once engaged, the individual completes a comprehensive assessment to understand their presentation fully. This assessment considers potential support needs, co-morbidities, clinical risks, safeguarding, and other complexities. The NGSN providers, who have established pathways to local services, can then determine the best support pathway based on the person's needs. By adopting this person-centred Stepped care model, individuals have choices and support within their local community, avoiding a disempowering automatic referral to the NHS. It emphasises relationship building, trust, and engagement, which is crucial for a group often experiencing high levels of stigma, shame, and distress. Peer coaching and recovery-oriented support are also prioritised, leading to improved retention and engagement.	

				This approach not only meets the clinical, emotional, social, and practical needs of individuals accessing the services but also enables collaboration and adherence to treatment and support plans. Implementing the Stepped model through the NGSN community-based approach ensures that third sector and community-based services are fully utilised, preserving their local knowledge and expertise. Overall, this model aims for a comprehensive and integrated approach to gambling support, leveraging community resources and expertise while ensuring personalised care that meets the unique needs of each individual.	

				The NGSN (National Gambling Support Network) providers possess extensive experience, expertise, and knowledge in the field of gambling harm treatment and recovery support. They offer holistic support programs that encompass various interventions, provided by mental health practitioners, support workers, counsellors, and psychotherapists. Many of these professionals are CBT (Cognitive Behavioural Therapy) qualified, which is a core component of the care model provided within the network. It's worth noting that CBT-led therapy is not exclusive to psychologists in the NHS and can be delivered by trained therapists as well.	

				Therefore, the CBT offered within the NHS is comparable to the counselling and therapeutic services available within the NGSN. To ensure effective support for individuals with a PGSI score of 8 or above seeking help for gambling related harms through community-based services like those in the NGSN, it is crucial to provide appropriate therapeutic interventions. These services should be able to offer clinically robust support unless the individuals have additional mental health issues or present clinical risk/safeguarding concerns, in which case further referrals can be discussed. Moreover, community-based services are well positioned to facilitate the reintegration of service-users back into their communities and society at large, which is a crucial aspect of long-term recovery. This challenges the notion presented in the draft that NHS clinics are the sole "gambling specialist service." In an ideal system, the local NGSN provider should offer both front-end and back-end support for high-needs clinical cases, as well as ongoing case management and recovery support for all other service users.	

				An existing example of this approach and the optimal model is a Recovery-Oriented System of Care (ROSC, SAMHSA (Substance Abuse and Mental Health Services Administration), 2009) that combines specialist care with 3rd sector and community provision to meet the personalised, cultural, and familial needs of individuals seeking help. It is doubtful that the proposed model will achieve this comprehensive approach.	

Beacon Counselling Trust	Guid eline	12	10	Our position statement. We challenge the draft guideline proposal that all individuals with a PGSI threshold of 8 or above should be referred directly to the NHS clinics, and our rationale for this position is outlined below. NICEs stated aims/principles: NICE guidelines are evidence-based recommendations for health and care in England. NICE Principle 6. Use evidence that is relevant, reliable and robust. NICE guidance aims to meet population needs by identifying care that is high quality, good value, and provides the best outcomes for people using health and social care services within the budget available." Robust international evidence supports that, NHS treatment, or in fact any treatment, should not be the first line of response to "Problem Gambling" as indicated through PGSI, for everyone. Treatment should be considered as a safety net to support those who are most negatively affected by the harms caused by gambling, and a PGSI score based on the past 12 months of that person's journey should not necessitate a referral directly to NHS treatment, before local community recovery and support options, and service-user choice, are even considered. A referral of all cases to the NHS would be an unnecessary use of a limited resource and would not work in the best interests of this patient group.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that in the future these services should be commissioned by the NHS, but they may be provided by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but must be fit for purpose in the future and cannot simply replicate the current provision. It is anticipated that the guideline will take a period of time to implement fully. The cost comparison between IAPT, BCT and NHS gambling clinics is not appropriate for assessing cost-effectiveness. The least costly option is not necessarily the most cost-effective one. It does not consider what type of care is provided in each setting (including assessment, support, treatment and aftercare), by whom (specialist or not), and the outcomes expected to be achieved in each setting. Moreover, the cost estimate of £2000 per referral is based on current NHS provision of 15 specialist gambling clinics and does not take into account the fact that NHS planned commissioning of gambling treatment and gambling support services, may be provided by a range of providers, including the NHS or the voluntary and charity sector. The introduction of the statutory levy (which is expected to raise approximately £90-100 million annually by 2027 – see Government response to the consultation on the structure, distribution and governance of the statutory levy on gambling operators - GOV.UK) is likely to increase the funding available to spend on gambling support

				This is a difficult field where less than 3% of the target population present for treatment (and our contention is that this proposal would reduce this rate by creating new barriers to treatment engagement) and support and where less than 50% of those complete an episode of treatment. Our concern is that to name a specific provider for treatment i.e. the NHS, unheard of in NICE guidelines construct, has the potential to create a barrier to help seeking, and cause significant harm to the patient, as a direct result of constraining service-user choice by excluding local community based 3rd sector services (in particular culturally appropriate and trusted services), engaging with whom is likely to be less daunting than with NHS services who inevitably will have less of a local (and peer-based) presence. As a consequence, the opportunity for early intervention is likely to be lost because of some of the limitations of online screening, the challenges of creating a timely and viable pathway from online screening to NHS service engagement and because of the lack of patient choice and ownership of the process.	and treatment services commissioned by the NHS and a significant reconfiguration of services is expected, as discussed above, to meet different levels of need. The recommendation to refer every person scoring 8+ on PGSI to NHS commissioned specialist gambling treatment services has been removed.

				The current model of gambling harms support is one that engages with thousands of service-users in this country and to dismantle this current model by these draft guidelines would carry the risk of increased harms in an addiction area where self-harm and suicide are a significant risk. We suggest an alternative model of stratified care incorporating a 'recovery before treatment' approach (based on a community model with a significant peer input) and present the argument for this below. We believe the current NICE proposal for referral to NHS services of all those with PGSI 8+ is not based on robust clinical, financial or outcome evidence, does not take alternative approaches into account, does not provide the best outcomes for patients and is not the best use of the resources available. We also have concerns that the PGSI is neither sensitive nor specific enough, that the cut-off of 8 is inappropriate and that the lack of pilot data and patient consultation about this model makes this proposal too high-risk and potentially counter-productive.	

				A Stratified Care Model Our submission, based on modelling developed over the last 11 years of working with this patient group and now as an integral part of the National Gambling Support Network (NGSN), is that it would be more appropriate and cost effective to adopt a stratified NGSN community based care-coordinated model as the pathway, which would naturally facilitate referral to NHS services, as the clinical presentation and patient choice conjoin, instead of an NHS-first approach.	

				Stratified care refers to identifying the needs of an individual based on an assessment that covers factors such as underlying mechanisms, risk factors, additional needs, previous responses to treatment etc., for which NHS services are an integral component and for which the NGSN providers, as community leads for Gambling Related Harms (GRH), are highly experienced and strategically placed to lead on, within an evidence-based, stepped care model where tertiary care need is determined through a full assessment process. This is based on the assumption of a 'whole systems' approach with integrated care and linked to the broader help and care system. This incorporates a recovery before treatment approach which we will explain more fully further down.	

				By utilising a stratified care model, if any individual presents to a community-based service with a PGSI score of 8 or above, rather than be referred directly for clinical interventions to the NHS, they would instead be referred directly to a gambling harms practitioner within a local NGSN gambling support provider, where their needs are negotiated through a positive therapeutic alliance and initial needs can be addressed to fit their circumstances and the urgency and severity of the need. On the basis of this contact, either appropriate interventions can be provided, or local support offered while referral to specialist care is managed. Once engaged they are invited to complete a full comprehensive assessment to gain a full understanding of their presentation, and understand the requirements of additional support needs, co-morbidities, clinical risk, safeguarding and other potential complexities. This is something that is already done as standard practice within the NGSN.	

				On the basis of a comprehensive assessment, the practitioner, along with the service-user, will decide on the best support pathway based on their presentation, utilising the NGSN provider's thorough and complete understanding of community-based assets in its area, such as mutual aid groups, debt services and partnerships with criminal justice and mental health providers. All regional NGSN leads have well-established pathways into local services which have been robustly developed over many years and services like Beacon Counselling Trust are best placed to facilitate these routes into support. This also means that there is a more direct pathway to support with co-occurring issues like debt, housing and relationship problems and involvement with the justice system.	

				Using a stratified model also promotes a person-centred approach and through the development of peer coaching generates new capacity and expertise in the local community. As the name suggests, person-centred care puts the person at the heart of their care. This stratification model (which has been in continuous development over years with our service-user/lived experience groups) adapts our services to the person's expectations and preferences based in that community, not the other way around and so can claim to be service user-led.	

				People are given support choices within the community, not treated with a disempowering approach, with an automatic referral to the NHS, although NHS referral is an option when discussing and assessing an appropriate pathway, that can be acted on immediately if there is evident immediate risk of harm. The skills and networks, including recovery-oriented and peer-based support, mean that relationship building can be at the heart of the screening and assessment process, building trust and thus improving retention and engagement for individuals who are likely to be experiencing high levels of stigma, shame and distress. This is particularly important for a group where the evidence suggests stigma acts as a significant barrier in help-seeking. By adopting this approach, those accessing our services feel more comfortable and confident in our service delivery whilst at the same time meeting their clinical, emotional, social, and practical needs, and where peers can assertively link them into community resources as part of a recovery focused model.	

				Consequently, they are much more likely to adhere to treatment and support plans that are collaboratively delivered and that is one of the primary reasons BCT's clinical outputs regarding improvement and recovery are among the highest in the UK. There is a concern if service-users were to be referred into the NHS clinics as the first point of referral, that this stratified, integrated model would not be utilised, and third sector and community-based services may be under-utilised, and their local knowledge and expertise lost. In support of the importance of a stratified care model, that focusses on multiple needs and holistic support, please see the below a case study from ex service-user of BCT who is now in recovery from gambling addiction:	

				This ex service-user accessed BCT in 2019 and entered treatment with a PGSI score of 27. He was in his fifties when he accessed our service and had been gambling for 9 years. He was referred by a mental health nurse following admission to hospital after an attempted overdose as a result of being arrested for gambling-related crime. The mental health nurse had recently attended a training session on gambling harms delivered by BCT Clinical Director which led to her referring him to BCT.	

				"I would have felt anxious about being referred to the NHS clinics, I would have questioned why I was being referred to a specialist gambling clinic and wouldn't have understood the reason why. It would have worried me because the position I was in I knew I needed to speak to someone urgently. I spoke to BCT the week of being released from hospital. I felt at the time very vulnerable and needed help there and then, looking back I know that such a quick referral to BCT was crucial to my wellbeing. If I was to have waited any longer than a week or two for support, I believe I would have made another attempt to take my own life. I would have wanted to know what the waiting list would have been like if I were to have been referred to the NHS clinic, and I also know I didn't want to be put into group support because I'd never done this before, and I was not used to telling anyone my story.	

				During my time waiting to be sentenced, there were three people that saved me from making a second attempt, and that was my therapist at BCT, the Clinical Director at BCT, and the CEO of EPIC Risk Management, who BCT were able to link me up with. He had very similar lived experience to me and this calmed me down and took away some of my fears, which stopped me making another attempt. My referral to BCT, starting support with my therapist there, and also speaking to the clinical director who linked with up with EPIC Risk Management, all happened within a week. Would this have ever happened for me if I were to be referred to an NHS clinic? After getting support with BCT they were also able to link me into my local GA which I still attend today and the group has been a big part of my recovery. I was wary of this at first but having the contact from BCT and knowing I could trust them based on the support they had already given me led to me eventually feeling confident enough to access GA.	

				I know that even today at 4 years clean of gambling and about to receive my 4 year pin from GA, I would still score at least 9 on a PGSI questionnaire, because of the long-term issues caused by my gambling addiction even though I am not gambling, if I was to complete a gambling assessment after I have been released from prison later this year, according to this model I would be referred to an NHS clinic, even though I am in a much better place. This is because of the ongoing issues I have around guilt, relationships etc. This would leave me questioning why I would be referred to the NHS when I am not gambling and am in a better position than I was 4 years ago. If I was going to the NHS clinic it would feel like I was going backwards and I would feel anxious about why, when I have received help from BCT in the past. Hearing NHS gambling clinic sounds daunting, and I know I would have felt daunted by this when it first came out 4 years ago."	

				Another relevant case study to support the need for a more holistic and community-based approach can be seen below. This service-user accessed a peer-based support service called 'Peer Aid' through Betknowmore for his gambling addiction: "I would be okay that support was available to me, but my concern initially would be how long do I have to wait for treatment to begin, NHS waiting times are long and to what capacity can they have, who would support me during the waiting period, also for me I was 8+ but had no immediate clinical need, my need was criminal justice support, debt, connection, not feeling isolated, family advice and rebuilding relationships - this was not a clinical diagnosis required it was more long term ongoing support as opposed to 6 sessions (gambling harm doesn't stop when you've stopped gambling) so I would be thinking what next and where am I going.	

				This support was invaluable and life changing. It gave me hope, empowerment, connection, it enabled me to have the longevity of support needed through pre-support, ongoing support and aftercare which I still use now 3 years on. Third sector also use lived experience, there is nothing more powerful than being around individuals who have walked in your shoes and get you with true empathy! This allowed me to build up trust quicker, open up and learn! Therapist can learn from a textbook but life experience far outweighs this. I was offered multiple pathways to recovery, not a one size fits all approach, and having choices and options worked a lot better for me than being told where to go." Validity and reliability concerns of using PGSI as a single point of access measure.	

				The nature of gambling and the impacts it causes can change significantly and the PGSI questionnaire is not the most accurate representation of an individual's full gambling harms journey and presentation when used alone. The questions used within the PGSI are relatively broad and do not capture the full clinical presentation of the individual person and their specific needs. The questions hold different levels of weight and assess different dimensions of someone's presentation. This was highlighted in the recently published report by GambleAware (2023) in which the questions were split into dimensions of either behaviour, or personal/social consequence. Within this report it was also found that treating each question as equivalent to each other would not be appropriate given items that look at feelings of guilt and loss chasing are less reliable indicators of severity when compared to items that cover issues such as finances and tolerance levels. This report therefore offers further evidence as to why this should be not used as a single measure to determine someone's support pathway.	

				Not only are the questions broad, they are asked on the basis of a 12-month span. An accurate risk presentation cannot be formulated from questions based over such a long timeframe. The PGSI also contains items that persist significantly beyond engagement in problem gambling and so may over-state immediate harms and risk. Furthermore, certain questions within the PGSI reflect the long-term legacy harms gambling addiction can cause. They can be significant issues for years with some individuals. These questions include: 'Have you felt gambling has caused financial problems for you or your household?' 'Have people criticised your betting or told you that you had a gambling problem…?' 'Have you felt guilty about the way you gamble, or what happens when you gamble?'	

				These are issues that can be ongoing within recovery, even when an individual has stopped gambling completely. If a service-user was to score high on these questions according to the proposed guidelines they would be a direct referral into clinical interventions within the NHS, even if they were not currently gambling. Recovery based support to address the legacy harms would be the most appropriate pathway in this instance and highlights the importance of using a more nuanced approach when determining a care pathway. That is why the stratified care model, in this regard is clearly more appropriate and effective. Furthermore, it is an inappropriate use of tertiary care services to engage with people who, as in the three examples provided, may already actually have stopped gambling. Recovery before treatment – part of the stratified care approach	

				Whilst the treatment offered by Tier 3B and 4 services, such as the NHS clinics, can play an important role in many people's recovery, it is often time-limited and can also be quite an intensive and intrusive process. Recovery approaches emphasise community engagement which can mean prevention and early intervention as well as aftercare and community support.	

				A 'recovery before treatment' model incorporates lived experience which is best facilitated by community-based services who are actively engaged in, and are members of, their communities, not NHS clinics. A recovery before treatment model is evidenced based and being adopted as the most appropriate model of support within other addiction services (outlined by the US Substance Abuse and Mental Health Services Administration (SAMHSA) in 2009). This model utilises community engagement and early intervention, through lived experience and multiple forms of support networks to facilitate an individual's recovery, and builds community recovery capital through networks of individuals with lived experience who give back. In the Dame Carol Black review of drug treatment, considerable focus is given to the central role of lived experience and Lived Experience Recovery Organisations (LEROs) as a central component of treatment and recovery, reflected in the 2022 UK Government drug strategy, "From Harm to Hope".	

				This moves away from using formal treatment as the first point of referral emphasizes the power of peers and communities, and the importance of long-term reintegration for preventing relapse and for building meaningful lives, while building the community visibility of recovery and challenging stigma and exclusion. The current proposed model within the draft guidelines does not take into scope the power of communities and peers, which has been recognised within the current drug strategy, From Harm to Hope (UK Government, 2022), which states 'peer-based recovery support services and communities of recovery are linked to and embedded in every drug treatment system' (2022, p43). One of the key benefits of such an integrated system is that, through active community engagement, aftercare blends with prevention and early intervention in a model in which recovery is the general aim and specialist treatment a form of tertiary care reserved for the most complex and severe cases.	

				See below case study from a female gambler in recovery who accessed Gordon Moody and the 'New Beginnings' programme within Betknowmore, a peer-based support service. This case study supports the importance of embedding lived experience within care pathways, and utilising a recovery before treatment approach: When asked how she would have felt being referred directly to an NHS gambling clinic, she stated: "I would have been very anxious and worried this possibly made me want to avoid any help whilst in active addiction, in the early days I was very aware that I needed to be careful who I trusted etc. I would have worried about waiting times and booking holiday off work, worried about what people thought as they wouldn't understand if they didn't have lived experience".	

				When asked how beneficial she found the support she received through the NGSN: “Very beneficial I started with GA online woman's preferred meetings then gordon moody where I did retreat and counselling which was fantastic to build a support network, after this I joined Epic and New beginnings it has really helped to speak with people who understand what I have been through and how I feel. I am sure this has kept me abstaining for 1 year”. Service-user choice	

				It is critical that the service-user is empowered to have ownership of their own treatment and recovery journey and to ensure that their individual needs are adequately addressed. The importance of service-user choice has not been highlighted within the draft, and it is imperative that this be taken into account following triage or assessment for gambling harms support, particularly given the importance of relationship-building in early involvement with specialist help or peer-based support, and the high rates of drop-out reported globally from gambling treatment services. There are a number of different support options that can be made available to a service-user following assessment, such as; Peer and lived experience support, including the use of peer navigators from the first point of contact Group support Practical advice and guidance Counselling and psychotherapy Stepped up specialist services, such as NHS treatment	

				Rather than an automatic referral to NHS clinics based on a PGSI score, local gambling harms support service should assess the individual and talk them through the options listed above. Their professional expertise, along with the service-user's own choice should determine what care pathway they are referred into. Empowerment and choice for the individual is likely to lead to not only higher rates of engagement but higher levels of subsequent treatment compliance. As a primary care mental health service IAPT is the most comparable NHS service to the NGSN. When reviewing typical IAPT costings through the PLICS submission system, with submissions made by 47 IAPT providers, the cost reported for those 47 providers in 2021 was £542.7 million, or £574.5 adjusted for inflation 2021-23, during which period they engaged with 1.2milion patients at a cost of £478.75 per patient. BCT in 2023 for comparison engaged with 4600 service-users, at a cost of £271.74 pp (IAPT IS 76% higher).	

				More alarmingly, the NHS gambling clinics are projected to cost at least £2,000 per referral (hansard.parliament.uk, 2022) with £6 million allocated per year and a plan to treat 3,000 patients per year. It is therefore not cost effective, nor best use of resources, to refer everyone presenting in the 'problem gambler' category to be moved directly to the NHS.	

Beacon Counselling Trust	Guid eline	12	10	Comparable treatment and specialisms within local gambling harms support services It is important to note that, if a service-user with a PGSI score of 8 or above chooses to access support through a community-based service such as those within the NGSN, appropriate therapeutic and support interventions can be offered in a clinically robust manner to these individuals, provided they do not present with additional mental health complexities or clinical risk/safeguarding concerns, in which case onwards referrals would be discussed.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. The guideline has also been amended to clarify that gambling treatment services will be commissioned by the NHS but there are likely to be delivered by a variety of providers who will offer a range of services as you describe.

				The NGSN providers hold a wealth of experience, expertise and knowledge in the field of gambling harm treatment and recovery support. Treatment services within the NGSN offer holistic support programmes through interventions provided by mental health practitioners, support workers, counsellors and psychotherapists. Many of these counsellors and psychotherapists are CBT qualified, which is a core offer within the model of care provided by organisations within the network. It is also important to note that CBT-led therapy is not always delivered by psychologists within the NHS and can often be delivered by trained therapists. The CBT offered within the NHS is therefore comparable to other counselling and therapeutic services within the NGSN.	

				Community-based services are also best placed to facilitate reintegration back into the service-user's community, and wider society, which is one of the most important pillars of long-term recovery. We would therefore challenge the statement within the draft that the NHS clinics are the only 'gambling specialist service'. In an optimal system, the local NGSN provider should be offering both front and back-end support for high needs clinical cases and ongoing case management and recovery support to all other service users. In drug treatment the optimal model is a Recovery-Oriented System of Care (ROSC, SAMHSA, 2009) which combines specialist care with NGO and community provision to meet the personalised, cultural, familial needs of the individual seeking help). It is highly unlikely that the proposed model will achieve this.	

GamCare	Guideline	12	010-012	Please see comment 4 above. The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five days from assessment to the offer of a first support session at GamCare. Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner. GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment.	Thank you for your comment. There is no suggestion in the guideline that access to services will only be via a GP referral, as a referral could be made by a range of professionals and practitioners, or via self-referral, and a new section has been added to the guideline on referral and triage and directing people to the correct level of service. The recommendations have been amended to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced

Royal College of Psychiatrists	Guideline	12	011 - 012	1.3.3. Again we would strongly advise to delete '(for example, a PGSI score of 8 or more, or a lower PGSI score but complex harms or comorbidities.)" because this is not a threshold used by all services and is not evidence based in terms of psychometrics. It is also not clear why all specialist services would need to screen people: if people have been referred for gambling disorder, NHS services – at least some – would then undertake a detailed clinical assessment including diagnostic interview, so screening in that setting is not needed, as this removes the need to use a screen. If there is a role for screening tools in particular services then this is of course fine – but it would depend on local pathways and in our view is not something that should be done prescriptively in the NICE guidelines.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

Betknowmore UK	Guideline	12	013 - 014	The NGSN is an existing integrated network that covers all GB regions, with existing referral pathways between providers and partnership working.	Thank you for your comment. The guideline has been amended to clarify that gambling treatment services will be commissioned by the NHS but there is likely to be a variety of providers who will deliver a range of services as you describe.
Parkinson's UK	Guideline	12	15	We believe this guidance should include recommendations that training includes a basic understanding of Parkinson's and Parkinson's medications and how these can be linked to harmful gambling.	Thank you for your comment. The guideline alerts professionals to the link between Parkinson's disease and harmful gambling but does not provide detailed recommendations on training (for this or any other topic). It instead advises what level of service should be provided and that this should be provided by competent staff.
Betknowmore UK	Guideline	12	015 - 017	Existing NGSN providers are trained clinicians and peer support workers. Betknowmore UK offers City & Guilds assured (previously NVQ accredited) training to its peer supporters. This is the first accredited Gambling Peer Support training programme in the UK.	Thank you for your comment and for telling us about this training for peer support. This has been passed to the NICE implementation team to consider when planning support activities for this guideline.

GamCare	Guid eline	12	015 - 017	GamCare supports the recommendation that providers should ensure that the workforce deliver support and treatment must trained and competent to do so. Following NICE recommendations, GamCare's treatment practitioners are trained in Cognitive Behavioural Therapy (CBT) skills and Motivational Interviewing, and this is embedded into everything we do.	Thank you for your comment, support of this recommendation and for telling us about the training of GamCare staff. The guideline recommends that all services use competent staff and collect data on outcomes as you describe.

				The charity has been addressing gambling harm for over 25 years with much of that that time being lead provider within the wider gambling system and have supported the advancement of support services as they are known today through independent evaluations and contributions through our data to national research. The majority of service users completing treatment showed improvements against GamCare's key success measures. Using CORE-10, the majority moved from 'moderate' to 'healthy' gambling behaviours (17.4 to 6.5), and using PGSI, they moved from 'problem gambling' levels to 'moderate levels (17.1 to 3.5). It is key to also see NHS specific treatment outcomes, which currently are not published, and waiting times, to ensure the best services possible for those who need them.	
Department of Health and	Guid eline	12		Rec 1.3.4 – also general recommendation around training.	Thank you for your comment. NICE guidelines do not generally provide detailed recommendations on the training needed to

Social Care – Office for Health Improvement and Disparities			015 – 017	Training for the workforce delivering support and treatment services should be holistic and ensure that professionals have a robust understanding of the influences to gamble including marketing and advertising and provide an understanding of the various products and related risks (not a sole focus on behaviour). Training should include causes of stigma which are described within the existing evidence base – such as narratives of individuals responsibility and normalisation, impact of culture and how gambling and addiction is viewed, and lack of wider understanding and harmful gambling and gambling-related harm. The training should include how stigma impacts willingness to disclose or ask for help given the associated shame and fear of repercussions, and support a person-centred approach.	implement guidelines but instead advise what level of service should be provided (which includes the topics you have listed), and that this should be provided by competent staff.

Haringey Public Health Department	Guideline	12	18	1.3.5 - We commend this point and strongly encourage the collection of high-quality data that encompasses appropriate risk factors to enable providers and commissioners to better understand how to target at-risk groups going into the future.	Thank you for your comment.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	12	018 - 020	1.3.5 - Service providers should routinely collect data on people entering services for harmful gambling, including demographics, baseline data on type and severity of gambling-related harms, and treatment outcomes. – Add and share this with partner agencies e.g. criminal justice, where appropriate, and in accordance with information sharing agreements.	Thank you for your comment. The advice to publish data has been added to this recommendation, so that these data can be shared.

GamCare	Guideline	12	018 - 020	GamCare support the importance of this recommendation. As the operator of the National Gambling Helpline, GamCare routinely collects significant quantities of data, that help us to determine emerging trends in gambling behaviour and demography. Last year we received 44,409 calls and communications through our helpline, with each contact being logged within our system. Therefore, GamCare has experience in gathering and collating large amounts of the requested data.	Thank you for your comment, support for this recommendation and telling us how GamCare collect these data.
				In addition, GamCare is expanding its data capacity with the creation of a new data insights team, to ensure that the quantities of data we collect are being used in a responsible and effective manner. We also collect data on our Extended Brief Interventions and Treatment outcomes, including completion rate and the change in PGSI score.	

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	12	018 - 020	Para 1.3.5 We suggest data to include demographics, baseline data on gambling activity [type, frequency, intensity and length of time person has been gambling], and type and severity of gambling related harms, and treatment outcomes. We see these as important data that can be used to inform future service developments and public health interventions.	Thank you for your comment and support for this recommendation, which already includes these data types.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	12	018 – 020	Rec 1.3.5 – The data should also capture is people are using other gambling services so analysis of duplication of services can be undertaken.	Thank you for your comment. The committee decided that the standardised dataset was likely to contain a wide number of parameters and those suggested were just key examples, so this has not been added.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	12	021 – general	Improving access to treatment. Overall, we welcome the recommendations for commissioners and providers of treatment in this section of the guideline.	Thank you for your comment.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	13	1	Overcoming stigma. We are pleased to note the inclusion of overcoming stigma in the guideline. We suggest that how we use language is important, especially for people who come from marginalised communities and groups and who may experience 'double discrimination.'	Thank you for your comment and support for these recommendations on overcoming stigma. The recommendations already acknowledge that people from certain groups may face greater levels of stigma.

Gordon Moody	Guideline	13	002-003	One of Gordon Moody's main strategic objectives is to reduce barriers and enhance accessibility to treatment by ensuring that each service user will receive the right treatment, at the right time in the right place. Which is why we welcome the guideline's focus on overcoming stigma and proposing a person-centred approach at all levels of engagement to reduce the impact of stigma and encourage access to treatment. There is a need to be dynamic in the way we reach different service users and understanding culturally informed insights and how we could best access communities that at present are under-represented in the treatment space, in a hope that we can reduce the inequalities we see.	Thank you for your comment and your support for the recommendations on overcoming stigma and encouraging access.

Gambling with Lives	Guid eline	13	4	1.4.2 - There is not enough here about stigma for anyone suffering gambling harm.	Thank you for your comment. An overarching section on stigma has been placed at the start of the guideline and information about normalisation of gambling has been included in the rationale.
His Majesty's Prison and Probation Service (HMPPS)	Guid eline	13	4	1.4.2 - Agree that these groups might find it difficult to access treatment but it should also be acknowledged that it can be difficult for anyone to access treatment and this should be highlighted	Thank you for your comment. The start of the recommendation states that stigma can affect anyone affected by gambling-related harms, before going on to highlight groups where this might be a particular issue.

Breakeven (Charity no 1158156)	Guid eline	13	4	There is considerable concern that the current draft of a Guideline will reduce client choice and deter people from seeking treatment for gambling problems. Our service users have expressed a desire for the freedom to choose between different services such as NGSN, NHS, and organisations like Gamblers Anonymous. These services offer valuable expertise that should not be underestimated or lost in this process. Protecting and enhancing patient/client choice is crucial, as it allows individuals to make informed decisions about their preferred treatment options. Restricting these choices may lead to people avoiding treatment services altogether, fearing the stigma associated with being labelled as "problem gamblers" and being referred to NHS clinics.	Thank you for your comment. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will likely be delivered by a variety of providers so people will still have choices (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. The guideline advises that services should be culturally sensitive.

				It's important to acknowledge that community-based treatment and support can play a significant role in reducing barriers to accessing services and enhancing client choice. The Guideline, as currently drafted, appears to overlook the high relapse rates seen across all addictions. People experiencing gambling harms may require multiple periods of varying types of support over many years. Therefore, flexibility, choice, and short waiting times are key factors in ensuring effective treatment, support, and prevention. In summary, it is essential to consider the feedback from service users and ensure that their freedom to choose between services is protected and enhanced. This is especially relevant for women, and groups that traditionally are reluctant to come forward for services in the NHS.	

				Groups from ethnic and diverse communities are not serviced and are underrepresented in the whole range of statutory services. The NGSN has a track record of developing in reach community services to address this exact problem. This guidance moves these groups further away and alienates them from accessing services to tackle gambling related harms to the individual, their families and the wider community, increasing health inequalities. The Guideline should also take into account the potential need for long-term support and the significance of community-based treatment options in reducing barriers to accessing services	

RCA Trust	Guid eline	13	4	There is considerable concern that the current draft of a Guideline will reduce client choice and deter people from seeking treatment for gambling problems. Our service users have expressed a desire for the freedom to choose between different services such as NGSN, NHS, and organisations like Gamblers Anonymous. These services offer valuable expertise that should not be underestimated or lost in this process.	Thank you for your comment. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will likely be delivered by a variety of providers so people will still have choices (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. The guideline clearly advises that services should be culturally sensitive.

				Protecting and enhancing patient/client choice is crucial, as it allows individuals to make informed decisions about their preferred treatment options. Restricting these choices may lead to people avoiding treatment services altogether, fearing the stigma associated with being labelled as "problem gamblers" and being referred to NHS clinics. It's important to acknowledge that community-based treatment and support can play a significant role in reducing barriers to accessing services and enhancing client choice. The Guideline, as currently drafted, appears to overlook the high relapse rates seen across all addictions. People experiencing gambling harms may require multiple periods of varying types of support over many years. Therefore, flexibility, choice, and short waiting times are key factors in ensuring effective treatment, support, and prevention.	

				In summary, it is essential to consider the feedback from service users and ensure that their freedom to choose between services is protected and enhanced. This is especially relevant for women, and groups that traditionally are reluctant to come forward for services in the NHS. The Guideline should also consider the potential need for long-term support and the significance of community-based treatment options in reducing barriers to accessing services.	
Ara recovery for all (Addiction Recovery Agency Ltd. Charity Number 1002224)	Guid eline	13	4	There is considerable concern that the current draft of a Guideline will reduce client choice and deter people from seeking treatment for gambling problems. Our service users have expressed a desire for the freedom to choose between different services such as NGSN, NHS, and organisations like Gamblers Anonymous. These services offer valuable expertise that should not be underestimated or lost in this process.	Thank you for your comment. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will likely be delivered by a variety of providers so people will still have (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. The guideline advises that services should be culturally sensitive.

				Protecting and enhancing patient/client choice is crucial, as it allows individuals to make informed decisions about their preferred treatment options. Restricting these choices may lead to people avoiding treatment services altogether, fearing the stigma associated with being labelled as "problem gamblers" and being referred to NHS clinics. It's important to acknowledge that community-based treatment and support can play a significant role in reducing barriers to accessing services and enhancing client choice. The Guideline, as currently drafted, appears to overlook the high relapse rates seen across all addictions. People experiencing gambling harms may require multiple periods of varying types of support over many years. Therefore, flexibility, choice, and short waiting times are key factors in ensuring effective treatment, support, and prevention.	

				In summary, it is essential to consider the feedback from service users and ensure that their freedom to choose between services is protected and enhanced. This is especially relevant for women, and groups that traditionally are reluctant to come forward for services in the NHS. Groups from ethnic and diverse communities are not serviced and are underrepresented in the whole range of statutory services. The NGSN has a track record of developing in reach community services to address this exact problem. This guidance moves these groups further away and alienates them from accessing services to tackle gambling related harms to the individual, their families, and the wider community, increasing health inequalities. The Guideline should also consider the potential need for long-term support and the significance of community-based treatment options in reducing barriers to accessing services	

		13	4	Over-pathologising service-users	

Beacon Counselling Trust	Guid eline			Whilst we agree a PGSI score of 8 or above should be flagged immediately as someone that requires support, using it as a single point of measurement to determine a referral into clinical interventions or treatment within the NHS will risk over-pathologising service-users, which may contribute towards stigma, based on the negative effects of labelling. A single score cut-off also creates risks around both 'misses' (people who under-report for fear of adverse consequences or stigmatised responses) or 'false positives' (with people who over-report, including for the legacy reasons outlined above). As we know, stigma is particularly prevalent in those experiencing direct or indirect gambling-related harms (Quigley, 2022) and can play a large part in preventing people from accessing support. There is also no evidence that the PGSI was meant to be used in this way or pilot data to suggest that it has adequate predictive validity.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. With the planned reconfiguration of gambling treatment services it is likely that services will be commissioned by the NHS but delivered by a range of providers so there will still be choices for (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments, and still be able to self-refer. The guideline clearly advises that people who are suicidal should be helped immediately, usually via crisis services.

				As already stated, it is also important to consider that all PGSI questions are asked based on the individual's experience over a timescale of 12 months. It gives a very broad overview of the individual's relationship with gambling, and it is therefore not appropriate to use this as a single access point of referral into the NHS clinics. To determine someone's full clinical presentation and whether there is a need for stepped-up care, a full assessment of their presentation should be required. Concerns around being labelled are supported in a case study given to us by an ex service-user of BCT: This ex service-user went to prison for a gambling-related crime and entered BCT in 2019. She was in her thirties when she initially accessed and had experienced a problem with her gambling for 3 years prior to accessing BCT for help. She was struggling with suicidal thoughts and self-harm as a result of her gambling. She was supported by BCT through one-to-one therapy before and during prison.	

				"I was at crisis point when I got in touch and I know I wouldn't have been able to wait, and because I was suicidal if I was put on a waiting list for the NHS it could have ended up disastrous. Being referred to an NHS clinic would have made me feel even more embarrassed. I was already feeling labelled and I think a referral to the NHS would have made me feel worse about that. I also would have been worried about things then being put on my medical records.	

				The support through BCT was completely non-judgemental and I was seen within a week which was important as I needed the help there and then. It was what saved me. I felt like I could call the service as and when I needed and someone was always there to speak to me. I always knew who was at the other end of the line no matter who it was I called. This was important because it made me feel more comfortable and less anxious about calling. My therapist was able to refer me to the clinical director who met me of a weekend and put a court report together for me as I had been charged with a gambling related crime. It felt personal and I felt like the only person being cared for whilst I was accessing support at Beacon.	

				I think this model could cause more harm for people who are at breaking point with gambling because they might not get seen straight away. The difference a day makes for someone who is suicidal is massive. I know there is a recommendation of CBT groups but I know for me I couldn't have been put straight in a group as at that point I couldn't even talk to my family about it. I also don't think an NHS clinic would have as much of a personal touch which was really important for me."	
Betknowmore UK	Guideline	13	004-007	The lack of trust that some minority communities have in the NHS may act as a barrier to their willingness to access NHS services for gambling harms. The Guideline should acknowledge this.	Thank you for your comment. The guideline already advises that people from some cultural backgrounds may face particular issues with stigma, shame and fear that prevent them accessing services and that services should be culturally sensitive and take into account ethnic background and religion.

Gordon Moody	Guideline	13	004-011	We believe that LGBTQIA+ and BAME communities should be added to the1.4.2 list of marginalised groups highlighted in the guideline.	Thank you for your comment. The recommendation has been amended to include people from any marginalised, minority or under-represented groups, which would include LGBTQ+ and BAME communities. The committee looked for evidence on methods to improve access for under-represented and marginalised groups such as those you mention but found no evidence and so made a research recommendation.
GamCare	Guideline	13	004-011	GamCare support this recommendation on the importance of recognising stigma, shame and fear surrounding the disclosure of gambling-related harms, However, GamCare would like to draw attention to the case that the NHS may, in some circumstances, act as a barrier to people accessing support and over pathologise those experiencing gambling harms.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will be delivered by a variety of providers so people will still have choices (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. The guideline clearly advises that services should be provided that are culturally sensitive.

				The NHS can act as a barrier due to a perceived lack of service user choice. Some individuals may not wish to use NHS services, whether it's due to the risk of experiencing stigma when visiting a GP, or due to their own preference. Moreover, due to the extensive capacity and expertise already available through charities, initial triage will likely allow for a smoother, local, and more efficient referral process. When someone is flagged as having a PGSI over 8, treatment options should be considered and explained to that person, including peer and lived experience support, group support, practical guideline, specialist services and treatment. Service-user choice should then determine the pathway, rather than a direct NHS referral without patient consultation. Being referred directly into 'specialist' treatment may feel overwhelming and result in service-users 'dropping out'.	

				Service-user choice led care can potentially see people get in touch with services quicker. Not all service-users with a PGSI score above 8 are comfortable or ready for specialist treatment. For example, peer recovery and support often represent a less daunting threshold and can act as an effective entry point to specialist services by working to address the effects of stigma. By exploring different options, they could potentially start to access support before their gambling-harms worsen any further. To better address stigma, it is vital not to over pathologise people by directly referring to the NHS specialist treatment immediately upon presenting with symptoms. This could result in service-users ultimately feeling more stigmatized and under pressure to enter treatment that they are not yet comfortable with. Stigma is particularly prevalent in those experiencing direct or indirect gambling-related harms (Quigley, 2022) and can play a large part in blocking people from accessing support.	

				Finally, PGSI scores give a 7-day snapshot of the individual's relationship with gambling and may not be appropriate to use as a single access point of referral into NHS clinical. Questionnaires e.g., CORE-10/PHQ-9/GAD-7, offer more accurate clinical assessment and avoid over/under treating someone, and should be delivered pre-NHS treatment (unless requested).	
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	13	7	Rec 1.4.2 – People who have had previous negative experiences in trying to access treatment and support (for gambling and in general) are likely to be a particular cohort who are reticent to access available treatment and support.	Thank you for your comment. The recommendation has been expanded to include people from any marginalised, minority or under-represented groups, but it is not possible to list all the groups who may be reticent to access services so this group had not been added.
Gambling Harm UK	Guid eline	13	7	We suggest that children and young people as a group are more likely to be susceptible to stigma and shame limiting support and treatment seeking behaviour.	Thank you for your comment. Children and young people are not included in the scope of this guideline so have not been added.

Betknowmore UK	Guideline	13	008-011	LGBTQ+ groups should be included in the list provided in the Guideline.	Thank you for your comment. The recommendation has been expanded to include people from any marginalised, minority or under-represented groups, which would include the LGBTQ+ community. The committee looked for evidence on methods to improve access for under-represented and marginalised groups such as those you mention but found no evidence and so made a research recommendation.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	13	12	1.4.3 - There is now work ongoing to have money retrieved from gambling companies that have not protected players from addiction/harm…..is it worth putting in a link to this as it may help those that feel there is real monetary help also available?	Thank you for your comment. It is correct that some of the money from Gambling Commission fines is used for beneficial causes related to victims of crime and gambling treatment, but this is not within the scope of the guideline.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	13	13	Para 1.4.3 we suggest 'use a person centred, empathic [standard form in the UK], non-judgemental approach and….' Our graduates from treatment have described a person centred approach as 'see gambling as something I do, not who I am.'	Thank you for your comment. The change to 'empathic' has been made.

Betknowmore UK	Guideline	13	013 - 015	Assurance of anonymity and privacy must be explicitly provided. There should be recognition that seeking support may place those experiencing domestic abuse in further danger.	Thank you for your comment. The recommendations already state that all conversations are private and confidential, and a caveat about the need to share information in cases where people's safety might be compromised has been added.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	13	014 – 015	Rec 1.4.3 – If individuals are already speaking with commissioners or treatment providers, they have already sought out help/support. Suggest re-wording this to say '…discuss with people any initial fears or concerns that may be preventing them from seeking help or having treatment for gambling-related harms or that may prevent them from continuing treatment and support in the future.'	Thank you for your comment. Having a conversation with someone about gambling-related harms does not always equate to seeking or undertaking treatment, however, the recommendation has been amended to include continuing with treatment, as you suggest.
GambleAware	Guideline	13	18	Different groups need specifically designed programmes that cater to specific needs not reasonable adjustments to existing provision. This will not support increased access to services, it will have the opposite effect.	Thank you for your comment. The recommendation advises that treatments should be modified for different groups, not just that reasonable adjustments should be made, so this recommendation has not been amended.
Betknowmore UK	Guideline	13	020 - 026	Groups specific to affected others should also be mentioned.	Thank you for your comment. Groups for affected others have been added to the list.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	13	020 - 026	Para 1.4.4 consider insert: services that are sensitive to neurodiversity, including towards people with autism and /or learning disabilities.	Thank you for your comment. These groups would already be covered in the advice to 'consider modifying treatments or their delivery for different groups, including making reasonable adjustments', so these groups have not been added as separate examples.
NECA (Charity Number 516516)	Guideline	13	General	The current version of the Guideline appears to reflect a missed opportunity to embrace a broad spectrum of provision in responding to Gambling related harms. The content has the potential to limit the treatment options available to individuals seeking help for gambling-related issues. The guidelines do not reflect the importance of being able to choose from a range of quality services, including those offered by NGSN, the NHS, and lived experience organisations. The expertise provided by these services should not be underestimated or disregarded as these guidelines appear to have achieved throughout the document.	Thank you for your comment. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will be delivered by a variety of providers so people will still have choices (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. The guideline clearly advises that services should be provided that are culturally sensitive, and other groups you mention such as women are already included as needing special consideration.

				It is crucial to ensure that individuals have the ability to make informed decisions about the treatment options that best suit their needs. Restrictions on these choices could deter individuals from seeking help due to the fear of stigma associated with being labelled as "problem gamblers" and being referred to NHS clinics. The guideline in its current form appears to fail to recognise the significant role that community-based treatment and support can play in reducing barriers to access and empowering individuals to make decisions that align with their specific requirements. Individuals experiencing gambling-related harm may require different types of support over extended periods. Therefore, flexibility, choice, and minimised waiting times are essential to ensure effective treatment, support, and prevention.	

				In conclusion, it is vital to consider the input from service users with lived experience ensuring that their freedom to choose between services is protected and expanded, particularly for women and marginalised groups who may face barriers to accessing NHS services. Furthermore, ethnic and diverse communities are currently underserved and underrepresented in statutory services. The NGSN has made strides in developing community services to address this issue, and it is crucial that this guidance does not isolate these groups further and worsen health inequalities.	

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	1314	001-026 001-028	Ignoring the impact and influence of the third sector perpetuates stigma. Individuals will be reluctant to attend specialist services and will further hide their problems rather than present to a low threshold, more accessible and usually run by those with lived experience service. The third sector plays a crucial role in addressing gambling harms for several reasons: Specialised Support: Third-sector organisations often specialise in providing support and resources tailored to the specific needs of individuals with gambling problems. They can offer various services, including counselling, helplines, support groups, and education, which may need to be more readily available through government or for-profit entities. Confidentiality and Trust: Many people with gambling problems may be hesitant to seek help due to the stigma associated with gambling addiction. Third-sector organisations often provide a safe and confidential space where individuals can open about their issues without fear of judgment or negative consequences. Holistic Approach: Third-sector services tend to take a holistic approach to addressing gambling harms. They often address not only the addiction itself but also its underlying causes, such as financial, psychological, and social factors. This	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will be delivered by a variety of providers so people will still have choices (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments.

				comprehensive approach is critical for long-term recovery. Advocacy and Awareness: Third-sector providers often advocate for policy changes, raise public awareness, and work to reduce the harm caused by gambling addiction. They can be effective in pushing for regulatory measures that protect vulnerable individuals from the negative impacts of gambling. Community-Based Support: Many third-sector organisations are deeply rooted in local communities, making them more accessible and relatable to those seeking help. They can provide valuable outreach and support within specific regions, increasing the chances that individuals with gambling problems will seek assistance. Diverse Services: Third-sector organisations can offer a diverse range of services, including financial counselling, legal support, mental health services, and peer support groups. This multi-faceted approach can address the complex needs of people struggling with gambling addiction. Independence and Objectivity: Third-sector organisations, unlike government agencies or for-profit gambling industry stakeholders, often operate independently. This independence allows them to provide more objective information,	

				support, and advocacy for individuals affected by gambling problems. Research and Innovation: Many Third-sector organisations lead research and develop innovative approaches to addressing different approaches to engaging those with gambling-related harms. They may pilot new treatment methods, prevention strategies, or community-based initiatives that can benefit those in need. Bridge to Formal Services: Third-sector services can serve as a bridge to formal treatment and support services, helping individuals access professional help when necessary. Peer Support: Many third-sector organisations offer peer support, allowing individuals with gambling problems to connect with others who have experienced similar challenges. Peer support can be particularly effective in providing encouragement and sharing strategies for recovery. In summary, third-sector services are essential in addressing gambling problems because they offer specialised, community-based, and holistic support that complements the efforts of governments and the private sector. They play a vital role in helping individuals affected by gambling addiction on their path to recovery and in raising awareness of the issue in society.	

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	14	001 – general	Supporting access for people with mental health problems. Our clinical experience to date supports the recommendations in this section.	Thank you for your comment.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	14	2	1.4.5 - Maybe recognise those with neurodiversity issues as these individuals may also find treatment difficult to access.	Thank you for your comment. These groups would already be covered in the advice in an earlier recommendation (as neurodiversity is not a mental health problem) to 'consider modifying treatments or their delivery for different groups, including making reasonable adjustments', so neurodiverse issues have not been added as a separate example.

Adferiad	Guideline	14	2	The guideline recognises that people with mental health problems may find it more difficult to access support and treatment for gambling related harms and yet offers no co-ordinated treatment options. Adferiad currently deliver a complex needs pathway for individuals experiencing complex comorbidities alongside gambling related harms.	Thank you for your comment. Later recommendations in the guideline in the section on principles of treatment specifically advises coordinated care for people with mental health problems. This has also been addressed in the revised models of care section of the guideline which provides advice the appropriate treatment for people with complex needs.
Parkinson's UK	Guideline	14	9	We are pleased to note the recommendation that referral and treatment pathways are easy to access, avoiding multiple assessments or steps. We would like the provision of joined-up care that integrates with their existing Parkinson's services. This is because people with Parkinson's tell us of the difficulties they experience in navigating a system that does not allow for this.	Thank you for your comment. Later recommendations in the guideline in the section on principles of treatment specifically advises coordinated care for people with comorbidities. This has also been addressed in the revised models of care section of the guideline which provides advice the appropriate treatment for people with comorbidities.

Gordon Moody	Guid eline	14	009 - 016	Recommendation 1.4.7 We believe that the importance of service-user choice has not been highlighted within the draft, and it is imperative that this will be taken into account following triage or assessment for gambling harms support. We also want to highlight that provision of NHS-commissioned services only, might act in itself as a barrier to access treatment.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will be delivered by a variety of providers so people will still have choices (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments.

				The NGSN offers a placed based approach which improves engagement at a local level in addition to the ability to connect people with what is available regionally and nationally ensuring a 'no wrong door' approach. Also, best placed for MI around referral to and engagement with NHS where appropriate and advocation and support to help improve engagement with providers such as the NHS or Tier 4. Integrated place-based systems will better ensure people are coordinated into the right intervention at the right time for them and protect NHS resource for people wanting this and able to access this that is right for their level of need. There is a need for stronger partnerships and integrated systems. NICE guidelines centre around the NHS and falls short of what is required. The proposed recommendations feel like a backwards step away from what has been established with the NGSN over the last few years.	

				We advocate for best practise recommendation to be introduced regrading signposting/referring procedures to allow for follow-up with the person and even better where appropriate and consent in place, with the service. The promotion of professional referrals and follow-up to improve engagement and avoid people falling between the gaps and experiencing ongoing harm can be crucial for a better access to treatment. In addition to all PGSI 8 plus being referred to the NHS-commissioned services there is an assumption that people are in a position to engage in structured appointment based individual or group treatment. We have evidence from referrals for R&C and residential of the need for people to come away from their home environment in order to regain control in a safe environment. The number of people who don't have stable home environments to start implementing change requires tier 4 intervention. The NICE proposal doesn't offer equity around access.	

Royal College of Psychiatrists	Guideline	14	015 - 016	1.4.7. small typo "designed to minimise" --> "be designed to minimise..."	Thank you for your comment. This typo has been corrected.
Royal College of Psychiatrists	Guideline	14	015 - 016	1.4.7. "by avoiding.... multiple assessments or steps". Multiple steps in clinical care pathways can be necessary – for example, digital pre-assessment followed by clinical assessment followed by MDT discussion. To merge such steps would not be appropriate. Instead could refer to e.g. ensuring patient pathways are efficient, streamlined, and designed to help foster patient engagement.	Thank you for your comment. This reference to multiple steps came from qualitative evidence that people found having to jump through multiple hoops or complete duplicate assessment paperwork was off-putting. This recommendation has been clarified to state this.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	14	017 - 021	1.4.8 - Page 14, Paragraph 1.4.8 Explain to people accessing treatment that: • all conversations are private and confidential – Whilst the basis for any information sharing is an individual's informed consent, this seems too definitive. There are limits to confidentiality e.g. if someone disclosed that they were going to commit a crime/intended to harm someone else.	Thank you for your comment. An addition has been made to this recommendation to state that in certain circumstances it may be necessary to share confidential information.

GamCare	Guideline	14	017-021	GamCare notes that the guideline document refers to 'gambling treatment services provided by the NHS' and would be grateful if the Committee could clarify that this is intended to mean 'gambling treatment services commissioned by the NHS', and could make that change accordingly.	Thank you for your comment. This recommendation has been amended and so no longer refers to NHS-commissioned or provided services.
The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	14	017-021	This sentence should include that third-sector services are free at the point of use. Otherwise, it is biased. Third-sector interventions also follow due process and are confidential and private. There is a failure to mention that primary care services are confidential and free.	Thank you for your comment. The recommendation has been revised to clarify that all services are usually free.
Betknowmore UK	Guideline	14	18	The Guideline should be revised to include that treatment and support services provided by the NGSN are also free to access, including the National Gambling Helpline.	Thank you for your comment. The recommendation has been revised to clarify that all services are usually free.

GambleAware	Guideline	14	18	By only focusing on the NHS, this line suggests that only NHS delivered treatment is free. The gambling treatment services provided by the third sector – which constitute the vast majority of current provision – are also free at the point of access. This line must be amended to reflect this, otherwise people may be discouraged from accessing third sector services because of a misconception they have to pay for them.	Thank you for your comment. The recommendation has been revised to clarify that all services are usually free.
NECA (Charity Number 516516)	Guideline	14	18	1.4.8 The NHS is generally free at point of access is a given but so are those of most providers should this not also be stated to reduce a potential barrier to accessing support? For example, there is no charge and Gambling Treatment and support services . In essence the majority of gambling services are free at point of access other than “private” providers.	Thank you for your comment. The recommendation has been revised to clarify that all services are usually free.

Royal College of Psychiatrists	Guid eline	14	21	1.4.8. All conversations being private and confidential - there are situations when it is appropriate and necessary to breach confidentiality so we recommend mentioning that, to keep in line with GMC and other professional guidelines.	Thank you for your comment. An addition has been made to this recommendation to state that in certain circumstances it may be necessary to share confidential information.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	14	022 - 026	1.4.9 - Gambling interventions should target the underlying causes of gambling to address the behaviour. There are many existing interventions in the CJS that target things like emotional management, problem solving, conflict management, substance misuse, relationship difficulties, social skills etc. The strategic ambition for HMPPS is to reduce the number of competing interventions and so consideration must be given to what alternative provision already exists before commissioning or designing new interventions. In the same section a recommendation is made to enable access to a gambling intervention ASAP. Consideration should be given to sequencing of rehabilitative services in accordance with risk of reoffending. E.g., are there criminogenic needs not associated with gambling that need to be prioritised to protect the public? This means this recommendation is not straight forward. It would be more appropriate to consider bespoke sentence planning that prioritises on need and addresses factors according to severity, influence on offending and reducing the risk of reoffending.	Thank you for your comment and for sharing more information on how services are sequenced in the criminal justice system. Recommendations on the sequencing of treatments for gambling-related harms and other mental health conditions are already included in the guideline section on principles of treatment. It is recognised that implementation of the recommendations in the criminal justice system may need some tailoring to fit in with the specific needs of people in that setting, and it is not possible for the guideline to set out the detail of how this should be done.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	14	27	1.4.10 - The recommendation to offer individual treatment as opposed to group treatment needs some modelling. Individual treatment is more resource intensive than group, and the academic evidence supports group interventions for improved learning. Some thought would need to be given to the model of treatment if this recommendation was to be expected. A more appropriate consideration would be to aim for group-based intervention with the exception of specific responsivity needs that prevent someone accessing group services. This is linked to my point above on bespoke planning in response to these broad recommendations.	Thank you for your comment. We have assessed the clinical and cost-effectiveness of individual and group interventions. We specifically developed an economic model to assess the relative cost-effectiveness between group CBT and individual interventions (CBT, behavioural therapies, counselling) as reported in Appendix I in evidence review F. The economic analysis suggested that group CBT is more cost-effective than individual treatments (because individual treatment is more resource intensive and not more effective than group treatment). Therefore, we made a recommendation to offer group CBT, unless the person does not wish to join a group, or group CBT is not possible or suitable; in these cases, individual CBT should be offered instead.

Gordon Moody	Guideline	14	027-028	Recommendation 1.4.10. It is essential we ensure equity of services and access around these and therefore have a broad range of options covering a spectrum from prevention through to long term recovery ensuring these are appropriate for different groups and communities with sufficient capability and capacity. People who present for tier 4 treatment commonly present with adverse childhood experiences or have experienced trauma. Treatment providers should recognise that some vulnerable populations (I.e. LGBTQIA+, BAME communities) may have additional complexities and comorbidities. GambleAware (2022) reports that gambling harm may be greater among those identifying as lesbian, gay, or bisexual. Furthermore, GambleAware (2022) found that as LGBTQ+ groups' increase their gambling, mental health worsens at a higher rate than the general population (17% vs 10%), suggesting gambling having a more deleterious impact upon these communities.	Thank you for your comment. The recommendation about stigma has been expanded to include people from any marginalised, minority or under-represented group, and the recommendations on treatment services make it clear that people with additional complexities would need to be triaged to a service that can meet these needs. The committee looked for evidence on methods to improve access for under-represented and marginalised groups such as those you mention but found no evidence and so made a research recommendation.

				In our experience, many people who require treatment for gambling harm also suffer from comorbid mental health diagnoses, physical disabilities and/or learning disabilities. The application process and treatment offered should be accessible to all, such as easy-read information sheets, aid adaptations, and sessions that are person-cantered. Treatment centres need to be cognisant of how to best work with people who have autism, ADHD or other neurodiverse needs. A treatment style that may be appropriate for one client may not be suitable for another, and so treatment should be tailored to the individual.	
GambleAware	Guid eline	14	28	We would agree with this recommendation, but are concerned that the NHS model does not currently align with it – as such if this recommendation is adopted it should be reflected in the NHS offer or alternative pathways should be considered (for example NGSN first approach) where practice aligns.	Thank you for your comment. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will be delivered by a variety of providers so people will still have choices (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments.

Midlands Partnership University NHS	Guideline	014 - 015	008 - general	Supporting and encouraging access and engagement This is a helpful section. Consider inserting an additional paragraph with the following bullet points:	Thank you for your comment and support of this section. The points you have raised are covered in more detail in the section of the guideline on models of care which advises that pathways should be timely, flexible, and take into account the needs of individuals. Therefore this has not been repeated in this section of the guideline.

Foundation Trust (MPFT).				The design and development of accessible, safe, effective and sustainable care pathways are informed by the experience of people using services and activity data identifying throughput, bottlenecks and drop outs. Services recognise that a 'one size fits all' may not deliver the desired levels of treatment and support for everyone. They build in flexibility to accommodate individual needs, in particular, for people presenting with more complex issues. There is clarity around how long people can expect to wait for assessment and treatment. Self-help information and signposting to alternative resources may be offered with lengthy waits. The service undertakes a regular, systematic review of its care pathways and opportunities for improvement using well established quality improvement methods. For example: The Health Foundation (2021) Quality improvement made simple: What everyone should know about health care quality improvement.	The use of data for quality improvement of services is not specific to gambling services and so this has not been included.

Royal College of Psychiatrists	Guideline (also supplement on network meta-analysis)	15	001 - 002	1.4.10. Also supplement including the network meta-analysis of psychological interventions and economic modelling. The draft guidelines appear to be suggesting that group therapy is first-line psychological treatment. However, the current evidence base for 1:1 CBT is considerably stronger in terms of the number of controlled studies available and the methodological quality of the available clinical trials. Outcomes with group therapy are relatively poorly studied especially beyond 3-month follow-up (whereas benefits from 1:1 CBT have been shown up to one year out). The guidelines categorically state on p36 that group CBT was more effective than individual CBT and more cost effective. This is an invalid statement not based on high (or even moderate) quality evidence and should be deleted. In supplement 'psychological and psychosocial treatment…' Appendix F, Grade Tables, it can be seen that the vast majority (possibly all?) psychological treatment studies were of low or very low methodological quality. The main conclusion of the network meta-analysis (NMA) conducted, while we welcome efforts to conduct one, should be that the vast majority (?all) of the clinical trials conducted previously for psychological interventions have low or very low methodological quality (this is based on the GRADE evidence listed in the guidelines supplement for the NMA). This means that conclusions relating to relative efficacy or safety should not be made – rather the conclusion	Thank you for your comment. We have responded separately to each point you have made below. <u>Size of the available evidence</u> It is true that, according to the findings of the relevant systematic review that informed the guideline, the current evidence base for individual CBT was larger than for group CBT, as the latter was assessed in 6 RCTs whereas individual CBT was assessed in 13 RCTs. However, the committee assessed the size of the evidence base before making recommendations and considered the size of the evidence for group CBT to be adequate in allowing formulation of relevant recommendations. <u>Methodological quality of the evidence</u> All studies included in the NMA were RCTs assessing psychosocial therapies, and, overall, they adopted similar methodology. There may be marginal differences between the trials assessing each of the two CBT modalities, but both individual CBT and group CBT trials were rated as being at very serious risk of bias. Although there are various other quality aspects in the trials included in the review that contribute to this rating, there is also a particular problem with psychological trials due to difficulties with blinding (which increases the risk of bias) and is not specific to trials in the area of harmful gambling. The low quality of studies is not a reason not to synthesise evidence using either pairwise MA or NMA, as long as the quality of the evidence is assessed and taken into account (if it is considered adequate) when formulating recommendations. There is no reason to specifically avoid NMA but employ pairwise MA for evidence synthesis when the quality of studies is overall low. If the quality of the evidence was considered to be too low to allow any conclusions on relative efficacy or safety to be made, as you suggest, then the committee wouldn't be able to make any recommendations on interventions for gambling that harms based on the evidence, but, instead, would need to base

				should be that we need new research to conduct high quality clinical trials to evaluate these treatments and their relative efficacy and safety; we cannot yet determine relative efficacy and safety with any reasonable degree of confidence for different psychological interventions due to pervasive methodological weaknesses in the literature. Overall, the NMA and conventional pairwise meta-analysis conclusions do not take account of the methodological quality of the included papers. Another issue is that principles of NMA are breached in multiple ways – for example, the NMA includes radically different interventions that cannot be compared (e.g. guided self-help versus intensive specialist CBT versus generic/non manualised group therapy versus 12 step – these are not similar interventions but radically differ in terms of 'dose', content, and underlying principles). It also appeared SSRIs (medication) had been included – again, this is not a valid comparison in this NMA for therapy due to transitivity assumptions being breached. It is also likely that many of the studies differed radically in nature of cohort included (e.g. was it in DSM-5 gambling disorder or at risk gambling or some other diagnosis or even no formal diagnosis by an expert), choice of measurement tools (many studies listed did not use validated outcome measures such as PG-YBOCS and GSAS); all of these contribute to critical concerns regarding breach of transitivity principles. Another example of a major issue is	recommendations on consensus. However, the committee considered the available evidence and judged that its quality was adequate to support treatment recommendations. Nevertheless, the low quality of the available evidence has been acknowledged in the guideline, therefore, research recommendations have been made to explore the long-term effectiveness and cost-effectiveness, including prevention of suicide and self-harm, of psychological treatments for gambling that harms as well as the effectiveness and cost-effectiveness of psychological or psychosocial interventions to reduce gambling symptoms and increase recovery capital (see Appendix K of Evidence review F). Please note that the GRADE profiles included in the evidence review assessed the quality of the evidence on additional outcomes assessed in pairwise meta-analysis (MA) (such as time spent gambling, gambling expenditure, psychological wellbeing, personal, social and life functioning, physical and mental health related quality of life) and outcomes assessed at follow-up, and not the quality of the evidence on outcomes included in the NMA (i.e. gambling symptom severity and gambling frequency, both at treatment endpoint). Therefore, although there is of course an overlap between the RCTs included in the NMA and those included in the pairwise MA, there may be several RCTs included in the NMA but not in pairwise MA and vice versa. Moreover, the quality in GRADE refers to various quality aspects of the evidence (risk of bias of the studies in each comparison but also inconsistency, indirectness, imprecision, and other considerations), and therefore conclusions cannot be directly extrapolated to the NMA evidence, even if the studies included in the NMA and pairwise MA were identical. In addition, for each NMA comparison, evidence comes from both direct and indirect comparisons, so the GRADE ratings for the same comparisons (but for different outcomes and/or timepoints and potentially different

				that the vast majority of therapy studies (see e.g. Table 5, p 52 of the supplement) used a weak control condition such as 'no treatment', 'TAU', or 'waiting list'. We note that very few studies used an appropriate control condition e.g. attentional control. TAU or waiting list or no treatment inflates effect sizes inappropriately for active treatments and are considered as methodologically weak control conditions by many researchers/clinicians.	studies) are even less directly relevant. To take into account the methodological quality of the NMA, we carried out a threshold analysis. Threshold analysis has been developed as an alternative to GRADE in guideline development, that can be used to assess the robustness of recommendations made to potential limitations in the evidence, when the recommendations are based on a NMA (see Phillippo et al., Annals of Internal Medicine 2019. 170: 538-546). The results of the threshold analysis suggested that the recommendation for group CBT made based on the NMA results was robust to potential changes in the evidence; if there were a large change in the estimate for individual behavioural therapy vs individual CBT, then the most effective treatment would change to individual behavioural therapy, however this would only occur if the estimate were substantially lower than lower limits of the 95% credible intervals from the 3 existing studies making this comparison (see details in Appendix M of the Evidence review F). Therefore, the committee was confident that they could make a recommendation for group CBT based on the NMA results. As described above, the methodological quality of the included papers was considered for the pairwise MA conclusions, using the GRADE profiles. <u>Follow-up data (beyond treatment endpoint)</u> The NMA synthesised data collected at intended treatment endpoint (i.e. at the timepoint when treatment was completed) from all included RCTs, which ensured consistency and comparability of the data considered. Regarding follow-up data beyond treatment endpoint, in the review there were indeed more trials of individual CBT measuring outcome at follow-up points beyond treatment endpoint compared with trials of group CBT. However, there were only 2 small individual

				The economic modelling part of the guideline / supplements similarly will not be accurate as there is virtually no UK research on costs of different gambling specific treatments and we have virtually no UK clinical trials or effectiveness studies. NICE does acknowledge this elsewhere in the draft – e.g. in terms of the research questions. Any modelling will be based on major assumptions that are unlikely to be valid and on research that is mostly methodologically flawed. Overall, research needs to address these issues in future in a rigorous way before such strong conclusions can be made. Due to these critical methodological and other issues, our view is that choice of therapy in terms of whether group therapy or 1:1 CBT therapy (or indeed an evidence-based brief intervention) should be based on individual patient needs through joint decision-making, taking into account the latest evidence base at the time, and local care pathways. This approach would also account for the fact the evidence base may evolve quickly in this field as research funding starts to become available, as is hoped for in the UK.	CBT RCTs assessing gambling symptoms at follow-up against a non-active control (no treatment), which, when meta-analysed, found a statistically significant difference at 7 months follow-up (SMD -0.38, 95%CI -0.74 to -0.02). One of these trials assessed gambling frequency at 7-month follow up and failed to show a statistically significant effect. Likewise, the other trial assessed remission at the same follow-up and also failed to show a statistically significant effect. There was only 1 small RCT comparing gambling symptoms between group CBT vs a non-active control (waitlist) at 1-month follow-up, which showed a statistically significant effect favouring group CBT (MD -7.16, 95%CI -8.92 to -5.39). We note that a small RCT that directly compared time spent gambling, gambling frequency, and remission between individual and group CBT at 6-month follow up did not find any difference between the two modalities (see GRADE tables in Appendix F). We consider this evidence overall weak, and would argue that follow-up effects are poorly studied for both modalities. <u>Statement on relative effectiveness between group and individual CBT</u> This section has now been modified, to clarify that relative effects referred to the comparisons of each active intervention versus no treatment. This is a valid comparison since the NMA adjusts for the different control conditions used in different studies. Group CBT was shown to have the highest relative effect versus no treatment among assessed treatment classes (rather than being shown to be more effective than individual CBT) and was the only treatment that showed evidence of effect compared with no treatment. However, group CBT was shown to be more cost-effective than individual CBT in the guideline economic analysis. <u>Principles of NMA being breached</u>

					In NMA, the transitivity assumption is breached if effect modifiers are not evenly spread within the network. Effect modifiers are factors that are independent to the primary exposure (treatment) and the outcome measured, which influence the magnitude of the treatment effect. Potential effect modifiers can include factors related to the intervention / comparator, population, and outcomes, as well as methodological factors. Psychological treatments included in the NMA may differ in terms of intensity or content but all are relevant, alternative options for the same study population that would, in principle, be considered as part of treatment decision-making, therefore it is appropriate to include them in the NMA. It is correct that intervention definitions can be potential effect modifiers, and care must be taken to account for this in an NMA. We carefully defined the “treatment nodes” in the network to be as similar as was feasible, including distinct nodes for the different types of control. We kept distinct intervention definitions within classes, and explored heterogeneity between interventions by fitting models where interventions had different effects within class (random class model) and where interventions had the same effect within class. We found both models gave a similar fit, suggesting that the effects within an intervention class were similar. In terms of heterogeneity between studies, this was low in the NMA of the frequency outcome, suggesting that differences between populations, and between interventions within a comparison, were small in the dataset. On the other hand, we found moderate-to-high heterogeneity in the NMA of the gambling symptom severity outcome, which was attributed to the range of symptom scales used in the analysis for the measurement of the outcome, which was unavoidable and was dictated by the availability of the data. We also explored whether there was any evidence of inconsistency between direct and indirect evidence, which can indicate issues with the transitivity assumption.

					We found that the global tests for inconsistency did not identify any evidence of inconsistency, although our exploratory analyses of specific comparisons did highlight a potential discrepancy for the Ladouceur 2001 study. For symptom severity Ladouceur 2001 study found a stronger benefit of CBT individual compared with waitlist than that seen from the indirect evidence. The NMA estimate for individual CBT vs waitlist was -1.58 (95%CrI -2.21, -0.97) compared with -3.57 (95%CrI -4.42, -2.71) in the inconsistency model (i.e. a difference of approximately -2). We explored the impact of a change in the data for this comparison in the threshold analysis, and found that conclusions were robust to a change in this estimate, and that it would need to be as extreme as -5.54 before the recommendation would change from group CBT to individual CBT (a much more extreme result than that found in the "inconsistent" Ladouceur 2021 study). The validity assumptions for the NMA relating to intervention definitions were therefore explored in detail and supported the conclusions drawn from the NMA. Other potential effect modifiers relate to the population for which these treatments are relevant and/or have been tested on. Several of these active treatments have already been compared with each other in head-to-head trials included in the NMA for the study population (people who currently experience gambling that harms), suggesting that their comparisons for this population are relevant and valid (for example, RCTs have compared motivational interviewing versus guided or pure self-help; individual CBT versus motivational interviewing; individual CBT versus guided self-help; group CBT versus 12-step programme; individual CBT versus behavioural therapy versus counselling versus motivational interviewing, all compared in a 4-arm trial; individual versus group CBT – please see Evidence review F, network plots for the outcomes of gambling symptom severity and gambling frequency in Figures 1 and 3,

					respectively, which depict the head-to-head comparisons available for the interventions included in the NMA, and also the GRADE tables in Appendix F, which show all comparisons that have been made in head-to-head trials considered individually or in pairwise MA. Even where this was not the case (i.e. head-to-head comparisons were not available between some of the active treatments), one of the reasons to conduct NMA is to make comparisons between interventions that have not been previously compared in head-to-head trials. SSRIs were included in the NMA because they have been directly compared with individual CBT, as shown in Figure 1, and were considered an alternative treatment option for the same study population and a relevant comparator, as specified in the review protocol. As SSRIs have been tested in the same population via a head-to-head comparison with a psychological intervention, there could be no breaching of the transitivity assumption. In any case, SSRIs do not participate in any loops, which might, in theory, 'threaten' transitivity if potential effect modifiers were unevenly spread within the network. They were also not considered in decision-making since they had only been tested in 15 people. Regarding the study population, as pre-specified in the review protocol it included adults who currently experience harmful gambling. Studies using gambling symptom scales were included (in addition to studies that limited inclusion to those with a diagnosis of pathological gambling) on the basis that such scales are widely used in RCT research and clinical practice to measure the severity of gambling symptoms. The committee were concerned that excluding studies that did not use diagnostic interviews would result in the exclusion of a large number of studies, and would have a disproportionate impact on the evidence base for some interventions, for example for self-help studies. The NMA dataset included 14 RCTs restricted to those with a diagnosis of pathological gambling disorder

					(DSM-IV/DSM-IV-TR/DSM-5); 22 RCTs that required participants to score above a clinical threshold on a gambling symptom scale; 11 RCTs included participants based on a self-identified gambling problem but the reported baseline means were above clinical threshold on a gambling symptom scale or in terms of diagnostic criteria; and 1 RCT included people at risk of or probable pathological gamblers (and baseline mean suggests an at-risk population on average). The gambling symptom scales that were used to identify relevant study populations for inclusion in the systematic review and NMA, as well as to measure effectiveness in terms of gambling symptom severity were selected based on the committee's expert advice. As long as the scales selected measure the same construct (gambling severity), as advised by the committee, and since we used SMD to synthesise this evidence, it was appropriate to combine this evidence using NMA. Frequency was straightforward to measure in the RCTs and no measurement scales were required. However, SMD was also used to synthesise the data due to differences in units (days or sessions), follow-up times and baseline frequency. Including studies with different controls in a NMA does not violate the transitivity assumption, because we do not "lump together" the different types of control. Instead, we allocated controls to separate, clearly defined, homogeneous network nodes, which allows us to estimate the different effects for the different types of controls, and hence explicitly adjust for these differences. Where the control was an active intervention, it was coded as the specific active intervention. Waiting list and no treatment were considered as separate controls, as they cannot be assumed to have the same effect (our analysis proved that, indeed, they do not have the same effect). Attention placebo was also assigned a separate node in the network.

					Regarding studies that used treatment as usual (TAU) as the control condition, when this involved an active intervention, then it was coded as such. There were only 3 studies in which the TAU control condition was coded as TAU in the network, forming an overall homogeneous group: 2 of them described TAU as information & referral to other services, and the other one described TAU (arm n=8) as ranging from no treatment to a variety of other treatments including counselling (please see Table 3 for a list of all active treatments and controls included in the NMA, and Figures 1 and 3 for all included head-to-head comparisons; Table 5 shows the relative effect of all treatment options versus no treatment, and does not show the comparisons made in individual RCTs). In the main Evidence review report, we presented the relative effects of all treatment classes versus no treatment (Tables 4-7), which was selected as the reference treatment because the committee advised that the majority of people experiencing gambling that harms currently receive no treatment (therefore, no treatment represents standard care at the moment). We agree that some control conditions (most notably waitlist) may inflate effect sizes, and for this reason we did not select waitlist as the reference. However, as long as such 'weak' controls are appropriately distinguished from each other and coded (which we did, as described above), they cannot inflate effect sizes against other, clearly defined, comparators. Please note that Supplement 4 of the guideline provides full results on the relative effects between all treatment classes included in the NMA (both between active treatments and between active treatments and inactive controls), as estimated in the NMA. Regarding potential effect modifiers, such as age and gender, these were not imbalanced across treatment comparisons. We ran various sensitivity and bias-adjusted analyses to explore the impact of

					missing data, source of funding and small study size (all potential effect modifiers) on the results. We are not aware of other potential effect modifiers that might not be evenly spread across comparisons, risking violation of the transitivity assumption. <u>Economic modelling</u> Decision-analytic economic modelling is a valid approach for assessing the cost-effectiveness of healthcare interventions (see, for example, Drummond et al., Methods for the Economic Evaluation of Health Care Programmes, 4th Edition, Oxford University Press 2015 (Chapter 9); Briggs et al., Decision Modelling for Health Economic Evaluation, Oxford University Press 2006). Some of the benefits of economic modelling compared with economic evaluation conducted alongside clinical trials are: - consideration of all relevant comparators: the guideline economic analysis assessed concurrently the relative cost-effectiveness of 7 treatment options; this would not be feasible within a clinical trial. - consideration of all relevant evidence: the guideline economic analysis used efficacy data from 39 RCTs and 4,996 trials participants synthesised in a NMA; an economic evaluation conducted alongside a clinical trial uses far more limited evidence. - longer time horizon: the guideline economic analysis used a time horizon of 2 years + 3 months, projecting events, costs and outcomes beyond the time horizon of RCTs included in the evidence review. -uncertainty: the guideline economic analysis explored the impact of various cost and clinical parameters, as well as other modelling assumptions made due to knowledge gaps, on the results. The guideline economic model was developed in consultation with the committee regarding the model structure, selection of clinical, epidemiological and cost data, and model assumptions.

					Intervention resource use was based on relevant data reported in the trials included in the guideline systematic review and NMA, supplemented with the committee's expert opinion on best routine practice in England, so that intervention resource use was relevant to the guideline context. Resource use was combined with national unit costs in order to estimate intervention costs in England. This is standard methodology for estimating intervention costs, so that no UK research on costs of different gambling specific treatments is required. The guideline economic model also incorporated cost data from two recent (2023) national reports (OHID and NIESR) (and therefore, in this aspect, it is directly applicable to the UK context) and used two different perspectives: NHS/PSS and public sector. It is very unlikely that an economic evaluation conducted alongside a trial would collect data on the range of costs considered within the guideline economic analysis. Data were synthesised in a probabilistic analysis, which allowed for the uncertainty around model inputs to be considered and reflected in the results of the analysis. Further sensitivity analyses were conducted to explore the impact of the uncertainty around model inputs and assumptions and assumptions on the results. The guideline economic model has strengths and limitations that are reported within the economic modelling report (Evidence review F, Appendix I, Discussion). The cost-effectiveness results, the uncertainty around them, and the strengths and limitations of the model were considered by the committee when making recommendations, alongside effectiveness evidence and people's individual needs. Consideration of cost-effectiveness is a core element of NICE

					principles (please see https://www.nice.org.uk/about/who-we-are/our-principles Principle 7. Base our recommendations on an assessment of population benefits and value for money). Nevertheless, the committee did acknowledge the knowledge gaps in assessing clinical and cost-effectiveness of psychological interventions, especially in the longer term, and for this reason made a research recommendation for this area. As more clinical and economic evidence is accumulated, it is anticipated that a wider range of gambling-specific treatments with evidence of efficacy and cost effectiveness for treating gambling that harms will become available.

Adferiad	Guideline	15	001-016	The treatment for gambling related harms should not centre around CBT being the only option. A range of psychological treatments and approaches should be offered. Beat the Odds (Living room in Cardiff) have a report "Evidence for psychosocial interventions for problem gambling, conducted by Tim Leighton, June, 2017. This report gives an evidenced based overview of treatment interventions.	Thank you for your comment. The systematic review of psychological and psychosocial treatments for people experiencing gambling that harms included evidence from RCTs and non-RCTs (experimental studies using a non-randomly assigned control group design with matched comparison or another method of controlling for confounding variables), as these study designs have the highest quality for assessing treatment effects. The study you refer to included other study designs that are of lower quality, e.g. before-after studies. The guideline systematic review included clinical evidence on a range of psychological and psychosocial treatments, including individual CBT, group CBT, individual behavioural therapies, counselling, motivational interviewing, guided self-help, self-help with no or minimal support, couple interventions, and twelve step group programme. The evidence for some of these interventions was very limited or uncertain, or did not show effect. Recommendations were based on treatments that showed evidence of clinical and cost-effectiveness in the NMA, pairwise meta-analysis and economic analysis undertaken to inform the guideline.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	15	003 - general	Treatment of harmful gambling and gambling related harms We view this as a helpful section overall.	Thank you for your comment.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	15	8	Considering the role that prison and probation staff can play in delivering interventions and signposting to services - it would be good for this to be mentioned in this paragraph.	Thank you for your comment. Criminal justice system staff have been added to this recommendation.

Gordon Moody	Guideline	15	008-011	Recommendation 1.5.1 Gordon Moody welcomes and agrees with the general principles of treatment listed in the guidelines.	Thank you for your comment and support for this section. The holistic treatment would encompass treatment of mental health concerns, and the other gambling-related harms such as domestic issues and financial concerns, but the network meta-analysis and economic analysis showed that the only treatments with adequate evidence that were clinically and cost-effective at reducing the severity of gambling were group and individual CBT. Motivational interviewing was also included as an option in some circumstances as it was

				We particularly welcome the recognition that people experiencing gambling related harms, including those affected by the gambling of others, require a holistic care approach. However, beyond this initial statement there is not guideline of how the holistic care should look like and in fact, the treatment recommendations are only limited to a very narrow range – motivational interviewing, one type of talking therapy (CBT) and one medication option (Naltrexone). Furthermore, there are no recommendations regarding holistic care, nor regarding care for people for whom interventions such as MI and CBT, who require a certain level of cognitive and emotional functioning, might actually be a barrier to access support.	found to be the next most cost-effective option following group CBT and an initial session of motivational interviewing was often part of the offered intervention in CBT trials, but on the other hand there was high uncertainty around its effectiveness as a standalone intervention. Evidence for other interventions (e.g. counselling, self-help, couples therapy) was very limited or did not suggest clinical and/or cost effectiveness in reducing gambling symptoms. Individual behavioural therapy (BT) was also shown to be marginally clinically and cost-effective however the evidence for BT was more limited than individual CBT and was characterised by higher uncertainty; moreover, the committee highlighted that BT lacks the cognitive element of CBT that is important in therapy, as cognitive errors are a maintaining factor in gambling that harms. Therefore, the committee decided to focus recommendations for psychological interventions on CBT rather than BT. Naltrexone was considered as an option for some populations, in whom psychological interventions had not achieved the desired outcomes or when the person experienced repeated relapses despite having received psychological intervention. For people with additional needs (such as people with learning difficulties) it is anticipated that reasonable adjustments will be made to appropriately adapt and tailor delivery of the recommended interventions to the person's preferences, level of understanding, strengths and needs, in line with good practice. These may include, for example, arranging for an advocate to support the person, allowing extra time or different formats for therapeutic sessions or offering written information about therapy and its goals. The NICE guideline on the delivery of psychological interventions for mental health problems in people with learning disabilities (NG54), provides a range of reasonable adjustments for people with cognitive impairments.

Gordon Moody	Guideline	15	008-011	Marginalised groups experience a disproportionate level of harm, data shows that people in areas of multiple deprivation are three times more likely to suffer from gambling related harm (Levi et al., 2021), however they are the group facing challenges in engaging with NHS, which is further evidence for the need to screen across touchpoints and facilitate referrals in to place based systems delivered locally by the voluntary sector. An effective integrated place-based system between the NHS and the voluntary sector will prevent harm, improve lives, reduce the demand and therefore cost to public services (I.e. housing and homelessness, health, criminal justice, social services).	Thank you for your comment. The committee agree that an integrated system that involves the voluntary sector and other services (as you describe) is helpful and this is described in the recommendations on overcoming stigma and supporting access, and in the recommendations on models of care and service delivery.

GamCare	Guideline	15	008-011	Please see comments 4 and 13. The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five days from assessment to the offer of a first support session at GamCare. Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner. GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment. GamCare recommend that TalkBanStop (TBS) is specifically mentioned in this guideline. TBS is a partnership that promotes a layered approach, combining practical tools with support to help individuals at risk of gambling related harm stop gambling and kick-start their recovery journey. The process begins with someone getting in touch with a trained Adviser on the National Gambling Helpline. At this point,	Thank you for your comment. There is no suggestion in the guideline that access to services will only be via a GP referral, as a referral could be made by a range of professionals and practitioners, or via self-referral, and a new section has been added to the guideline on referral and triage and directing people to the correct level of service. The recommendations have been amended to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced. The committee decided not to recommend specific tools and agreed that a variety of tools were available and people may need to use more than one.

				individuals will be able to access a free Gamban licence and will be told about the benefits of self-excluding with GAMSTOP if they have not done so already. Case study findings shows that TalkBanStop reflects several benefits as a three-tool layered approach. These included: a strengthening of gamblers' perceptions that they could not circumvent the tools, that was more sustained over time; and, due to the bank blocks in place were also restricted from gambling in-person. As a result, no individuals had gambled over the fieldwork period. A user of Gamban, GAMSTOP and merchant code blocking and therapy said: "The fact that I've used that service [GAMSTOP] with the blocking software and the counselling has given me, like, three big pillars to stand on. Not only can't I use my own name, I can't do it anyway on my phone, and I'm getting it in my mindset through the counselling that I don't want to do it and that I'm changing my behaviours towards it. So, I think, the use of all three together is why I am so positive and why I have had, like, such quick success, well, such better feelings within myself and such positivity in my life[1]."	

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	15	9	That practitioners and staff should model non-gambling behaviours. In a therapeutic environment, it is important that all staff model appropriate behaviours - this applies to not just those who are delivering the intervention, but any ancillary/additional staff. In this instance it would mean that staff should not gamble on the premises & avoid behaviour or conversations that are gambling related – such as scratch cards, lottery syndicates etc.	Thank you for your comment. The guideline recommendations on reducing stigma provide advice on the appropriate attitudes and behaviour of staff and this would apply to all staff. The committee agreed that standards of professional conduct would require them to abstain from gambling while at work.
Betknowmore UK	Guid eline	15	012 - 015	Meeting affected others individually is essential to ensure that they are not being subjected to domestic abuse or coercion and control. There should not be a presumption that the affected other (usually a woman) is willing to support the person engaged in harmful gambling.	Thank you for your comment. The recommendation already states that involving affected others relies on both parties agreeing to this arrangement. The separate recommendations later in the guideline on interventions for families and affected others already contain advice to provide help to affected others by themselves, so this has not been repeated here.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	15	012 - 015	1.5.2 - Whilst there is broad support for integrating protective relationships into the treatment process, there also needs to be some caution applied. Safeguards need to be in place for people affected by other people's gambling, free from any pressure or expectation that they support the person who gambles. People affected by others' gambling will have their own recovery journey which needs to be acknowledged. Also, there is a practical implication for this. If we are talking about group-based intervention, how do friends and family become involved? How is this facilitated, for example, in prisons in terms of escorts, gate passes, security clearance, physical space etc. This would need some planning to facilitate and goes back to the earlier point about resourcing in the broadest sense, it is about pressures on front line staff.	Thank you for your comment. The recommendation already states that involving affected others relies on both parties agreeing to this arrangement. The separate recommendations later in the guideline on interventions for families and affected others already contain advice to provide help to affected others by themselves, so this has not been repeated here. It is not anticipated that affected others would participate in the group CBT sessions as these are designed for the treatment of people experiencing gambling that harms. The practicalities of how these recommendations are implemented in the criminal justice system will need special consideration by that system and would not be the level of detail that would be included in the guideline. However, this concern will be passed on to the implementation team to consider when planning relevant support activity.

Royal College of Psychiatrists	Guideline	15	016 - 017	1.5.3. Abstinence is not always the aim that patients have when engaging with services - we suggest this be deleted i.e. delete "(typically abstinence)" because this may result in patients not engaging with clinical services since they are not seeking complete abstinence but do wish to seek harm reduction. It is also important to consider that people may change their mind e.g. initially wishing for harm reduction - then later deciding to aim for abstinence. Or vice versa.	Thank you for your comment. The committee agreed that it was generally more effective if people aimed to stop gambling, not just to reduce gambling. The wording in the recommendation is 'typically' which allows some flexibility if there are people who do not wish to aim for abstinence, so this has not been changed.
GambleAware	Guideline	15	17	This assumes that abstinence is the desired outcome for anyone experiencing any level of gambling harm. This is not necessarily the case, particularly for affected others who are not directly impacted by harmful gambling. Incorporating this narrative within the guidelines makes them less person-centred and too prescriptive. This reference should be deleted or prefaced with “for example”.	Thank you for your comment. The committee agreed that it was generally more effective if people aimed to stop gambling, not just to reduce gambling. The wording in the recommendation is 'typically' which allows some flexibility if there are people who do not wish to aim for abstinence, so this has not been changed.

Gambling with Lives	Guid eline	15	18	1.5.4 - Improving mental health should be mentioned here.	Thank you for your comment. The wording of the bullet about anxiety and distress has been expanded to clarify that this is about improving mental health.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	15	018 - 022	General Principles of Treatment. Para 1.5.4 Consider: 'Discuss with the person and those close to them if present if they have other goals that are important to them and that would help reduce the chances of a return to gambling harms over the long term, for example: Increase financial stability Improve family relationships Increase alternative activities and interests'	Thank you for your comment. The recommendation only provides some examples of goals that may be important, and so the discussion advised would enable any other goals to be considered. This list has therefore not been changed.

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	15	General	NICE appears to have a narrow definition of treatment. Treatment starts as soon as the individual crosses the threshold to seek help and involves multiple areas of intervention. In the context of caring for those experiencing gambling harm, treatment should refer to the range of therapeutic interventions and support services aimed at helping individuals who are struggling with problematic gambling behaviours.	Thank you for your comment. The guideline already provides details of the information and support that should be provided to people affected by harmful gambling, but the evidence from the NMA showed that the only intervention which was cost-effective to reduce the severity of gambling was CBT, and that group CBT was the most cost-effective option, so this has been recommended as the mainstay of treatment, which will address the psychological and behavioural aspects of gambling as you suggest. There was no evidence that 'counselling' or 'family therapy' were effective treatments so these have not been recommended (although the involvement of affected others in treatment has been recognised). The committee recognised that people will need additional support with harms such as financial issues, relationship issues, mental health support and this is included in the recommendations, as well as peer support. The guideline also

				This should include interventions designed to address the psychological, emotional, and behavioural aspects of gambling to support individuals in their efforts to achieve and maintain recovery. Providing information and support is an area of great strength for the third sector. They offer peer support, affected other support and they can reach out to those in hard-to-reach communities. They are the first point of contact for many individuals and the first step in a patient's journey. Their role and skill in this area need to be more visible in this section. Treatment for problem gambling can encompass various components, including the following: Assessment:	includes recommendations on assessment as well as ongoing support and relapse prevention.

				Counselling and Therapy: Individual and group counselling or therapy sessions are core components of gambling addiction treatment. These sessions provide a safe and supportive environment for individuals to explore the underlying causes of their gambling addiction, develop coping strategies, and work on changing their behaviours and thought patterns. This can and is often delivered by counsellors (mental health practitioners) or those with lived experience. Both groups have training and supervision. Cognitive-Behavioural Therapy Support Groups: Financial Counselling: Medication: Family Therapy: Relapse Prevention: Education: Aftercare and Continuing Support: Treatment doesn't end when counselling sessions conclude. Aftercare and ongoing support are essential to help individuals recover and address any challenges that may arise after the initial treatment phase.	

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	16	001 – 002	Rec 1.5.5 in terms of cost-effectiveness, whilst this is the ideal scenario, if there are occasions where a treatment is very effective, but less cost effective wouldn't it still be considered in certain scenarios e.g. complex cases?	Thank you for your comment. The recommendation aims to emphasise that offered interventions should be evidence based. In some scenarios, e.g. complex cases, it is possible that a treatment's relative effectiveness is different, which would affect its relative cost-effectiveness. However, a treatment's relative clinical and cost-effectiveness on a specific population should be assessed against other treatments that are available for this particular population, rather than in comparison with different populations (e.g. complex vs non-complex cases). So, even if a treatment is less cost-effective in more complex cases compared with non-complex cases, the right comparison would be versus alternative treatments for more complex cases. In any case, provision of evidence-based treatments should take into account individual needs and preferences, as described in the section of the guideline on general principles of treatment.

Gordon Moody	Guideline	16	001 - 003	Recommendation 1.5.5 does not describe the possible settings of treatment, thus excluding the possibility of creating a wider range of setting that can meet people needs for support. There is a clear need for varying levels of service for people experiencing varying levels of gambling harm. At the extreme end of this, there needs to be Tier 4 (residential provision) for people experiencing severe gambling harm, who may have tried other forms of treatment. Other prevalent characteristics in the population seeking residential support are the presence of highly complex social or family dynamics such as homelessness, lack of job, loss of family, domestic violence, a criminal history, a history of adverse or traumatic childhood experiences, isolation, lack of social support, and/or living in a highly stressful or risky environment. The proposed treatment interventions in the guideline do not have the scope to address these issues in a holistic, person-centred manner, henceforth making the access to continuous recovery nearly impossible for people presenting with such needs. There is evidence of the above factors impacting ability to access not only NHS gambling services (Rigbye & Griffiths 2011, Cowlishaw & Kessler., 2017) but also similar health services such as IAPT (Martin et al., 2022, Zavlis, 2023) hence recommendation to place based systems.	Thank you for your comment. The NMA of treatments for reducing the severity and frequency of gambling looked for evidence for residential treatment, but did not find any evidence that met the protocol criteria. As a result the committee were unable to recommend this as a specific intervention. This recommendation on different ways of delivering treatments (such as remotely or in-person) was based on qualitative evidence that people wanted these options to access treatment, but there was no qualitative evidence that people wanted residential treatment. While a number of guideline recommendations relating to other aspects of treatment were made on the basis of committee consensus and experience, recommendations with substantial cost implications need to be based on strong evidence. The committee understand that a parallel but non-evidence-based piece of work on treatment need conducted by the Office for Health Improvement and Disparities may have included consideration of residential treatment, but at the present time, until more evidence is available, it is not possible to recommend this a specific setting for care in the NICE guideline.

				Recent interest has been taken in evaluating residential treatment as an emergent model of care for harmful gambling (Morefield et al. 2014; Muller et al. 2017). Residential gambling treatment is generally accessed by a small sub-section of people experiencing severe gambling harm. Research suggests that being immersed in a supportive environment, away from day-to-day challenges and stressors, can be particularly beneficial for some patients, particularly those with complex needs and comorbid conditions (Leavens, 2014). Results have shown significant improvement for those accessing treatment (Morefield et al. 2014; Muller et al. 2017). Gambling treatment in UK has been delivered largely by third sector organisations for more than 50 years, and the experience of such organisations should play a larger role in describing what works in treatment for gambling related harms. Gordon Moody has helped people to reclaim and rebuild their lives free from gambling addiction in safe, supported residential environments since 1971. Over the next 50 years, Gordon Moody remained the only specialist and dedicated residential facility for gambling harms and the experience of working in a residential setting with this service users group helped develop the unique therapeutic residential programme which is offered today.	

				Gordon Moody's men and women residential treatment programmes have been centred around the therapeutic community model, a model that has been proven to be highly effective in working with people living with both addiction and mental health problems (Vanderplasschen et al, 2013, Magor-Blatch et al.,2014, de Andrade et al.,2019). Our model offers a holistic treatment experience, embracing a whole-person approach in the delivery of care. The residential nature of the treatment is a vitally important element for some in addressing their gambling related harms – and in turn enables those who have been through the programme to resettle successfully in the wider community (Griffiths et al., 2001) The therapeutic approaches used to deliver the programme are in line with the evidence base in relation to what works to address gambling related harm and include a multifaceted range of interventions such as: Brief Interventions, Financial Education, Self-Help Tools, Personal and Skills Development, Motivational Interviewing, Mindfulness, Cognitive Behavioural Therapy as well as a number of integrative therapeutic techniques ranging from transactional analysis to person-centred psychotherapy or art and creative psychotherapy. As many as 80% of Gordon Moody applicants have already sought help elsewhere for their	

				gambling issues. This does not mean these other forms of help have not worked, but it does mean Gordon Moody is often their last hope. What is more important than anything is that our programmes work, and they have a significant positive impact in supporting people to embrace recovery. Below you can see outcome monitoring data between 01/01/2020 and 31/08/2023, using the Problem Gambling Severity Index (PGSI), Clinical Outcomes in Routine Evaluation (Core-10) and Generalized Anxiety Disorder (GAD-7) questionnaires, showing significant post-treatment improvement both in terms of gambling severity and mental health indicators.	

				An important aspect to mention is that it takes between 6 to 8 weeks in treatment for the level of psychological distress, as measured by the CORE-10 tool, to drop from a high to a low level for most of our services users, which indicated the importance of having enough time in the residential setting to build up new coping mechanisms before moving into community support. Given the evidence presented we would want to ask for the inclusion in the guideline of a residential setting reference similar to what is found in the Drug Misuse NICE guidelines: "1.5.1 Inpatient and residential settings 1.5.1.1 The same range of psychosocial interventions should be available in inpatient and residential settings as in community settings. These should normally include contingency management, behavioural couples therapy and cognitive behavioural therapy. Services should encourage and facilitate participation in self-help groups. 1.5.1.2 Residential treatment may be considered for people who are seeking abstinence and who have significant comorbid physical, mental health or social (for example, housing) problems. The person should have completed a residential or inpatient detoxification programme and have not	

				benefited from previous community-based psychosocial treatment." We are happy to work together with the NICE committee to implement the residential treatment criteria and thresholds established with our NHS and NGSN partners over the last three years, which are now part of the national gambling services model of care.	

Royal College of Psychiatrists	Guideline	16	001 - 003	1.5.5. (and relevant elsewhere) - We do not know which interventions are cost effective for gambling disorder, in the UK or globally - there is not enough independent UK (or for that matter international) research. Any calculations by NICE in this area, such as those conducted, are likely to be very inaccurate due to a lack of independent research on this topic in the UK and numerous assumptions due to knowledge gaps. In the absence of rigorous high-quality health economic evidence for different treatment pathways, research evidence of efficacy/effectiveness and being in the patient's best interests (e.g. accounting for risks and benefits) should be the overriding factors, taking into account the latest evidence at the time of clinical judgement being made.	Thank you for your comment. It is true that there was very limited published economic evidence on the cost-effectiveness of interventions for gambling that harms (there was only one study from New Zealand assessing 2 psychosocial interventions, which has been included in the economic evidence review). This is why an (independent) economic model was prioritised and developed in this area to assess the cost-effectiveness of psychosocial interventions for gambling that harms. Decision-analytic economic modelling is an entirely valid approach for assessing the cost-effectiveness of healthcare interventions (see, for example, Drummond et al., Methods for the Economic Evaluation of Health Care Programmes, 4th Edition, Oxford University Press 2015 (Chapter 9); Briggs et al., Decision Modelling for Health Economic Evaluation, Oxford University Press 2006). Some of the benefits of economic modelling compared with economic evaluation conducted alongside clinical trials are: - consideration of all relevant comparators: the guideline economic analysis assessed concurrently the relative cost-effectiveness of 7 treatment options; this would not be feasible within a clinical trial. - consideration of all relevant evidence: the guideline economic analysis used efficacy data from 39 RCTs and 4,996 trials participants synthesised in a NMA; an economic evaluation conducted alongside a clinical trial uses far more limited evidence. - uncertainty: the guideline economic analysis explored the impact of various cost and clinical parameters, as well as other modelling assumptions made due to knowledge gaps, on the results. - longer time horizon: the guideline economic analysis used a time horizon of 2 years + 3 months, projecting events, costs and outcomes beyond the time horizon of RCTs included in the evidence review.

					The guideline economic model was developed in consultation with the committee regarding the model structure, selection of clinical, epidemiological and cost data, and model assumptions. It incorporated cost data from two recent (2023) national reports (OHID and NIESR) (and therefore, in this aspect, it is directly applicable to the UK context) and used two different perspectives: NHS/PSS and public sector. It is very unlikely that an economic evaluation conducted alongside a trial would collect data on the range of costs considered within the guideline economic analysis. Consideration of cost-effectiveness is a core element of NICE principles (please see https://www.nice.org.uk/about/who-we-are/our-principles Principle 7. Base our recommendations on an assessment of population benefits and value for money). The guideline economic model has strengths and limitations that are reported within the economic modelling report (Evidence review F, Appendix I, Discussion). The cost-effectiveness results, the uncertainty around them, and the strengths and limitations of the model were considered by the committee when making recommendations, alongside effectiveness evidence and people's individual needs. Nevertheless, the committee did acknowledge the knowledge gaps in assessing clinical and cost-effectiveness of psychological interventions, especially in the longer term, and for this reason made a research recommendation for this area. As more clinical and economic evidence is accumulated, it is anticipated that a wider range of gambling-specific treatments with evidence of efficacy and cost effectiveness for treating gambling that harms will become available.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	16	4	Rec 1.5.6 – '…including online and in-person)…' By using the term 'including' this suggests that there is another option. Is this the case?	Thank you for your comment. This recommendation has been amended to clarify that remote options include telephone or video-conference, or that interventions can be delivered in-person.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	16	4	Para 1.5.6 Consider clarifying that on-line can mean video conferencing and the use of computerised CBT for treatment of gambling harms.	Thank you for your comment. This recommendation has been amended to clarify that remote options include telephone or videoconference, or that interventions can be delivered in-person. Online did not mean use of computerised CBT as guided and pure self-help (including guided or pure computerised CBT, respectively) were not found to be clinically or cost-effective in the guideline NMA and economic analysis.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	16	004 - 011	1.5.6 - How is digital intervention supported? Who pays for any equipment that might be needed for this to happen? Is there a digital contract needed? In which case, commercial teams need to be engaged to release funding.	Thank you for your comment. The recommendation did not suggest that digital interventions be used. Online does not mean use of computerised CBT as guided or pure self-help (including guided or pure computerised CBT, respectively) was not found to be clinically or cost-effective in the guideline NMA and economic analysis. The recommendation has been amended to clarify that treatment can be offered in-person or remotely, for example via telephone or videoconferencing. Therefore, no digital contract is needed.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	16	004 - 011	1.5.6 - Ensure that a variety of methods (including online and in-person) are available for delivering treatments. Discuss the different methods with the person, including that: • online treatment may be more convenient and less time-consuming than in-person treatment – Comment - where available/permissible as online treatment may not be available as an option in a prison setting.	Thank you for your comment. This recommendation has been amended to clarify that remote options include telephone or videoconference, or that interventions can be delivered in-person. Online does not mean use of computerised CBT as guided or pure self-help (including guided or pure computerised CBT, respectively) was not found to be clinically or cost-effective in the guideline NMA and economic analysis. It is recognised that implementation of the recommendations may pose specific challenges in the prison environment, and this level of detail cannot be included in the guideline but this has been passed to the implementation team for consideration when support activity is being planned.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	16	007 - 008	Consider adding: 'Computerised CBT helps with speedier access to treatment and enables people to complete self-guided treatment in their own space and time with clinical support by text, telephone, or face to face'.	Thank you for your comment. This has not been added as guided or pure self-help (including guided or pure computerised CBT, respectively) was not found to be clinically or cost-effective in the guideline NMA and economic analysis. The recommendation has now been amended to clarify that 'online' means by videoconferencing, but that delivery by telephone could also be an option.

Royal College of Psychiatrists	Guideline	16	009 - 011	1.5.6. In relation to the statement that in-person treatment is more likely to lead to the development of a more supportive therapeutic relationship: we are not aware of any research showing this for gambling disorder and unless this statement is based on clear evidence it should be deleted. There are situations where greater and more supportive therapeutic alliance may be achieved via online consultations – for example, patients who have a preference for online therapy or would disengage from treatment if asked to physically attend a gambling service a large distance from where they live.	Thank you for your comment. This recommendation was based on evidence from the qualitative review on what works best in gambling treatment services (see evidence review K) which identified some limitations of remote appointments, so this has not been amended. The recommendations advise that a choice of methods should be available and so it is not recommended that people would be forced to attend a service.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	16	11	Consider adding insert: services will need to ensure that people do not face digital exclusion from on-line and computerised treatment.	Thank you for your comment. The recommendation offers a choice of remote or in-person support and so people should not be excluded. However, this consideration has been added to the equality impact assessment for this guideline.

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	016 & 35	011 - 014	There is no mention of the RCGP competency framework, nor any professional competencies which are currently in place, such as those for group therapists. Managing gambling disorder per se is not that dissimilar from managing patients with other mental health problems, in that it involves a mixture of bio-psycho-social interventions. There are generic competencies which exist and which are incorporated into the basic training of health professionals across several disciplines. RCGP Primary Care Competency Framework	Thank you for your comment. The committee discussed whether to include specific named competency frameworks in the guideline but agreed that these were often profession-specific and related to different areas of practice and so it was not possible to list them all here, and so they have left the recommendation more general.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	16	012 - 020	1.5.7 - Recognise that some mental health conditions and other comorbidities may be: • a consequence of gambling-related harms and may resolve or improve with successful treatment for harmful gambling, - Add '…or be exacerbated by an unwillingness to address these harms/engage with treatment'.	Thank you for your comment. This addition to the wording has not been made as it implies fault on behalf of the gambler and could be perceived as very stigmatising.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	16	14	Rec 1.5.7 – Reference to ‘gambling-related harms’ should be replaced by ‘gambling’. In this scenario, the mental health conditions are the gambling-related harm.	Thank you for your comment. This has been changed to 'gambling that harms' (as not all gambling is harmful or leads to any consequences at all).
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	16	19	Rec 1.5.7 – Reference to drug and alcohol dependence as a sever comorbidity which would require treatment before engaging in gambling treatment. Whilst dependence may make gambling treatment challenging, it should not be a barrier to access. We would suggest re-wording as ‘… that they may require treatment first, to improve engagement with treatment for harmful gambling, which may also be concurrent’	Thank you for your comment. The committee decided that in some cases alcohol or drug problems were so severe that they precluded treatment of harmful gambling (people cannot engage with CBT if intoxicated). The bullet point above this refers to people who have issues that need to be addressed concurrently with harmful gambling. No changes to the recommendations have therefore been made.

Parkinson's UK	Guideline	16	21	For people with Parkinson's, we would like to see established links between neurological services and neuropsychiatrists in integrated multidisciplinary teams and that these services are linked into acute mental health teams and crisis pathways. We spoke to people with Parkinson's who described the issues they experience when care is not joined up. We also spoke to neuropsychiatrists who explained the benefits of being linked into mental health teams to support people who require crisis management, especially when presenting with suicidality.	Thank you for your comment. Parkinson's disease has been added as an example of a physical health condition in this recommendation as you suggest.
Parkinson's UK	Guideline	16	26	We believe this guidance should include recommendations that trained competent practitioners have a basic understanding of Parkinson's and Parkinson's medications and how these can be implicated in harmful gambling.	Thank you for your comment. Parkinson's disease has been added as an example of a physical health condition in this recommendation but the committee were aware that competent practitioners would be aware of the link with Parkinson's disease and medication and so did not add this to the recommendation.

Royal College of General Practitioners	Guid eline	16	26	Rec 1.5.9 - We are concerned that no reference has been made to the RCGP competency framework or any current professional competencies. We are concerned that GPs may only be adequately trained to identify and address gambling-related issues if the guidelines include competency frameworks that are written by the profession.	Thank you for your comment. The committee discussed whether to include specific named competency frameworks in the guideline but agreed that these were often profession-specific and related to different areas of practice and so it was not possible to list them all here, and so they have left the recommendation more general.
The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guid eline	16	026 - 027	Training should come after competencies, not before. Initially, it is important to define the competencies needed to deliver care to those with gambling-related harms, then the curriculum needed to meet these competencies and then the training which can be delivered to demonstrate that the competencies are met.	Thank you for your comment. The committee were aware that that practitioners would be trained and then be assessed and deemed competent, so they did not reorder these words. The evidence upon which these recommendations were based (see evidence review K) showed that people wanted to be treated by practitioners with gambling-specific training and who were empathic as well, and the guideline already includes recommendations on both these attributes, so no further change has been made to this recommendation.

				The Primary Care Gambling Service has written a competency framework for primary care that has been peer-reviewed by several members of the committee and has been endorsed by the RCGP. This competency framework provides the building blocks for the education of the primary care workforce in the UK. It is raising awareness of gambling harms across the profession and has led to an accreditation process for primary care practices and primary care networks. RCGP Gambling Harms Hub	

				Furthermore, Page 35 the committee came to this recommendation (1.5.1-1.5.11). by seemingly asking the committee whether patients wanted to be treated by 'trained, competent' practitioners. This does not make sense as if asked do you want to be treated by an 'untrained, incompetent' practitioner the answer would clearly be 'no'. What the questions asked should have been much more nuanced and linked to evidence. For example, there is significant evidence in the addiction and other field that individuals do best when treated by competent and empathic practitioners, rather than focusing on the specific training or designation of that practitioner. Project MATCH	

Betknowmore UK	Guideline	16	026 - 028	Within the NGSN, providers of clinical treatment and peer support receive high levels of training. Betknowmore UK's peer supporters receive the Gambling Peer Support training. This was the first such training programme in the UK to be accredited, first by NVQ and now assured by City & Guilds. Betknowmore UK has also participated in the developed of a Gambling Recovery Peers Core Competencies Guide.	Thank you for your comment and telling us about the peer supporters' competency guide. The committee discussed whether to include specific named competency frameworks in the guideline but agreed that these were often profession-specific and related to different areas of practice and so it was not possible to list them all here, and so left the recommendation more general.
Gordon Moody	Guideline	16	026 - 028	We agree with recommendation 1.5.9 that "treatments for harmful gambling should be delivered by trained, competent practitioners who meet agreed competency framework criteria" but at the moment there is no such agreed competency framework so how would service providers follow this recommendation?	Thank you for your comment. The committee were aware of a number of different competency frameworks for gambling treatments. They discussed whether to include specific named competency frameworks in the guideline but agreed that these were often profession-specific and related to different areas of practice and so it was not possible to list them all here, and so left the recommendation more general.

GambleAware	Guideline	17	001-018	We agree with this suggested model of delivery. This approach is already present in the NGSN and this should be acknowledged and provided as the exemplar for how this can be successfully done.	Thank you for your comment. This recommendation would apply to all services delivered in all settings, and this may change in the future, so there is no need to name a specific current service as an exemplar.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	17	2	Rec 1.5.10 – Suggest re-wording the para and adding bullet (line 7) on to the end of the sentence to clarify. '…in a way that develops and builds a therapeutic relationship with the person by:'	Thank you for your comment. The recommendation already includes the need to build a therapeutic relationship and so this change has not been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	17	3	Rec 1.5.10 – Re-word to 'being understanding, empathetic…..'	Thank you for your comment. This rewording does not fit in with the stem of the recommendation so this change has not been made.
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	17	3	Para 1.5.10 Suggest: is understanding, empathic [standard form in the UK] supportive and helpful	Thank you for your comment. The change to empathic has been made.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	17	4	Rec 1.5.10 – Re-word to 'encouraging ownership…'	Thank you for your comment. This rewording does not fit in with the stem of the recommendation so this change has not been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	17	6	Rec 1.5.10 – Bullet does not make sense. Suggestion to rephrase as 'avoiding stigmatising language'	Thank you for your comment. This has been changed to 'avoids stigmatising language'.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	17	7	Rec 1.5.10 – Delete the bullet point as included in opening para (line 2)	Thank you for your comment. This is not included in the opening paragraph so this change has not been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	17	8	Rec 1.5.10 – Re word to 'encouraging a 2-way dialogue…'	Thank you for your comment. This rewording does not fit in with the stem of the recommendation so this change has not been made.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	17	9	Para 1.5.10 Consider adding insert: 'is constructional and aims to develop the person's understanding, skills and resources to manage gambling harms now and in the future.'	Thank you for your comment. The committee decided that this additional text was a description of the intervention itself (for example CBT) and so did not include this in the recommendation.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	17	010 – General	Peer Support Para 1.5.11 We agree that peer support is critical as an integral part of the support and treatment for gambling related harms for people who wish to engage with it.	Thank you for your comment.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	17	011 – 012	Rec 1.5.11 – Re-phrase para to read 'Peer support is an integral part of the support and treatment for gambling-related harms and should be offered to all those who wish to engage with it.' Guidance on where to seek unbiased peer support should be included here. Perhaps it could be via NHS Digital pages and/or local public health teams?	Thank you for your comment. NICE recommendations start with actions wherever possible so this change to the wording has not been made. The guideline already recommends that all gambling treatment and support services should be provided without influence or involvement from the gambling industry, so this has not been repeated here. Peer support will be provided by a range of gambling treatment and support services so it is not possible to put a national link in here relating to its availability.
His Majesty's Prison and Probation Service (HMPPS)	Guid eline	17	011 - 018	1.5.11 - Offer peer support as an integral part of the support and treatment for gambling-related harms for people who wish to engage with it. Explain that peer support can provide: • an opportunity to discuss aspects of recovery (social and personal) with others who have been through the same experiences – Replace 'the same' with 'similar' as no two experiences are exactly the same.	Thank you for your comment. This change has been made to 'similar'

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	17	15	Rec 1.5.11 – Replace ‘same experiences’ with ‘similar experiences’	Thank you for your comment. This change has been made to 'similar'
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	17	17	Rec 1.5.11 – Suggest the inclusion of an additional bullet here – ‘advice on what worked for others.’	Thank you for your comment. This change has been made, using the wording 'an opportunity to hear…'
Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	18	1	Para 1.5.13 Suggest ‘….Start treatment as soon as possible after diagnosis assessment’	Thank you for your comment. CBT would only be offered to people experiencing gambling that harms, so a diagnosis assessment may show that they have low levels of harm, so this change has not been made.

GamCare	Guideline	18	001-006	As NICE recommends, GamCare's Gambling Support Practitioners are trained in Cognitive Behavioural Therapy (CBT) skills and Motivational Interviewing. However, we draw the committee's attention to the lack of evidence that CBT is sufficient or effective in treating complex cases where harms are multiple and persistent. CBT does not address the diverse, enduring harms that gambling can cause. Trauma-informed approaches are being recognised by clients, who value support provided by other people with lived experience, diminishing shame and building hope.	Thank you for your comment. The NMA and economic analysis carried out for this guideline found that group CBT, followed by individual CBT, was the most clinically and cost-effective at reducing gambling severity so this is the intervention that is recommended. The committee were aware that where necessary, the practitioner would adjust the CBT to take into account other factors that increase the complexity of harms, and may decide that dealing with this complexity first before CBT can be started may be preferable. This also does not prevent people being offered other support as outlined in the other guideline recommendations such as help with other financial, domestic and social problems, treatment of comorbidities and peer support. The guideline has been amended to remove PGSI as the sole determinant of gambling treatment and a new section on referral and triage has been added.

				The Guideline should not yet be recommending NHS clinical treatment for those with an 8+ PGSI score until there is sufficient outcomes and cost-effectiveness data to support this recommendation. To accurately determine someone's complete clinical presentation and the necessity for stepped-up care, a comprehensive assessment of their situation should be required (see above).	

Betknowmore UK	Guideline	18	001 - 016	The support offered should include a range of psychological treatments and approaches and not assume that group CBT will be effective for everyone. Our experience suggests that 1:1 support can often be necessary before group support is offered.	Thank you for your comment. The NMA and economic analysis carried out for this guideline found that group CBT was overall the most clinically and cost-effective at reducing gambling severity so this is the intervention that is recommended. People may need 1:1 support as well, and if group CBT is not suitable individual CBT can be offered as an option, which was also found to be clinically and cost-effective. Motivational interviewing was also included as an option in some circumstances, as it was found to be the second most cost-effective option following group CBT, and an initial session of motivational interviewing was often part of the offered intervention in CBT trials, but on the other hand there was high uncertainty around its effectiveness as a stand-alone intervention. Evidence for other interventions (e.g. counselling, self-help, couples therapy) was very limited or did not suggest clinical and/or cost effectiveness in reducing gambling symptoms. Individual behavioural therapy (BT) was also shown to be marginally clinically and cost-effective, however the evidence was more limited than individual CBT and was characterised by higher uncertainty; moreover, the committee highlighted that BT lacks the cognitive element of CBT that is important in therapy, as cognitive errors are a maintaining factor in gambling disorder. Therefore, the committee decided to focus recommendations on CBT rather than BT. No changes to the recommendations have therefore been made.

GambleAware	Guideline	18	001-016	CBT should only be recommended if appropriate and as part of a holistic approach. The current draft suggests this should be a standard approach to treatment, but this is not necessarily the case, is not what all people will choose, and does not foster the therapeutic alliance that has been recommended elsewhere.	Thank you for your comment. The NMA and economic analysis carried out for this guideline found that group CBT, followed by individual CBT, was the most clinically and cost-effective at reducing gambling severity so this is the intervention that is recommended. This does not prevent people being offered other support as outlined in the other guideline recommendations such as help with other financial, domestic and social problems, treatment of comorbidities and peer support. Motivational interviewing was also included as an option in some circumstances, as it was found to be the second most cost-effective option following group CBT, and an initial session of motivational interviewing was often part of the offered intervention in CBT trials, but on the other hand there was high uncertainty around its effectiveness as a stand-alone intervention. Evidence for other interventions (e.g. counselling, self-help, couples therapy) was very limited or did not suggest clinical and/or cost effectiveness in reducing gambling symptoms. Individual behavioural therapy (BT) was also shown to be marginally clinically and cost-effective, however the evidence was more limited than individual CBT and was characterised by higher uncertainty; moreover, the committee highlighted that BT lacks the cognitive element of CBT that is important in therapy, as cognitive errors are a maintaining factor in gambling disorder. Therefore, the committee decided to focus recommendations on CBT rather than BT.

Royal College of Psychiatrists	Guid eline	18	001 - 016	1.5.13 & 1.5.14 & 1.5.15. Please see our earlier point: patients should be given the choice of available psychological treatments (e.g. group therapy based CBT or 1:1 therapy based on CBT) and the appropriate choice made through shared decision-making on an individual basis, taking into account the latest evidence, and local pathways. There is insufficient clinical or health economic evidence, in our view (including analyses within the guidelines), to advocate at a national level (i.e. in a blanket fashion) for group therapy over 1:1 CBT in terms of prioritisation/sequencing. Relatedly, what about brief interventions? There is also evidence for those but they are not really mentioned very much. These are likely to be useful for example in milder cases of gambling disorder or those at risk of gambling disorder – there are controlled trial data to support them.	Thank you for your comment. The NMA and economic analysis conducted for this guideline identified that group CBT was overall the most clinically and cost-effective treatment for reducing gambling severity, and individual CBT, which was also found to be clinically and cost-effective, is offered as an alternative treatment option for some people (not in terms of sequencing), so there is a choice for people. Motivational interviewing is also included as an option in some circumstances as the class of motivational interviewing was found to be the second most cost-effective treatment following group CBT. An initial session of motivational interviewing was often part of the offered intervention in CBT trials, but on the other hand there was high uncertainty around its effectiveness as a standalone intervention and it does not replace CBT. Evidence for other interventions (e.g. counselling, self-help, couples therapy) was very limited or did not suggest clinical and/or cost effectiveness in reducing gambling symptoms. Individual behavioural therapy (BT) was also shown to be marginally clinically and cost-effective, however the evidence for BT was more limited than individual CBT and was characterised by higher uncertainty; moreover, the committee highlighted that BT lacks the cognitive element of CBT that is important in therapy, as cognitive errors are a maintaining factor in gambling disorder. Therefore, the committee decided to focus recommendations on CBT rather than BT. Please note that brief interventions (e.g. brief CBT, brief motivational interviewing) have been considered in the NMA and pairwise meta-analyses that informed recommendations (please see Table 3 in Evidence Report F, which describes the interventions included in the systematic review, as classified for the NMA) – these were categorised within the broader classes of e.g. individual CBT or motivational interviewing, as appropriate. The recommendations provide guidance on the number of CBT sessions, but fewer or more CBT sessions may be offered, according to individual needs.

Royal College of Psychiatrists	Guideline	18	001 - 016	1.5.13 & 1.5.14 & 1.5.15. The optimal number of CBT sessions is not clear and is likely to differ a great deal depending on clinical context. For example, in clinical trials there is evidence to support efficacy of brief interventions, short term interventions, and longer interventions (typically against waiting list, but some studies have had a more rigorous control condition- albeit not many). As such it is felt that the exact number of sessions should not be prescribed in the guidelines (since they are not backed by clear evidence). Number of sessions should be determined on a case by case basis. For example, in some people affected by gambling harms, fewer sessions – or even a brief intervention – may be preferable (in terms of effectiveness, tolerability, and/or health economically).	Thank you for your comment. The NMA and pairwise meta-analyses that informed the guideline recommendations did consider brief interventions (please see Table 3, which describes the interventions included in the systematic review, as classified for the NMA – these were categorised within the broader classes of e.g. individual CBT or motivational interviewing, as appropriate). The number of sessions for group and individual CBT reported in the recommendations are based on the number of sessions reported in the RCTs considered in the review, which also assessed brief interventions, supplemented with the committee's expert advice. The recommended number of sessions are those that should be 'usually' provided, according to the recommendation. We have now added clarification that, in some cases, more sessions may be required, or fewer sessions may be sufficient (depending on individual needs).

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	18	004 - 006	1.5.14 - Offer individual CBT if group therapy is not possible (for example, there are no other people available to form a group), it is assessed as not suitable for the person, or the person does not wish to join a group. – 'No other people' is too generic as there are issues of appropriateness or suitability pertaining to the composition of the group.	Thank you for your comment. This has been amended to specify that it is if no other people are available to join a *suitable* group.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	18	6	Rec 1.5.14 – Suggest that it may be useful to include an example of why group CBT therapy may be assessed as not being suitable for an individual.	Thank you for your comment. The committee decided that this may be in a person who was too distressed to undertake group CBT or had additional trauma to address which they would not wish to discuss in a group situation. However, the committee were aware that there could be many other reasons and so chose not to give a limited number of examples.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	18	007 - 016	1.5.15 - What are we defining as gambling-specific CBT training? CBT is well grounded in the evidence for what works, and across HMPPS we use CBT based intervention to target the underlying causes of any offending behaviour. This is because there are a well-evidenced set of criminogenic needs which underpin a whole host of offending behaviour, so CBT based therapies will target those, rather than the gambling per se. This links back to the question of whether there is something already offered that can meet this need. Focus on relapse prevention risks contradicting the direction of travel in interventions that focuses less on planning for failure, and more developing skills and strategies to promote success. Strength-based approaches are more motivational, and so any form of contingency planning for individuals should focus on strengths and achieving success.	Thank you for your comment. The committee were aware that that the management of triggers and stimuli in gambling was different to the management of other addictions and so competence in delivering CBT to this population would be needed. Likewise the committee decided that due to the aggressive promotion and marketing of gambling a very important component of treatment was recognising the risk of relapse and planning to reduce the chances of it happening, rather than ignoring it, so including relapse does focus on achieving long term success.

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	18	007-16	Concerning the number of therapists per group. Having read the recommendation for this guideline on page 36 line 17, you have used custom and practice rather than evidence to define the number of therapists needed and the number of sessions. Dame CG is a lifetime fellow of the institute of group analysis and trained group therapists, she is not aware of any evidence of the number of therapists. They usually advice 1 therapist for groups up to around 15, 2 for groups up to 40 and 2 or more for much larger groups. The NHS does not generally accommodate more than 1 therapist per average sized group expect in very specialist areas, such as eating disorder, personality disorders or forensic settings. Workforce issues alone would make two therapists per group very difficult. This recommendation will silt up specialist services. Having a model that reflects the actual evidence is important.	Thank you for your comment. The recommendation was made based on the committee's expert advice on good practice, as the majority of studies included in the review did not report the number of therapists involved in group therapy. The committee advised that the second practitioner (co-facilitator) plays a very important role in ensuring participants' safety, that all participants are involved in the sessions, and in following up participants. Nevertheless, your concerns have been acknowledged and the recommendation has been amended to state that group CBT should be delivered 'ideally'' by 2 practitioners. Regarding placement on waiting lists: the committee made recommendations for evidence-based psychological treatments such as motivational interviewing, group CBT, and, if group CBT is not suitable or acceptable, individual CBT as an alternative treatment option, to ensure that more people receive appropriate treatment. It is anticipated that if these treatments are available, users of the guideline would make a sensible decision for their clients and provide therapy, following the guideline recommendations, rather than place them on waiting lists.

				The evidence discussed on the NICE committee stated that placement on a waiting list once an individual has reached out for help has a worse effect on an individual than no treatment. It is important to highlight this to stakeholders and users of the guideline so that they can make sensible decisions for their patients to avoid placement on waiting lists. If everyone with a PGSI of more than 8 is to be directed to a specialist service for group therapy with 2 therapists this a real risk.	

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	18	008 - 011	Para 1.5.15 Suggest clarifying that group CBT delivered by two practitioners will need to balance efficacy vs availability and timing of group treatments. Given available resources, our experience is that pre-booked groups of 6 to 8 participants can be managed effectively with a competent CBT therapist. Having two practitioners per group inevitably means waiting longer for treatment.	Thank you for your comment. The recommendation was made based on the committee's expert advice on good practice, as the majority of studies included in the review did not report the number of therapists involved in group therapy. The committee advised that the second practitioner (co-facilitator) plays a very important role in ensuring participants' safety, that all participants are involved in the sessions, and in following up participants. Nevertheless, your concerns have been acknowledged and the recommendation has been amended to state that group CBT should be delivered 'ideally'' by 2 practitioners.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	18	12	Rec 1.5.15 – With reference to 'current treatment manuals' will everyone know what these are and where to find them? Would it be useful to include appropriate hyperlinks?	Thank you for your comment. This recommendation has now been amended to refer to 'evidence-based treatment protocols', i.e. protocols tested in clinical trials. Such protocols are available for both group and individual CBT in clinical trials with evidence of effectiveness and some have been published as stand-alone guides. The committee were aware they were often updated and different services may choose to use slightly different versions and so did not add links to them.
Royal College of Psychiatrists	Guid eline	18	12	1.5.15. Manualised treatment is mentioned – however, just because someone has manualised an intervention does not mean it is feasible to deliver or an effective treatment. Clinics should by preference, where feasible, use manualised CBT that has been validated in one or more clinical trials. Such treatments do exist. Also it is not clear if there is an evidence-based (clinical trial tested) group therapy CBT manual available at this time for use in the NHS.	Thank you for your comment. This recommendation has now been amended to refer to 'evidence-based treatment protocols', i.e. protocols tested in clinical trials. Such protocols are available for both group and individual CBT in clinical trials with evidence of effectiveness.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	18	12	Para 1.5.15 We would expect treatments (both group treatments and any additional treatments or 'elective' therapies) to be delivered in ways that are consistent with the assessment and formulation of gambling harms, and with the current evidence base (not necessarily current treatment manuals). We note that the main treatment manuals that have been published with an associated evidence base pre-date the significant expansion of gambling technologies.	Thank you for your comment. This recommendation has now been amended to refer to 'evidence-based treatment protocols', i.e. protocols tested in clinical trials. Such protocols are available for both group and individual CBT in clinical trials with evidence of effectiveness. Thank you for informing us about your treatment approaches. Individual behavioural therapy (BT) was also shown to be marginally clinically and cost-effective, however the evidence for BT was more limited than individual CBT and was characterised by higher uncertainty; moreover, the committee highlighted that BT lacks the cognitive element of CBT that is important in therapy, as cognitive errors are a maintaining factor in gambling disorder. Therefore, the committee decided to focus recommendations on CBT rather than BT. Dealing with triggers is included in the relapse prevention recommendation as you state, and no evidence was found for the use of EMDR so this has not been recommended.

				In addition, we think it is helpful to take a trans-diagnostic approach (which is consistent with the principles of formulation) and to offer integrated cognitive and behavioural treatments with a strong evidence base that target common elements across a range of conditions or disorders. For example, consideration of behavioural activation for depression and CBT approaches to problem solving are helpful evidence based CBT tools that people can use to develop a balanced lifestyle that promotes wellbeing, acts as a buffer to stressful events and reduces the chances of relapse in experiencing gambling harms. Stimulus control strategies may help in developing an initial break from gambling but may be less effective over the longer term given the ubiquity of gambling related situations and cues. Hence, our experience is that exposure response prevention and EMDR used in anxiety related conditions are also helpful in managing urges / cravings (which have a physiological component) to gamble and are, therefore, included in our treatment offer.	

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	18	13	Para 1.5.15 We are concerned that the figures given for the length of treatment for group and individual therapy become accepted benchmarks for gambling harms treatment services. Our experience is 10 sessions for group therapy with additional individual 1 to 4 sessions of 'elective' therapies if required, and 6 to 10 sessions for individual therapy. As an alternative, we would suggest an emphasis on the underlying principles for length of sessions (or 'treatment dosage'). These are that treatment length reflects individual need and the specific treatment components and interventions applied.	Thank you for your comment. The number of sessions for group and individual CBT reported in the recommendations are based on the number of sessions reported in the RCTs considered in the review, supplemented with the committee's expert advice. The recommended number of sessions are those that should 'usually' be provided, according to the recommendation. We have now added clarification that, in some cases, more sessions may be required, or fewer sessions may be sufficient (depending on individual needs).
Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	18	015 - 016	Para 1.5.15 Suggest that relapse prevention is built into CBT group or individual treatment from the outset.	Thank you for your comment. The final bullet of this recommendation already states that the CBT should include a relapse prevention component, as you suggest.

Royal College of General Practitioners	Guid eline	18	18	Rec 1.5.16 - Considering the current workload of this additional and uninitiated task, we question why GPs should continue the prescription of naltrexone. The system is gradually moving towards GPs refraining from undertaking tasks they have not initiated themselves.	Thank you for your comment. The recommendation has been revised to state that naltrexone should be started by or under the supervision of a specialist and the reference to shared care has been removed. However, a link has been included to the national prescribing guideline for naltrexone in gambling disorder which does refer to shared care if agreed by the GP. There may be GPs with a special interest in gambling who would be happy to undertake this responsibility and the guideline does not preclude them from doing this.
Haringey Public Health Department	Guid eline	18	18	1.5.16 - There appears to be quite limited evidence behind the use of naltrexone in this setting. We would strongly recommend studies be conducted for this off license use to build evidence-based practice.	Thank you for your comment. There was evidence for the use of naltrexone (see evidence review E) which the committee decided was sufficient to allow them to make a weak 'consider' recommendation. In addition, the guideline makes a number of research recommendations relating to pharmacological treatment as the committee decided that more research was needed in this area.

GambleAware	Guideline	18	018-021	We do not support this recommendation as there is no evidence to support the use of naltrexone for the treatment of gambling harms. The evidence review acknowledges this, yet this recommendation has been made regardless.	Thank you for your comment. There was evidence for the use of naltrexone (see evidence review E) which the committee decided was sufficient to allow them to make a weak 'consider' recommendation. In addition, the guideline makes a number of research recommendations relating to pharmacological treatment as the committee decided that more research was needed in this area.
Royal College of Psychiatrists	Guideline	18	019-021	1.5.16. Under the reasons to consider medication, we strongly urge adding 'the person does not wish to engage with psychotherapy or cannot tolerate it'. Put differently, patients should be given the choice of medication if it is clinically indicated and they do not wish to pursue therapy. This would be usual practice for other mental health conditions. Therapy is associated with adverse events for some individuals so it would not be right to ‘force’ them to receive this treatment when medication would help, is indicated, and there is a patient preference for this.	Thank you for your comment. The committee decided that psychological therapy should be the preferred treatment and should always be offered first, in preference to an unlicensed medication with known side-effects. They therefore agreed to keep it as an alternative for certain groups but not to recommend it as an option for all people.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	18	21	Rec 1.5.16 – Re-word ‘with psychological treatment’ to ‘after having received psychological treatment’.	Thank you for your comment, This has been changed to 'despite having received psychological therapy.'
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	18	22	Rec 1.5.16 – Unclear why reference is made to August 2023. Is this necessary or can it be clarified why this is important?	Thank you for your comment. This relates to the date when the draft guideline was published, and clarifies that this information about licensed status was correct at that date.
Royal College of Psychiatrists	Guideline	018 - 019	General	We understand that a NICE guideline recommendation for pharmacological treatment of harmful gambling with naltrexone (even as a second line intervention) would be a major innovation of clinical practice and support this evidence-based approach.	Thank you for your comment.

Royal College of Psychiatrists	Guideline	018 - 019	General	We were surprised that the draft guideline only recommends naltrexone and not nalmefene, which is available in the UK as Selincro (and recommended with restrictions by NICE 2014, TA325, for the treatment of alcohol dependence). A recent network meta-analysis by Ioannidis et al. (under review) found evidence for naltrexone and nalmefene separately showing efficacy:	Thank you for your comment. You are correct that there was also evidence of benefit with nalmefene. However the doses used were far in excess of the licensed doses used in the UK, and the committee had no experience of its use and so decided not to include recommendations on its use in national guidance at this stage. The paper you reference includes all the evidence on nalmefene that the committee used to make the recommendations (see evidence review E) and is also a pre-print that has not been reviewed yet and which includes the statement: 'This article is a preprint and has not been peer-reviewed. It reports new medical research that has yet to be evaluated and so should not be used to guide clinical practice.'

				Pharmacological Management of Gambling Disorder: A Systematic Review and Network Meta-Analysis | medRxiv. All the analysed individual RCTs are published and referenced in the manuscript. A recent Cochrane review meta-analysed "opioid receptor antagonists" in one group (Dowling et al. 2022). A recommendation for naltrexone and nalmefene would effectively double the pharmacological options in this condition, especially if one of the medications is not tolerated. Dose-related liver toxicity is a well-known side effect of naltrexone, whereas this is not the case with nalmefene, which could be prescribed with less monitoring requirements.	
Medicines optimisation team, Centre	Guid eline	19	001 - 004	Rec 1.5.17. 'Naltrexone should be started by, or under the supervision of, an	Thank you for your comment. The recommendation has been revised to state that naltrexone should be started by or under the supervision of a specialist and the reference to shared care has been removed.

for Guidelines, NICE				appropriately qualified or experienced specialist. After the initial prescription, subsequent prescriptions may be issued in primary care using a shared care agreement.' I am aware that NHS England and the National NHS Advisory Group for Gambling Disorder are developing a National Prescribing Guidelines for Naltrexone in Gambling Disorder. The wording in this recommendation is different to the wording in the draft version of the national prescribing guidelines that I have seen. This says that treatment would be initiated by a specialist clinician in the NHS Gambling Treatment Service. Prescribing and monitoring responsibility would only be transferred to primary care (under a shared care agreement) when treatment had been initiated by the NHS Specialist Gambling Service, and efficacy and stable dosing had been established.	However, a link has been included to the national prescribing guideline for naltrexone in gambling disorder which does refer to shared care if agreed by the GP. There may be GPs with a special interest in gambling who would be happy to undertake this responsibility and the guideline does not preclude them from doing this.

				Please can this be discussed with the committee to ensure that there is consistency in wording between the NICE guideline and the national prescribing guidelines being developed regarding who initiates treatment and when it could be transferred to primary care prescribing under shared care agreement.	

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	19	001 - 006	1.5.17 - Why should GPs continue the prescription of naltrexone? If this is the case, this needs to be done under shared care arrangements. GPs are busy enough doing their work rather than taking additional, unfunded work. The system is moving away from asking GPs to undertake work which they have not initiated. Naltrexone used for gambling disorder is an off-label indication and an individual being treated with naltrexone must be under the supervision of an NHS Specialist clinic or an intermediate primary care service that has the appropriate competencies and supervision in place. We do not support this paragraph in the NICE guidelines – General practitioners working in practices would not find this acceptable.	Thank you for your comment. The recommendation has been revised to state that naltrexone should be started by or under the supervision of a specialist and the reference to shared care has been removed. However, a link has been included to the national prescribing guideline for naltrexone in gambling disorder which does refer to shared care if agreed by the GP. There may be GPs with a special interest in gambling who would be happy to undertake this responsibility and the guideline does not preclude them from doing this.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	19	001 - 016	Pharmacological treatment for harmful gambling. Para 1.5.17 to Para 1.5.19 Prescription of Naltrexone. Consider: Using shared care agreements with primary care to enable its longer term and safely in combinations with other treatments. Identifying a timeline for typical use of Naltrexone. Clarify risks and benefits at the start of treatment and with continued treatment. Having remote consultation systems in place to enable equitable treatment. Note that not all services will have a mental health nurse, as identified by the model in Evidence review E.	Thank you for your comment. The recommendation has been revised to state that naltrexone should be started by or under the supervision of a specialist and the reference to shared care has been removed. However, a link has been included to the national prescribing guideline for naltrexone in gambling disorder which does refer to shared care if agreed by the GP and provides much more detailed advice on the use of naltrexone, as you request. It is acknowledged that not all services will have a mental health nurse. The unit cost of a mental health nurse was used for costing purposes, but other types of health professionals may be involved in the provision of pharmacological interventions for people experiencing gambling that harms. This has now been clarified in the text.

Royal College of Psychiatrists	Guid eline	19	4	1.5.17. We would like to highlight the newly available National Prescribing Guidelines for Naltrexone in Gambling Disorder, which has been approved by the National NHS Advisory Group for Gambling Disorder, NHS England, after an extensive consultation process. It can be accessed via NHS gambling treatment services – e.g. see link here: https://www.southernhealth.nhs.uk/our-services/a-z-list-of-services/gambling-service. We recommend avoiding the term 'share care guidelines' – this has a very specific meaning referring to local processes to agree 'Shared Care Protocols' or 'Shared Care Agreements'. However, there is not a legal or mandatory requirement for one of these to be in place, to enable treatment. For example, a patient's given GP and NHS gambling treatment service can mutually agree to Naltrexone treatment for a given patient using the National Guidelines, irrespective of presence or otherwise of local formal Shared Care Agreements. Local areas could also choose to adopt the National Guidelines as formal Shared Care Agreements, or develop their own, but this requires local processes and may be extremely slow due to gambling disorder not being perceived as a local priority in some areas – as well as stigma against people with addiction. In the meantime, it is important patients can obtain this evidence based treatment through individual agreement between service providers and primary	Thank you for your comment. The recommendation has been revised to state that naltrexone should be started by or under the supervision of a specialist and the reference to shared care has been removed. However, a link has been included to the national prescribing guideline for naltrexone in gambling disorder which does refer to shared care if agreed by the GP. There may be GPs with a special interest in gambling who would be happy to undertake this responsibility and the guideline does not preclude them from doing this.

				care clinicians, ideally using National Prescribing Guidelines.	

Medicines optimisation team, Centre for Guidelines, NICE	Guid eline	19	005 - 006	Rec 1.5.17. Could a link to the NHS England shared care protocol page be included here rather than a link to the responsibility for prescribing between primary and secondary/tertiary care 2018 document. The NHS England shared care protocol page includes more recent information on this issue and more recent guidance. It also includes a link to the Responsibility for prescribing between primary and secondary/tertiary care 2018 document.	Thank you for your comment. The recommendation has been revised to state that naltrexone should be started by or under the supervision of a specialist and the reference to shared care has been removed. Instead a link to the national prescribing guideline for naltrexone in gambling disorder has been included, which contains more details on shared care arrangements.
Medicines optimisation team, Centre for Guidelines, NICE	Guid eline	19	007 - 008	Rec 1.5.18 ‘Consider’ continuing psychological treatment in combination with naltrexone. The ‘consider’ here doesn’t appear to be in-line with what is written in the rationale section where it says that ‘Based on their knowledge and experience, the committee agreed that naltrexone should not replace psychological therapy but that psychological therapy should	Thank you for your comment. The rationale has been revised to state that continuing psychological treatment would be an individualised decision.

				continue when people are started on naltrexone.' Continuing psychological treatment with naltrexone would also be in-line with the summary of product characteristics (SPC) for its licensed indications as the SPC's say it should be used within a comprehensive treatment program including psychological guidance or as part of a comprehensive programme of treatment.	
Royal College of Psychiatrists	Guideline	19	009-016	1.5.19. The information about prescribing Naltrexone (e.g. baseline tests) is currently incomplete/partial relative to the complex considerations needed to prescribe this medication. We recommend reference to the National Prescribing Guideline, which gives more detailed information. It was also not clear why renal function test would be required as part of usual practice for naltrexone.	Thank you for your comment. The information about prescribing naltrexone has been amended to make it more complete, but a link has also been included to the national prescribing guidelines on naltrexone which contain much more detailed information. Naltrexone is contraindicated in severe renal impairment so it would be necessary to check renal function before commencing it.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	19	10	Rec 1.5.19 – Assumption that professional engaging with the guideline will be unable to check kidney and liver function themselves, therefore suggest re-phrasing to 'kidney and liver function should be assessed, and treatment commenced only if within acceptable/normal ranges.' (Could potentially detail these ranges)	Thank you for your comment. The recommendation has been amended as you suggest. Normal ranges have not been included however, as these may vary between laboratories.
Medicines optimisation team, Centre for Guidelines, NICE	Guid eline	19	10	Rec 1.5.19 bullet point 1: I am aware that NHS England and the National NHS Advisory Group for Gambling Disorder are developing a National Prescribing Guidelines for Naltrexone in Gambling Disorder. This includes information on tests/counselling points for patients that need to be done before naltrexone is started. The information in the draft national prescribing guidelines is much more detailed than what could be included in NICE recommendations.	Thank you for your comment. The information about prescribing naltrexone has been amended to make it more complete and more in accordance with the national guidance, but a link has also been included to the national prescribing guidelines on naltrexone which contain much more detailed information, as you state.

				There is a difference between the draft NICE recommendation and the draft national prescribing guideline, in that the draft national prescribing guideline recommends LFTs before starting naltrexone but not kidney function tests (although severe renal impairment is a contraindication to naltrexone use and the SPC says it should be used cautiously in mild-moderate renal impairment/disease). Please can this be discussed with the committee regarding this difference. Inconsistency between the 2 products could cause confusion in practice and cause difficulties with implementation. I have only seen a draft version of this national prescribing guideline and so alterations could have been made to it.	
Betknowmore UK	Guid eline	19	010 - 016	The practitioner should also take a history of substance dependency.	Thank you for your comment. The need to check that the person is not taking opioids has been added to the recommendation.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	19	11	Rec 1.5.19 – Insert phrase so sentence reads '...to avoid taking opioids while taking naltrexone.'	Thank you for your comment. 'Taking' has been added to this sentence.
Medicines optimisation team, Centre for Guidelines, NICE	Guid eline	19	11	Rec 1.5.19 Did the committee also discuss the importance of making sure that people are not taking opioid containing medicines or drugs before naltrexone is started (including prescribed opioids, over-the-counter opioids or illicit opioid containing substances). Does something need including on this? SPC for naltrexone says that treatment with naltrexone should only be considered for patients who have had a sufficiently long period of time free of opioids.	Thank you for your comment. The need to check that the person is not taking opioids has been added to the recommendation.

Medicines optimisation team, Centre for Guidelines, NICE	Guideline	19	012 - 013	Rec 1.5.19 bullet point 3 I am aware that NHS England and the National NHS Advisory Group for Gambling Disorder are developing a National Prescribing Guidelines for Naltrexone in Gambling Disorder. This includes dosage information. There are some differences between the draft NICE recommendations and this national prescribing guideline.	Thank you for your comment. The committee were aware that the new national naltrexone in gambling disorder guideline includes a higher dose, but decided that this would only be in limited circumstances, and that they did not therefore want to recommend this dose in a national guideline. Similarly, the committee decided that a usual course of treatment would be up to 6 months, and that longer course would be unusual so did not amend their recommendation. Finally, they also wished to adopt a conservative approach to dose titration so left this as 25 mg for 3 days. A link to the national naltrexone guideline has now been included from these recommendations.

				The draft version of the prescribing guidelines that I have seen says that the usual dose of naltrexone for this indication is 50mg a day (so the same as the NICE recommendation). However, it also says that higher doses than 50mg a day (up to a recommended maximum of 150mg/day) can be used where clinically indicated. Although it should be noted that 150mg a day is three times the maximum daily dose of 50mg a day for the licensed indications. I haven't been involved with the development or QA of this prescribing guideline and the dose wasn't referenced in the draft version I saw, so I don't know what evidence/resource or information this dosage is based on. I have only seen a draft version of this prescribing guideline and so alterations could have been made to this.	

				The draft NICE recommendations on length of naltrexone treatment '4 to 6 months.' Is this the full length/course of treatment that is being recommended by NICE i.e. a maximum of 4 to 6 months? The draft national prescribing guideline implies that naltrexone would be a longer-term treatment (i.e. it discusses stopping naltrexone treatment after 1 to 2 years in most cases). Can this be discussed with the committee regarding what they are recommending on treatment length and consistency with the national prescribing guidelines in development. Also, the draft national prescribing guideline says first day (trial dose) 25mg, then usual dose of naltrexone is 50mg a day. Whereas draft NICE recommendations recommend 25mg a day for 3 days before increase to 50mg a day. Inconsistency between the 2 products could cause confusion in practice and cause difficulties with implementation. Can this be discussed with the committee. I note that there are people listed as being involved in the national prescribing guideline development who are also on the guideline committee.	

Medicines optimisation team, Centre for Guidelines, NICE	Guid eline	19	014 - 016	Rec 1.5.19 bullet point 4 I am aware that NHS England and the National NHS Advisory Group for Gambling Disorder are developing a National Prescribing Guidelines for Naltrexone in Gambling Disorder. This includes monitoring information. The information in the draft national guidance is much more detailed than what could be included in NICE recommendations. It includes information on monitoring for efficacy and side-effects including advice on how to deal with side-effects and information on frequency of testing e.g. for LFT's. The draft NICE recommendation mentions the onset of chest pains or palpitations as side-effects. The draft national prescribing guideline includes information on several potential side-effects including common ones such as nausea, headache, joint pain, restlessness and anxiety and rare side-effects such as suicidal ideation and idiopathic thrombocytopenia.	Thank you for your comment. The information about prescribing naltrexone has been amended to make it more complete and more in accordance with the national guidance, but a link has also been included to the national prescribing guidelines on naltrexone which contain much more detailed information, as you state.

				Can it be discussed with the committee why they have specifically highlighted onset of chest pains and palpitations? These aren't included in the draft national prescribing guidelines (version I saw) although they are included as potential side-effect's in the SPC for naltrexone.	
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	19	16	Consider adjustment of other pharmacological interventions to help with gambling harms, for example, reduction of aripiprazole, optimisation of medication for ADHD or Bipolar Affective Disorder. Close working and liaison with other mental health organisations remains fundamental in these situations.	Thank you for your comment. A new recommendation stating that aripiprazole and medication for Parkinson's should be reviewed in conjunction with specialist services has been added to the section of the guideline on assessment The committee were not aware of gambling due to drugs for ADHD or bipolar disorder.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	19	17	Rec 1.6 – Description of re-lapse feels like a short-term issue. It may be helpful to describe in more detail what is meant by recovery and that this can be a lengthy journey. With support, the individuals can maintain recovery in the long-term, but should be clear that, as with any other addiction, there is always of inherent risk of relapse if a person gambles again.	Thank you for your comment. The first and second recommendations in this section already describe relapse as 'part of the recovery journey' and the last recommendation advises that additional interventions and support may be necessary, so changes have not been made to these recommendations.

				Service providers should develop positive, asset-based models of recovery and share learning from other recovery services and networks (such as those for alcohol and drug use).	
Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	19	017-025	1.6 Relapse and ongoing support. We strongly endorse this section.	Thank you for your comment.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	19	General	1.6 - Some of the language in this section could be revisited, as per previous comment, to be framed as future focused, strength based and capability building, rather than focused on failure. Planning for success rather than planning to manage 'failure'.	Thank you for your comment. The committee were aware that relapse could be very distressing but being realistic about its occurrence was helpful and allowed people to not view it as a failure, so it was preferable to acknowledge it rather than pretend it doesn't happen.
Medicines optimisation team, Centre for Guidelines, NICE	Guideline	19	General	Should recommendation 1.5.17 and 1.5.18 be switched around. So, rec 1.5.18 first and then rec 1.5.17?	Thank you for your comment. The committee decided that the two recommendations about prescribing naltrexone should come together - to whom and by whom - and then the details about considering psychological therapy should follow, so this change has not been made.

Royal College of Psychiatrists	Guideline	19	General	1.5.18. Whether or not to treat patients with medication and therapy sequentially, or in parallel, should be decided at the level of individual care, taking into account the relative risks and benefits, and the latest evidence base. There is no evidence, to our knowledge, from clinical trials that doing both treatments at the same time is preferable. For example, in NHS gambling services, a patient might receive a course of CBT; once completed; if they are still symptomatic, medication may be tried if indicated. There are often clinical grounds to not treat with medication and therapy at the same time, as it is not in the person's best interests. For example, if a patient has experienced no benefit from CBT, it would not make sense to continue it with medication (for example) and could in fact lead to unnecessary harms / side effects as well as costs (since therapy is – like any treatment – associated with adverse events in some people, and also has a cost consequence). Sequencing of treatments is an area where there are extremely few (possibly no) clinical trials in gambling disorder in the literature. In the absence of any direct evidence, and due to low methodological quality of many of the therapy studies, and any modelling being inaccurate, it would in our view be inappropriate to recommend a particular type of sequencing or to state that medication 'must' be used at the same time as therapy.	Thank you for your comment. The committee decided that psychological therapy could be continued for people taking naltrexone and this may be beneficial in many cases, but agreed this would be an individualised decision and so made a weaker 'consider' recommendation. The recommendation does not state that the two must be used together. In addition, the committee made a research recommendation relating to combination therapy as they recognised there was a lack of evidence.

Royal College of Psychiatrists	Guideline	19	General	To our knowledge, there are no clinical trials supporting the notion that a combination of CBT + pharmacotherapy is preferable to pharmacology alone after a trial of CBT. While there needs to be some ongoing psychoeducation, it would seem unreasonable to expect them to have ongoing CBT during a trial of medication. We suggest adding a general recommendation for research to assess the efficacy of pharmacological agents as monotherapy.	Thank you for your comment. The committee did not identify any evidence for combination therapy but agreed that psychological therapy could be continued for people taking naltrexone and this may be beneficial in many cases, but agreed this would be an individualised decision and so made a weaker 'consider' recommendation. The committee made a research recommendation relating to combination therapy as they recognised there was a lack of evidence for the effectiveness of pharmacological therapy with and without psychological therapy.
Gambling with Lives	Guideline	20	001 - 010	1.6.2 - Blocking tools should also be mentioned here.	Thank you for your comment. Blocking tools have been added to this recommendation.

Betknowmore UK	Guid eline	20	003 - 004	Data of rates of relapse should be provided to help destigmatise relapse. Research shows that around 50% of people in recovery relapse, and follow-up aftercare sessions are essential to prevent relapse, https://doi.org/10.1556/2006.2021.00009	Thank you for your comment. The committee discussed that stating that relapse was not uncommon may help reduce the feelings of stigma and shame that can be associated with relapse but that stating that this rate was 50% may have the opposite effect and discourage people from treatment, and so agreed not to add this this detail.
Adferiad	Guid eline	20	003 - 004	Aftercare is an integral part of Adferiad's treatment offer, within the guidelines more detail is needed on how best to ensure individuals do not fall through the gaps following the end of their treatment.	Thank you for your comment. The guideline includes recommendations advising that relapse prevention and ongoing support are important aspects of treatment, but here was very little evidence available to guide the committee in the choice of effective interventions to prevent or treat relapse so it was not possible to make detailed recommendations for specific interventions.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	20	11	Rec 1.6.3 – Unclear what is meant by 're-access'. Does it meant that individuals should be able to continue on their treatment pathway from the point of exit, rather than having to start at the beginning again? Could this be clarified? Also suggestion that 're-access' could be replaced by 're-assessment?	Thank you for your comment. The committee decided that rapid re-entry to therapy would need to be provided on an individualised basis as it would vary. For example, some people might need to return for some extra sessions of CBT shortly after completing a course and would not need re-assessment, while others may return for peer support and others may return after a relapse and need a full re-assessment. This recommendation has therefore been reworded as 'rapid re-entry to therapy'.
Betknowmore UK	Guid eline	20	17	Groups considered to be at higher risk of relapse should be inclusive, e.g. LGBTQ+ communities.	Thank you for your comment. The committee decided that people at higher risk of relapse would be identified individually by their practitioner, as the reasons for relapse may vary, and so did not add specific groups to this recommendation. However, this has been added to the equality impact assessment for the guideline.

Gordon Moody	Guideline	20	019 - 025	We believe that recommendation 1.6.5 should contain more detailed guidelines of aftercare and ongoing support recommendation, especially for people presenting with complex needs and co-morbidities. Service users leaving Gordon Moody's programmes are offered up to 6 months of targeted aftercare support provided by our outreach and aftercare recovery workers. The level of work is more intense within the first two months of leaving, with contact reducing thereafter, and is generally divided into 3 different stages, with progress, goals and action plans being reviewed every 2 months. After the successful completion of one recovery year service users are encouraged, if they so wish, to engage in our peer-mentoring programme.	Thank you for your comment and for telling us about the service offered by Gordon Moody. The guideline includes recommendations advising that relapse prevention and ongoing support are important aspects of treatment, but there was very little evidence available to guide the committee in the choice of effective interventions to prevent or treat relapse so it was not possible to make detailed recommendations for specific interventions. As there was so little evidence the committee made a research recommendation and so hopefully future research will allow for the development of evidence-based recommendations.

				There is a focus on carrying forward the goals and priorities ascertained during treatment and the transition plan, ensuring that we can enable a sustainable recovery journey for our alumni. Historically, in UK, community-based services are best placed to facilitate reintegration back into the service-user's community, and wider society, which is one of the most important pillars of long-term recovery (Albertson et al., 2015). This is why Gordon Moody is delivering a significant part of the aftercare programme in collaboration with lived experience organisations such Whysup, BetKnowMore or EPIC Restart Foundation that are facilitating a wide range of peer-based support programmes. Also, consideration should be given to the role of peer-mentors and experts by experience in offering ongoing support services (Eddie, 2019, Kowalski 2020). More guidance would be needed around how to involve peer mentors and do this safely and well, the training, supervision etc and guidance around support / approach if a peer mentor experiences difficulties.	

				More detail would be needed in regards with the services and settings delivering support with legacy harms. A growing body of research supports the effectiveness of long-term recovery residence (living houses, Oxford houses, recovery houses, half-way houses etc.) in sustaining abstinence and support those who would need to rebuild their life free of addiction (The Society for Community Research and Action, 2013, Reif, 2014, Martinelli, 2020) Recovery residences are sober, safe, and healthy living environments that promote recovery from addictive behaviours and associated problems. At a minimum, recovery residences offer peer-to-peer recovery support with some providing professionally delivered clinical services all aimed at promoting abstinence-based, long-term recovery.	

				At Gordon Moody each of the residential services benefits from a recovery house facility, as well as links into regional providers for access to a local step-down supporting housing offer for service users who want to re-locate and re-start their life. Residents in the Recovery Houses are supported to move into independence and achieve long lasting, self-sustaining recovery.	
His Majesty's Prison and Probation Service (HMPPS)	Guid eline	20	019 - 025	1.6.5 - Discuss with the person what additional treatment or support they may need. This could include: support with legacy harms (for example, relating to employment, finance, health, housing, relationships, or legal issues) which may be provided by the voluntary sector or other organisations. – Not necessarily 'legacy' as these could arise/impact suddenly, at any point in the present. Suggest replacing with 'associated'.	Thank you for comment. This has been changed to 'ongoing' harms.

Adferiad	Guideline	21	001 - 020	The guideline recognises the extend of harms experienced by affected other, but offers no protective measures for those that may be experiencing domestic abuse, coercive control or financial instability.	Thank you for your comment. The committee took an 'all-harms' approach throughout the guideline and so many of the recommendations in all the other sections of the guideline (identifying people experiencing harms, initial help, information and support overcoming stigma, principles of treatment) all apply to affected others, and this is explained at the beginning of this section, and so these recommendations have not been repeated here. This includes advice on help for domestic abuse and financial assistance.
Betknowmore UK	Guideline	21	001 - 020	The Guideline recognises that the extend of harms experienced by affected others can be profound yet dedicates only 1 page to their support needs. This is insufficient. There is no mention, for example, of the specialist legal assistance affected others often need, their support needs when they are in contact with the criminal justice system, and the gambling-related domestic abuse and coercive control they may be experiencing.	Thank you for your comment. The committee took an 'all-harms' approach throughout the guideline and so many of the recommendations in all the other sections of the guideline (identifying people experiencing harms, initial help, information and support, overcoming stigma, principles of treatment) all apply to affected others, and this is explained at the beginning of this section, and so these recommendations have not been repeated here. This includes advice on help for domestic abuse and financial assistance.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guid eline	21	001 - 021	1.7 Interventions for families and affected others. We welcome the recommendations made in this section. Our partner (Adfam) has emphasised the importance of offering help and advice to families and affected others in their own right, as well as helping to support individuals in their recovery. Adfam also notes that reaching out to families can be a challenge. Individuals undergoing treatment do not always provide a connection to their families. Some families hesitate to seek help and support for themselves, reflecting shame and stigma they experience with gambling harms. As a consequence, family support projects may take a while to establish.	Thank you for your comment and sharing the work of Adfam. The committee agreed that families and affected others need support, and so advised this but there was very little evidence available that allowed them to recommend specific interventions. As there was so little evidence the committee made a research recommendation.

GamCare	Guideline	21	001-021	Please see comment 5 above. GamCare would like to raise that the guideline proposed will have a real and detrimental impact on people are experiencing gambling harm. It will affect service-users lives and has the potential to ultimately harm people.	Thank you for your comment. Substantial changes have been made to the guideline based on stakeholder comments and the committee do not agree that the final guideline will have a detrimental effect on care.

Royal College of Psychiatrists	Guideline	21	001 - 021	1.7.1. This section states that gambling treatment services should provide interventions for families and affected others. While of course affected others should receive support, the term 'interventions' suggests a formal treatment programme for affected others but NHS gambling services are not generally commissioned to do this and furthermore there are (to our knowledge) no evidence-based interventions from controlled clinical trials (or using other appropriately rigorous methodologies) that could be used in NHS clinical settings for this purpose. Essentially it is important not to conflate specialist tertiary clinical care pathways for those affected by gambling disorder with more general support that should be provided for affected others who do not themselves have gambling disorder. Specialist NHS clinics are best placed to delivery clinical care for gambling disorder but other services are likely to have the skills and be better placed to provide support for affected others (e.g. independent charities), with these different organisations working in collaboration to help address societal gambling related harms together. The role of NHS clinics can be to signpost affected others to services offering support, psychoeducation, etc. Clarification of these issues is critical as otherwise it may be assumed that NHS clinics can address all gambling related harms without support from other industry independent organisations.	Thank you for your comment. The title of this section has been changed to 'Interventions and support for families and affected others'. The committee took an 'all-harms' approach throughout the guideline and so many of the recommendations in all the other sections of the guideline (identifying people experiencing harms, initial help, information and support, overcoming stigma, principles of treatment) all apply to affected others, and this is explained at the beginning of this section, and so these recommendations have not been repeated here. The committee were disappointed that, as you state, there is no evidence for particular interventions for affected others and so they made a research recommendation. There is no suggestion that families and affected others can only receive support from NHS gambling clinics.

His Majesty's Prison and Probation Service (HMPPS)	Guideline	21	9	That this stigma is raised considerably if the person experiencing harmful gambling is in a prison. The guidelines mention the stigma that is attached to families of problem gamblers. My point in that there is added or magnified stigma for those same family members if the problem gambler is also serving a prison sentence.	Thank you for your comment. The committee agreed that the family and affected others of people experiencing gambling that harms who are in prison may face additional stigma, but this may be true of people in prison for a wide variety of reasons and so this has not been added specifically to the recommendations.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	21	010 - 011	Rec 1.7.1 – Re-word the sentence to sat '…friends and others close to the people who are experiencing harmful gambling as they do on the person themselves.'	Thank you for your comment. This has been reworded to refer to 'affected others' which makes the wording much simpler.
Gordon Moody	Guideline	21	012 - 020	We welcome the inclusion of recommendations 1.7.1 and 1.7.2 for families and affected others in the guideline, but we consider that more clarity should be provided regarding the possible assessment, interventions and ongoing support offered for affected others	Thank you for your comment. The committee took an 'all-harms' approach throughout the guideline and so many of the recommendations in all the other sections of the guideline (identifying people experiencing harms, initial help, information and support, overcoming stigma, principles of treatment) all apply to affected others, and this is explained at the beginning of this section, and so these recommendations have not been repeated here. The committee agreed that families and affected others need support,

				We believe that the depth of the recommendations is limited, falls short of what is needed and almost feels tokenistic. The recommendations need to address the different levels of intervention needed (I.e. support for an affected other and the harm they have experienced, conjoint interventions, mediation sessions). We believe far more support is required and affected others are fundamental a treatment pathway for those recovering from a gambling disorder. Therapeutic support is required for those most affected by someone else's gambling, the harms experienced by an affected other can be significant, global research tells us that up to 25 harms can be identified (Irie, 2022). Gordon Moody recognises that often an affected others well-being can be affected long after the gambling behaviours have ceased. We believe that holistic treatment, focusing on communication, support and coping skills is required for affected others.	and so advised this but there was very little evidence available that allowed them to recommend specific interventions or therapeutic support. As there was so little evidence the committee made a research recommendation.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	21	019 - 020	Rec 1.7.2 – In terms of the line '…and so support their recovery.' Wit would be beneficial to clarify whose recovery this refers to, is it the person experiencing harmful gambling or the affected other, or both?	Thank you for your comment. The phrase 'and so support their recovery' has been removed as this makes the recommendation clearer
Gambling with Lives	Guideline	21	General	1.7 - This section should include practical measures such as installing blocking tools and money management. It must also stress here that the condition is not the individual's fault.	Thank you for your comment. The committee took an 'all-harms' approach throughout the guideline and so many of the recommendations in all the other sections of the guideline (identifying people experiencing harms, initial help, information and support, overcoming stigma, principles of treatment) all apply to affected others, and this is explained at the beginning of this section, and so these recommendations have not all been repeated here. This includes advice on installing blocking tools and money management. There is no suggestion in the guideline that gambling-related harms are the fault of an individual, but there are clear recommendations on awareness of and overcoming stigma.

RCA Trust	Guideline	22	9	Unbiased Information. The statement "Evidence-based information from a reliable source that has been produced without input or influence from organisations with a conflict of interest, such as the gambling industry, and which clearly states who it was produced by and the source of funding."	Thank you for your comment. The committee were aware that the messages contained in information produced by organisations funded by the gambling industry did not emphasise the addictive nature or potential harms of products or the marketing of gambling and may use terms such as 'responsible gambling' and other such language which could be taken to imply blame and was potentially stigmatising. Based on this the committee decided that information should be unbiased as they defined.
				Clearly implies that information currently used is biased in some format. Yet there is absolutely no evidence presented for that statement. This is a false narrative that is a theme throughout the guidance which at best misguided. This narrative creates another potential hurdle which could stop people accessing appropriate interventions. There is an opportunity to reduce barriers and provide clear and transparent information which aids in the flow of those who require treatment to access it.	

Ara recovery for all (Addiction Recovery Agency Ltd. Charity Number 1002224)	Guid eline	22	9	Unbiased Information. The statement "Evidence-based information from a reliable source that has been produced without input or influence from organisations with a conflict of interest, such as the gambling industry, and which clearly states who it was produced by and the source of funding." Clearly implies that information currently used is biased in some format. Yet there is absolutely no evidence presented for that statement. This is a false narrative that is a theme throughout the guidance which at best misguided. This narrative creates another potential hurdle which could stop people accessing appropriate interventions.	Thank you for your comment. The committee were aware that the messages contained in information produced by organisations funded by the gambling industry did not emphasise the addictive nature or potential harms of products or the marketing of gambling and may use terms such as 'responsible gambling' and other such language which could be taken to imply blame and was potentially stigmatising. Based on this the committee decided that information should be unbiased as they defined.
Royal College of Psychiatrists	Guid eline	22	009 - 012	'Unbiased information'. It is not only information that needs to be free from bias and industry influence but also procedures, processes, people, care provision, policy, research, practice, etc.	Thank you for your comment. The recommendations on models of care already advise that commissioners and providers should be free from industry influence, and so the guideline already states that information and all services should be free from industry influence.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	22	013 – general	Recommendations for research We endorse both key and other recommendations for research proposed by the committee.	Thank you for your comment.

Royal College of Psychiatrists	Guid eline	22	016 - 018	There are numerous tools purporting to assess gambling related harms but the problem is that they have not been validated properly for specific contexts. For discussion see Randy Stichfield's chapter in 'The Wiley-Blackwell Handbook of Disordered Gambling' or more recent books including chapter by the same author in 'Gambling disorder: a clinical guide to treatment, by Grant and Potenza). A given tool is highly affected by context and base rate of disorder and so tools need to be validated for specific purposes in specific populations. It is recommended that the research recommendation might be adjusted to highlight these issues. Also (kindly see earlier point) research needs to be mindful about the differences between screening tools, diagnostic tools, and severity tools – the literature and indeed draft Guidelines tend to conflate these whereas different tools are needed for each of these purposes.	Thank you for your comment. The committee recognised that there are differences between tools to screen for gambling that harms and tools to assess the severity of gambling-related harms and so made research recommendations relating to these areas (see appendix K in evidence review B for full details).

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	22	017 – 018	For information, the KCL project to devise one question to screen for gambling harms across adult social care has now completed. More information is available here Adult social care and gambling harms - King's College London (kcl.ac.uk)	Thank you for your comment. The committee reviewed the outcomes of this work and took it into consideration when finalising their screening questions recommendation.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	22	017 & 020	Should we not also be asking whether the setting in which questions are asked makes a difference in identifying gambling harm.	Thank you for your comment. The details of the research recommendations about screening questions are in appendix K in evidence review B and this includes details of settings.
Betknowmore UK	Guideline	22	20	Recommendations for research No. 2 - Such tools should also be developed to assess the harms of affected others.	Thank you for your comment. The committee were aware that there were already validated tools used for affected others such as the Family Member Questionnaire and so did not add a research recommendation relating to this.

Royal College of Psychiatrists	Guideline	022 - 026	General	As part of the call for new research, we would ask Committee to highlight the need for more psychiatry-led clinical academic research. This would seem vital given that as the Committee found in many of their evidence reviews, the field has a real lack of rigorous research studies free from major methodological issues (in fact, the NICE Committee noted much of the evidence to be of low quality). Part of the reason for this is a lack of involvement of appropriate experts in the research and a lack of independent research funding in the past.	Thank you for your comment. Details of all the research recommendations are specified in appendix K of the relevant evidence reviews, and these specify a proposed outline for the research that is needed.
Royal College of Psychiatrists	Guideline	022 - 026	General	Recommendations for research. We welcome these recommendations, but would highlight the urgent need to study 'efficacy' as well as 'effectiveness'.	Thank you for your comment. Details of all the research recommendations are included in appendix K of the relevant evidence reviews, and these specify a proposed outline for the research that is needed, the majority of which include outcomes similar to the ones you have highlighted as important. However, it

				This could easily be addressed by referring to the need to study 'efficacy, clinical effectiveness, safety/tolerability, acceptability, and cost effectiveness' (or similar phrase) – we need all these from a research point of view from a range of different studies. We recommend noting that a variety of studies and methodological designs are likely to be needed to address these different components. Also it would be important to assess safety and acceptability for all types of treatment (both medication and therapy treatments can be associated with adverse events; e.g. Quaid et al. Patient experience of lasting negative effects of psychological interventions for anxiety and depression in secondary mental health care services: a national cross-sectional study. BMC Psychiatry 2021).	would be up to the researchers to define the final set of relevant outcomes which could include efficacy, clinical effectiveness, safety and acceptability.

Betknowmore UK	Guideline	23	002-004	Recommendations for research No. 3 - The absence of this evidence suggests that the Guideline should not yet be recommending NHS treatment for those with PGSI scores of 8 and above until there is sufficient outcomes and cost-effectiveness data to support this recommendation.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.
Betknowmore UK	Guideline	23	009-010	Recommendations for research No. 5 - The long-term effectiveness of peer support should also be assessed.	Thank you for your comment. The long-term effectiveness of peer support is included in the research recommendation 'What is the effectiveness and cost-effectiveness of psychological or psychosocial interventions to reduce gambling symptoms and increase recovery capital?'. Full details of this are given in appendix K of evidence review F.

Royal College of Psychiatrists	Guideline	25	General	There should be a research recommendation to study individual pharmacological treatments in their own right (not only as combinations of medications but also as monotherapies). We suspect this is an accidental oversight given that combination pharmacological treatments are already mentioned in the research recommendations, as is the need to study individual therapies.	Thank you for your comment. The research recommendation on combination pharmacological and psychological therapies does include a suggestion that one arm should be pharmacological therapies alone. The full details are given in appendix K of evidence review E.
Royal College of Psychiatrists	Guideline	25	General	We understand that there is no appropriate high-quality peer-reviewed published cost-efficiency analysis of naltrexone (or other opioid receptor antagonists) in harmful gambling and support this as a research recommendation.	Thank you for your comment.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	26	9	In respect of the term ‘people who gamble’ earlier in the document, this is phrased as people experiencing harmful gambling, not all who gamble. Whilst both work, the document should be consistent.	Thank you for your comment. The wording has been changed to 'affected others' to simplify this sentence.

GamCare	Guideline	27	001 - 006	Please see comment 1 above. GamCare has been the leading provider of information, advice, and support for anyone affected by gambling harms for over 25 years. We operate the National Gambling Helpline, provide structured support for anyone who is harmed by gambling, create awareness about safer gambling and treatment, and encourage an effective approach to safer gambling within the gambling industry. GamCare is also the System Coordinator of the National Gambling Support Network (NGSN), a network of service oriented charities working to support people affected by gambling-harms, which are the largest scale providers of specialist services whose staff and volunteers hold professional expertise. The majority of GamCare service users completing treatment showed improvements against GamCare's key success measures. Using CORE-10, the majority moved from 'moderate' to 'healthy' gambling behaviours (17.4 to 6.5), and using PGSI, they moved from 'problem gambling' levels to 'moderate levels (average scores of 17.1 to 3.5)[2]. This depth of experience and delivery of treatment provides us with expert insight and understanding of the gambling landscape and the impact on third sector treatment provision. The guideline recommends that people with a PGSI score of 8 and above be directed to NHS commissioned specialist services. The guideline itself highlights that PGSI is not a robust clinical tool and the Gambling Commission states that "there are a number of caveats that need to be	Thank you for your comment and for the information about GamCare services. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

				considered" and "the term 'at-risk' can imply that people who are classified as low or moderate risk gamblers on the PGSI are not experiencing harm now will do in the future when in fact they are showing signs of problematic behaviour now but remain below the threshold for 'problem' gambling". PGSI is currently used by GamCare and the NGSN to assess someone's gambling harm at the start, at intervals throughout and at end of an intervention, which helps to determine progress and outcome but does not determine their treatment pathway. GamCare and the NGSN also employs questionnaires including the CORE-10, PHQ-9, and GAD-7, alongside service-user choice which offer more accurate clinical assessment and avoid over and under treating some, alongside wider risk assessments. While PGSI talks about the level of risk, it does not specify a type of treatment associated with different types of risk. There is no evidenced based correlation between a PGSI score and a specific mode of intervention or treatment. The guideline must clearly set out the rational of using PGSI as tool to decide a treatment pathway and the evidence for this approach.	

NIHR, Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London	Guideline	27	3	Note that different wording of a question might lead to variations of positive endorsement, for example a question about being 'worried' will likely have a higher endorsement rate than one which uses a term such as 'affected'. Practitioners may want to consider this when choosing the questions used. See: https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcad155/7205469	Thank you for your comment. The committee were aware of the work carried out at King's and noted that the questions King's had devised were very similar to the ones they had agreed. However, in order to make the questions as simple as possible and relevant to people who gamble and affected others they agreed that use of the term 'worried' would capture concerns and be easily understood.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	27	20	When referring to 'violence or domestic abuse' whilst there is evidence of engagement in this, but also experiencing these.	Thank you for your comment. This improvement to the wording has been made to include 'experiencing'.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	27	23	Explicit reference made to practitioners asking about 'another person's harmful gambling'. From the recs above, there doesn't seem to be an indication that practitioners should be screening people as 'affected others'. If this a specific recommendation, this needs to be drawn out and made more explicit.	Thank you for your comment. Thie question advised as a screening tool is 'Are you worried about your own or another person's gambling?' so this would identify 'affected others'.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	27	26	Would it be beneficial to include examples of occupational groups who may be at increased risk?	Thank you for your comment. Examples of occupational groups who are at increased risk are already included in the recommendation.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	27	026 – 028	For information – the PHE evidence review of risk factors for gambling-related harms found some evidence to support the claim that certain medications or those with certain neurological conditions may be at increased risk of harm.	Thank you for your comment. The recommendations on at-risk groups already include that people on certain medications or with certain neurological conditions may be at increased risk.

GamCare	Guideline	28	001 - 003	Please see comments 1 and 4 above, and comment 27 below. GamCare has been the leading provider of information, advice, and support for anyone affected by gambling harms for over 25 years. We operate the National Gambling Helpline, provide structured support for anyone who is harmed by gambling, create awareness about safer gambling and treatment, and encourage an effective approach to safer gambling within the gambling industry. GamCare is also the System Coordinator of the National Gambling Support Network (NGSN), a network of service oriented charities working to support people affected by gambling-harms, which are the largest scale providers of specialist services whose staff and volunteers hold professional expertise. The majority of GamCare service users completing treatment showed improvements against GamCare's key success measures. Using CORE-10, the majority moved from 'moderate' to 'healthy' gambling behaviours (17.4 to 6.5), and using PGSI, they moved from 'problem gambling' levels to 'moderate levels (average scores of 17.1 to 3.5)[3]. This depth of experience and delivery of treatment provides us with expert insight and understanding of the gambling landscape and the impact on third sector treatment provision. The guideline recommends that people with a PGSI score of 8 and above be directed to NHS commissioned specialist services. The guideline itself highlights that PGSI is not a robust clinical tool and the Gambling Commission states that	Thank you for your comment and for the information about GamCare services. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. There is no suggestion in the guideline that access to services will only be via a GP referral, as a referral could be made by a range of professionals and practitioners, or via self-referral, and a new section has been added to the guideline on referral and triage and directing people to the correct level of service. The recommendations have been amended to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced.

				"there are a number of caveats that need to be considered" and "the term 'at-risk' can imply that people who are classified as low or moderate risk gamblers on the PGSI are not experiencing harm now will do in the future when in fact they are showing signs of problematic behaviour now but remain below the threshold for 'problem' gambling". PGSI is currently used by GamCare and the NGSN to assess someone's gambling harm at the start, at intervals throughout and at end of an intervention, which helps to determine progress and outcome but does not determine their treatment pathway. GamCare and the NGSN also employs questionnaires including the CORE-10, PHQ-9, and GAD-7, alongside service-user choice which offer more accurate clinical assessment and avoid over and under treating some, alongside wider risk assessments. While PGSI talks about the level of risk, it does not specify a type of treatment associated with different types of risk. There is no evidenced based correlation between a PGSI score and a specific mode of intervention or treatment. The guideline must clearly set out the rational of using PGSI as tool to decide a treatment pathway and the evidence for this approach. The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five	

				days from assessment to the offer of a first support session at GamCare. Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner. GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment. GamCare notes that the guideline document refers to 'gambling treatment services provided by the NHS' and would be grateful if the Committee could clarify that this is intended to mean 'gambling treatment services commissioned by the NHS', and could make that change accordingly.	

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	28	9	Re-word sentence to say '…encouraged people to seek help and provided signposting and further sources of help…'	Thank you for your comment. This rationale section has been reworded and reordered to reflect the changes to the recommendations.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	28	010 - 011	Provide clarity to sentence by adding the following '…for those experiencing greater gambling-related harms, as well as for the more complex cases including relapse and those with comorbid conditions.'	Thank you for your comment. This rationale section explains the evidence that was identified to support the recommendations on initial support to be provided in all settings and this level of assessment would not be expected at this stage, so this addition has not been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	28	16	Is there specific evidence that gambling increased the risk of suicidality in affected others?	Thank you for your comment. The recommendations on increased risk of suicide are based on the committee's knowledge and experience and relate to the person experiencing gambling that harms, so this has been clarified in the recommendations and rationale.

GamCare	Guid eline	28	019 - 022 & 023 - 031	In the context of the Committee's findings of 'very limited evidence about the accuracy of tools to identify and assess gambling-related harms in people presenting to a specialist gambling treatment service', and that there is 'no evidence for the accuracy of the PGSI', GamCare outlines that there does exist treatment and support of a comparable level to that within the NHS.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The committee recognise that a wide variety of services are required to meet the needs of people with gambling-related harms, but the introduction of the compulsory levy and the subsequent planned reconfiguration of gambling treatment and support services is likely to lead to a move to NHS-commissioned services, although these are likely to be provided from a variety of providers.

				Community services, e.g., the NGSN offer clinically appropriate therapeutic and support for clients with an 8+ PGSI score – and have significant experience, expertise, and knowledge of gambling-harm treatment and recovery. NGSN services offer holistic support programmes through interventions provided by mental health practitioners, support workers, counsellors, and psychotherapists. Many are CBT qualified – a core offer within the NGSN's model of care. CBT-led therapy is not always delivered by NHS psychologists and is often delivered by trained therapists. The CBT offered within the NHS is therefore comparable to other counselling and therapeutic services within the NGSN.	

				Community-services are also best placed to facilitate reintegration back into the service-user's community, and wider society – an important pillar of long-term recovery. In this context, we would therefore be very grateful for clarification around the implication within the guideline document that NHS clinics are the only 'gambling specialist service'. Naturally, where presenting with additional complexities or clinical risk and safeguarding concerns, referrals into NHS clinical services are discussed routinely with the patients/clients and referrals are made into those services.	

GamCare	Guideline	29	001-004	GamCare supports the Committee's research recommendation on tools to assess gambling-related harms and would welcome the opportunity to support the Committee in its development of those tools. GamCare is pleased to work with the Committee to offer the latest and most up to date anonymised data to support this effort. We further emphasise our concern, given the Committee's own findings, that the PGSI is being considered for use as a referral mechanism into specialist treatment with an 8+ score.	Thank you for your comment. The research recommendations are available for all funders/researchers to access and NICE welcomes research conducted that provides evidence to meet the identified research gaps. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support.

GamCare	Guideline	29	008-015	GamCare recognises the Committee's understanding that revised commissioning arrangements for existing treatment services and new services is likely to have substantial resource implications, such as for setting up new services, employing new staff, or transferring services currently provided by other providers into NHS-commissioned services. GamCare equally recognises the Committee's understanding that there are high costs to the NHS and society associated with harmful gambling, and that the costs of new treatment services may be offset by cost savings if people experiencing harmful gambling are treated effectively in the new services. In this context GamCare emphasises that more work is required to understand this value for money and cost savings to the NHS and society. We note that OHID, in its evidence review on gambling harms, recognises that its own quantitative analysis was limited by the available data. For example, it was reliant on review-level evidence to understand risk factors for gambling and harmful gambling, which proved difficult as the reviews were low quality and relied heavily on cross-sectional studies. GamCare would welcome greater research into value for money in the development of the draft Guideline. We note that, in the context of the potential for NHS clinics to treat patients/clients with an 8+ PGSI score, that the NHS clinics are less cost-effective than existing NGSN providers.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. As you state, the introduction of the compulsory levy and the subsequent planned reconfiguration of gambling treatment and support services is likely to lead to a move to NHS-commissioned services, although these are likely to be provided by a variety of providers. The estimate of £2,000 per referral does not cover solely the cost of a group CBT course. There are other aspects of care per referral including assessment, treatment and support as well as follow-up and aftercare; moreover some people will require alternative or additional treatment with motivational interviewing, individual CBT, or medication. The comparison between NHS clinics and the NGSN provider costs do not take into account what type of care is provided in each setting (including assessment, support, treatment and aftercare), by whom (specialist or not), and the outcomes expected to be achieved in each setting. A cost-effective service is not necessarily the least costly service, but a service where additional benefits (and potential future cost-savings) outweigh additional provision costs, compared with current care, according to the NICE cost-effectiveness thresholds. Moreover, the cost estimate of £2000 per referral is based on current NHS provision of 15 specialist gambling clinics and does not take into account the fact that NHS is planned to commission gambling treatment and gambling support services, which may be provided by a range of providers, including the NHS or the voluntary and charity sector. The introduction of the statutory levy (which is expected to raise approximately £90-100 million annually by 2027 – see Government response to the consultation on the structure, distribution and governance of the statutory levy on gambling operators - GOV.UK).is likely to increase the funding available to spend on gambling support

				They are due to cost at least £2000 per referral, with running costs of £6m/year (excluding set up). For the overwhelming majority, the NHS core treatment option is 8-10 hours of group CBT. £2,000/head for group CBT is 2-400% of the cost that you can buy group CBT for privately. Support should include a range of psychological approaches and not assume group CBT will be effective for everyone. 1:1 support can often be necessary before group support is offered.	and treatment services commissioned by the NHS and a significant reconfiguration of services is expected, to meet different levels of need. As there is currently largely unmet need for these services (according to OHID figures on treatment needs: https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates/gambling-treatment-need-and-support-in-england-main-findings-and-methodology) and the financial and social costs associated with gambling-related harms are very high (according to OHID figures https://assets.publishing.service.gov.uk/media/63bc25b4d3bf7f262c5ad31f/The-economic-cost-of-gambling-related-harm-in-England_evidence-update-2023.pdf but also NIESR figures https://www.niesr.ac.uk/wp-content/uploads/2023/04/The-Fiscal-Costs-and-Benefits-of-Problem-Gambling.pdf), it is anticipated that expanded, NHS commissioned, gambling treatment and gambling support services will gradually cover a larger part of the population needs, resulting in benefits and cost-savings that are likely to offset, at least partially, the high costs associated with gambling-related harms.

				As a primary care mental health service IAPT is the most comparable NHS service to the NGSN. Typical IAPT costings reported in 2021 were £542.7m (£574.5M adjusted for inflation 2021-23), during which period they engaged with 1.2m patients at a cost of £478.75 per patient. We note that in 2023 NGSN provider Beacon Counselling Trust engaged with 4600 service-users, at a cost of £271.74 pp (IAPT IS 76% higher). If every person who scored an 8 or above on the PGSI score was referred directly to the NHS from BCT, the cost would be an additional £6.5 million to the Treasury when moving away from the current system. Of those going through GamCare's first assessment at the start of their 'episode', 64% of people have a PGSI score higher than 8 in (22/23). This amounts to about 4,006 people. We believe that this would result in a significant increase to the funding required for treatment in NHS clinics. We are pleased that GamCare will be able to continue providing our value support and treatment as a commissioned service by the NHS to ensure sustainable and cost-effective support for those who need it.	

GambleAware	Guideline	29	009 - 015	The ambition of the guideline is to ensure more people experiencing gambling harms are identified and can access the right support for their needs. This may increase resource use across the whole system, i.e. not just for the NHS but also for the NGSN which currently treats the majority of people. This needs to be reflected accordingly.	Thank you for your comment. The implementation of the guideline is likely to lead to increased costs to the NHS but it is anticipated this will be met by the introduction of the compulsory levy, and the move to NHS-commissioned services, which are likely to be delivered by a range of providers. Your comments will be passed to the NICE resource impact team for consideration when assessing the resource impact of the guideline.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	29	13	Reference made to the 'expansion' of gambling treatment services. It will likely be (subject to outcome of the DCMS consultation on the Statutory Levy which closes on 14/12) be more of a system re-design with the NHS potentially taking on full commissioning responsibility for treatment services. Should reference be made here to the live consultation? Consultation on the statutory levy on gambling operators - GOV.UK (www.gov.uk)	Thank you for comment. The wording here has been changed to 'reconfiguration of funding and delivery' instead of expansion. Reference has not been made to the consultation because this will have finished by the time the guideline is published.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	29	013 – 015	Given the levy will focus on research, prevention and treatment, is it anticipated that there will be a greater emphasis on upstream preventative actions which in turn will reduce numbers of those reaching 'crisis point' and therefore numbers requiring intensive treatment and support should fall. May also be pertinent to mention other DCMS WP commitments to strengthen protections against harms e.g. Strengthening information messaging including on the risks associated with gambling, introduction of max stake limits on online slots and financial risk checks. High stakes: gambling reform for the digital age - GOV.UK (www.gov.uk)	Thank you for your comment and the information you have supplied about other workstreams. The committee recognised that there is additional work ongoing to reduce the harms from gambling but agreed that there are currently a large number of unidentified people with gambling-related harms, and that the short to medium term impact of the guideline would be to increase the number of people entering treatment.
His Majesty's Prison and Probation Service (HMPPS)	Guideline	29	24	HMPPS agrees that the gambling industry should not provide information to people experiencing gambling related harms and that information should be unbiased.	Thank you for your comment.
GambleAware	Guideline	29	024 - 027	We are in total agreement that industry should have no influence over treatment services.	Thank you for your comment. The revised guideline does not imply that treatment services that are industry funded are less effective. However, the section of the guideline this comment refers to relates

				However, it is misleading and inaccurate to imply that treatment services that are industry funded are less effective – there is no evidence to suggest that industry funding reduces quality or equates influence. The services provided through the NGSN have no industry influence. This statement may discourage healthcare professionals from referring to these services, and may also turn people experiencing harms away from self-referring.	to the provision of unbiased information and does not relate to treatment services so this sentence has not been changed.

GamCare	Guideline	29	024 - 027	Please see comment 12 above. The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five days from assessment to the offer of a first support session at GamCare. Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner.GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment.	Thank you for your comment. There is no suggestion in the guideline that access to services will only be via a GP referral, as a referral could be made by a range of professionals and practitioners, or via self-referral, and a new section has been added to the guideline on referral and triage and directing people to the correct level of service. The recommendations have been amended to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced.

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	029 – 030 - 031	General	Patient choice does not appear to figure at all in these guidelines. The is significant evidence amongst thousands scholarly articles that people involved in decisions about their health and care report. Greater satisfaction with the services their receives. Experience less regret about the decisions that they have been supported to make. More likely to say that the decision made was the most appropriate one for them. NICEs own guidelines in this and other areas, promote patient choice and yet these gambling guidelines do not take account of the choices and preferences of people affected by these guidelines. Instead, there appears to be a dictate that patients are translated into a number (PGSI >8) and based on this they must be seen in specialist NHS commissioned services. This is not in keeping with patient-centred care, nor with involving patients and their carers in decisions about their health.	Thank you for your comment. This section of the rationale relates mainly to the provision of information so it is not clear how this section limits patient choice. Provision of information about harms, services and treatments aims to increase patient choice. The models of care and service delivery section has also been extensively revised. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide, and that although more services are likely to be commissioned by the NHS in the future they may be provided by a range of providers including the voluntary sector. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition and self-referral will remain an option.

				The individual should have the choice not to be directed to a specialist service, but to be managed within other providers, including and importantly within the third sector provision. Being engaged in a service able to deliver some care is surely better than losing the patient to treatment due to the requirement for them to be moved on. It is better to retain in care, nudged from pre-contemplation to contemplation to treatment rather than insist on what NICE appears to consider 'gold standard' treatment by a specialist service. It needs to be recognised that many patients experiencing gambling harms will find it difficult to navigate and access NHS services or will choose not to attend these services and therefore an alternative option must be available.	

				The recommendation in this guideline is confusing. Some places state that individuals should be signposted to the NHS website to seek help while other places suggest that a person-centred, empathetic non-judgemental approach should be offered. If it is the latter, then it is important to provide patient choice, not insist that they are directed towards a particular service. The lack of mention of the third sector along with the major role it plays in local communities in supporting individuals in starting treatment is an omission in this guideline. Understanding how individuals from minority groups, with English not as their first language, will access NHS clinics when experiencing gambling harms is challenging. The third sector plays a crucial role, serving as the primary point and, in most cases, the initial pathway into treatment.	

				The conventional NHS appointment system for clinics could pose a setback for individuals grappling with gambling-related harms. Swift access to assistance is crucial once a patient decides to seek help. Encouragement and proactive engagement are key factors, and there's a risk of losing patients if the traditional approach of scheduled NHS appointments for clinics is adhered to. Instead of merely sending "Did Not Attend" (DNA) letters for missed appointments, a more responsive strategy is needed. Follow-ups should be conducted to address missed appointments, and individuals should be checked on to ensure their well-being. This patient-centred approach aligns with the services currently provided in non-specialist settings, emphasising the importance of a more flexible and supportive framework to better serve those in need of assistance for gambling-related issues. Providing an agile service is paramount.	

His Majesty's Prison and Probation Service (HMPPS)	Guideline	29	General	How the recommendations might affect Service - However, effective identification and treatment may reduce the number of people experiencing longer term or more serious harm from gambling, which may lead to savings to the NHS.- Not just the NHS but also the CJS and society more generally e.g. welfare and unemployment services, housing services.	Thank you for your comment. This has statement on the impact has been amended to include a wider perspective of cost-savings
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	30	25	Suggest the phrase 'information about harmful gambling' is amended to 'information about the risks and harms of gambling'	Thank you for your comment. This change to the wording has been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	31	1	Add in 'and the voluntary sector' after institutions.	Thank you for your comment. This change to the wording has been made.

GambleAware	Guideline	31	006 - 009	There is already a significant amount of unbiased information available about gambling harms that is provided by GambleAware and the NGSN. There is absolutely no industry influence or involvement in this information. Stating that the NHS will have to develop its own information to remove bias inaccurately suggests existing information is compromised and there is no evidence to support this statement. This will dissuade people from using it, putting them at risk of further harm. It must be made clear that unbiased information is already readily available and that it can be accessed outside of the NHS.	Thank you for your comment. The committee were aware that the messages contained in information produced by some organisations did not emphasise the addictive nature or potential harms of products or the marketing of gambling and may use terms such as 'responsible gambling' and other such language which could be taken to imply blame and was potentially stigmatising. Based on this the committee decided that information should be unbiased as they defined.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	31	7	Re-word sentence to '…information, treatment and support…'	Thank you for your comment. This section is about information and support so 'treatment' has not been added.

GambleAware	Guideline	31	013 - 025	As referenced in the evidence review document for the model of care document – there is information available that has not been used to date in this process that would have been useful for the development of the guideline.	Thank you for your comment. No evidence was identified that met the protocol criteria for the review so in accordance with NICE methodology, this was deemed an empty review.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	31	17	Need to include reference to affected others. Suggest amending sentence to '…best way to identify, assess and manage harmful gambling and provide treatment and support for gambling related harms…'	Thank you for your comment. This rationale has been amended to reflect the revised recommendations and so this sentence is no longer present.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	31	026 – 027	As discussed in previous comment, would this benefit from some clarification as to what is meant by free from industry influence or any conflicts of interest'? We know that this can mean different things to different people.	Thank you for your comment. Some more detail about the link between funding and services has been added to this sentence to provide clarification.

GambleAware	Guideline	31	026 - 029	We are in total agreement that industry should have no influence over treatment services. However, it is misleading and inaccurate to imply that treatment services that are industry funded are less effective – there is no evidence to suggest that industry funding reduces quality or equates influence. The services provided through the NGSN have no industry influence. This statement may discourage healthcare professionals from referring to these services, and may also turn people experiencing harms away from self-referring.	Thank you for your comment. This wording about less effective treatments being offered by some organisations funded by the gambling industry was not evidence-based and so has been removed.

GamCare	Guideline	31	026 - 029	Please see comment 12 above. The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five days from assessment to the offer of a first support session at GamCare. Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner. GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment.	Thank you for your comment. There is no suggestion in the guideline that access to services will only be via a GP referral, as a referral could be made by a range of professionals and practitioners, or via self-referral, and a new section has been added to the guideline on referral and triage and directing people to the correct level of service. The recommendations have been amended to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced.

GambleAware	Guideline	32	001-004	We would argue that it has not achieved this through these recommendations	Thank you for your comment. The recommendations have been substantially revised based on stakeholder feedback and so it is hoped they will now maximise entry to an appropriate level of treatment.
GambleAware	Guideline	32	008-012	It would be beneficial for there to be an examination of NHS and NGSN data on outcomes. This would build the evidence base to inform the most appropriate treatment pathways for patients.	Thank you for your comment. The collection and publication of standardised and routine outcomes data by all services will, as you suggest, allow for the effectiveness of different services to be assessed and lead to service improvements.

GamCare	Guideline	32	013-017	Please see comments 1, 4, 7 and 12 above. GamCare has been the leading provider of information, advice, and support for anyone affected by gambling harms for over 25 years. We operate the National Gambling Helpline, provide structured support for anyone who is harmed by gambling, create awareness about safer gambling and treatment, and encourage an effective approach to safer gambling within the gambling industry. GamCare is also the System Coordinator of the National Gambling Support Network (NGSN), a network of service oriented charities working to support people affected by gambling-harms, which are the largest scale providers of specialist services whose staff and volunteers hold professional expertise. The majority of GamCare service users completing treatment showed improvements against GamCare's key success measures. Using CORE-10, the majority moved from 'moderate' to 'healthy' gambling behaviours (17.4 to 6.5), and using PGSI, they moved from 'problem gambling' levels to 'moderate levels (average scores of 17.1 to 3.5)[4]. This depth of experience and delivery of treatment provides us with expert insight and understanding of the gambling landscape and the impact on third sector treatment provision. The guideline recommends that people with a PGSI score of 8 and above be directed to NHS commissioned specialist services. The guideline itself highlights that PGSI is not a robust clinical tool and the Gambling Commission states that	Thank you for your comment and for the information about GamCare services. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. There is no suggestion in the guideline that access to services will only be via a GP referral, as a referral could be made by a range of professionals and practitioners, or via self-referral, and a new section has been added to the guideline on referral and triage and directing people to the correct level of service. The recommendations have been amended to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced. Thank you for sharing details of the work GamCare does with the criminal justice system and for highlighting the need for gambling services to be available to the criminal justice system. The need to include people within the criminal justice system in assessment and treatment is included in the recommendations on models of care and service delivery, and other recommendations on identification, information, access and treatment.

				"there are a number of caveats that need to be considered" and "the term 'at-risk' can imply that people who are classified as low or moderate risk gamblers on the PGSI are not experiencing harm now will do in the future when in fact they are showing signs of problematic behaviour now but remain below the threshold for 'problem' gambling". PGSI is currently used by GamCare and the NGSN to assess someone's gambling harm at the start, at intervals throughout and at end of an intervention, which helps to determine progress and outcome but does not determine their treatment pathway. GamCare and the NGSN also employs questionnaires including the CORE-10, PHQ-9, and GAD-7, alongside service-user choice which offer more accurate clinical assessment and avoid over and under treating some, alongside wider risk assessments. While PGSI talks about the level of risk, it does not specify a type of treatment associated with different types of risk. There is no evidenced based correlation between a PGSI score and a specific mode of intervention or treatment. The guideline must clearly set out the rational of using PGSI as tool to decide a treatment pathway and the evidence for this approach. The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five	

				days from assessment to the offer of a first support session at GamCare. Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner. GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment.	

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	32	013 – 017	The work referenced in this para will be published online in the coming weeks and therefore a link can be included.	Thank you for your comment. The guideline has been amended to remove the PGSI score of 8 as a cut-off to define the care pathway, so this section of the rationale has been rewritten and the OHID work is no longer referenced.

GamCare	Guideline	32	018 - 026	Please see comment 29 above. As NICE recommends, GamCare's Gambling Support Practitioners are trained in Cognitive Behavioural Therapy (CBT) skills and Motivational Interviewing. However, we draw the committee's attention to the lack of evidence that CBT is sufficient or effective in treating complex cases where harms are multiple and persistent. CBT does not address the diverse, enduring harms that gambling can cause. Trauma-informed approaches are being recognised by clients, who value support provided by other people with lived experience, diminishing shame and building hope. The Guideline should not yet be recommending NHS clinical treatment for those with an 8+ PGSI score until there is sufficient outcomes and cost-effectiveness data to support this recommendation. To accurately determine someone's complete clinical presentation and the necessity for stepped-up care, a comprehensive assessment of their situation should be required (see above).	Thank you for your comment. The NMA and economic analysis carried out for this guideline found that group CBT, followed by individual CBT, was the most clinically and cost-effective at reducing gambling severity so this is the intervention that is recommended. The committee were aware that where necessary, the practitioner would adjust the CBT to take into account other factors that increase the complexity of harms, and may decide that dealing with this complexity first before CBT can be started may be preferable. This also does not prevent people being offered other support as outlined in the other guideline recommendations such as help with other financial, domestic and social problems, treatment of comorbidities and peer support. The guideline has been amended to remove PGSI as the sole determinant of gambling treatment and a new section on referral and triage has been added.

GambleAware	Guideline	32	019 - 023	The stability of the system that we currently lead is vital – a smooth transition to whatever new model is chosen, and its long-term future quality, must be ensured. The gambling harms ecosystem cannot afford to lose the expertise of the National Gambling Support Network (NGSN) in the new model. As such, it is imperative that the guideline outlines the role of the third sector in providing treatment and referrals pathways to these. Otherwise, we are concerned that healthcare professionals will not feel supported to refer to these services, instead focusing only on NHS delivered services.	Thank you for your comment. The guideline has been amended to clarify that in the planned reconfiguration of gambling services after the introduction of the statutory levy, there is likely to be a move to more NHS-commissioned services but that the services will be delivered by a range of providers, so it is anticipated that much of the existing expertise will be retained.

NECA (Charity Number 516516)	Guid eline	32	23 26	This implies that the NHS will be the only service to commission services and that all other services may therefore cease to be used unless NHS commissioned. This is not currently the position, and, in any case, this guideline was drawn up before any decision on funding has been made. (Currently out for consultation) How this will look is still awaited. This statement has the potential to cause distress and destabilisation of current treatment services that will affect individuals negatively and induce a barrier to care. We are unsure of this as the “new treatment services” in this statement are likely to be having to replace the existing service. In addition, as the “new services” are untested is it certain they would be cost effective? Indeed, it could be that they will not be successful at all – where is the evidence? We do not feel that this statement can be made.	Thank you for your comment. The guideline has been amended to clarify that in the planned reconfiguration of gambling services after the introduction of the statutory levy, there is likely to be a move to more NHS-commissioned services but that the services will be delivered by a range of providers, so it is anticipated that much of the existing expertise will be retained. The transition to the reconfigured services is likely to take some time and so the destabilisation of services will hopefully be minimised. The 'new services' refers to the NHS gambling clinics, although these have already been set up so this statement has been removed, and the impact now refers to the change to NHS-commissioned services.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	32	24	In respect of the mention of 'costs to the NHS…' OHID produced a cost report that could be referred to as a useful source of information, but it doesn't include a cost of gambling treatment https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1128002/The-economic-cost-of-gambling-related-harm-in-England_evidence-update-2023.pdf	Thank you for your comment. We have added relevant information on the estimated costs associated with gambling-related harms in the guideline context section. We would like to reassure you that the data in this report have been used to inform the guideline economic analysis.
GamCare	Guideline	33	001 - 017	Patient choice is an important component of treating addiction. For gambling harm, service users want autonomy and access to information, enabling them to make choices about support via the NGSN, NHS services, and organisations like Gamblers Anonymous. In the committee's recommendations, it is highlighted that factors such as a lack of awareness of available support, challenges in navigating support systems, fear and stigma, and worries about confidentiality could potentially deter individuals from accessing gambling treatment services.	Thank you for your comment. The guideline has been amended to clarify that in the planned reconfiguration of gambling services after the introduction of the statutory levy, there is likely to be a move to more NHS-commissioned treatment services but that the services will be delivered by a range of providers, and some support services will be provided by the voluntary sector. In addition a new section on referral and triage has been added to the guideline to enable people to reach the most appropriate level of support and treatment, and people will still be able to self-refer. The guideline already advises that services will need to support people with different need, for example women-only groups and culturally sensitive services.

				With this in mind, a singular treatment pathway into the NHS may inadvertently act as a barrier to support as individuals are unaware of different forms of treatment or have a preference to avoid a healthcare setting that they associate with stigma. Therefore, community-based treatment and support play a pivotal role in reducing barriers to accessing services while simultaneously enhancing client choice. The guideline does not adequately recognise that individuals experiencing gambling harms may require multiple periods of various types of support over the course of many years, particularly when experiencing relapse. Some minority communities exhibit lower levels of trust in NHS services. When coupled with the elevated levels of stigma associated with gambling harms, individuals from these communities may be less likely to seek help from the NHS.	

				Women with lived experience have shared instances of experiencing poor outcomes from NHS gambling services. These experiences have led to heightened stress and anxiety, contributing to the development of their gambling harms. In contrast, the NGSN providers are integrated into local communities. They engage in outreach activities to improve the accessibility of their services, for a more inclusive approach.	

GambleAware	Guideline	33	008 – 009	We agree that stigma may be worse for some groups of people, including migrants or people who are unfamiliar with NHS systems, and people from cultural backgrounds where gambling is prohibited. With this in mind, the NHS should not be the first or default point of access to treatment for gambling harms, as these groups also have a historical mistrust of the NHS. This risks further alienating these groups and acting as a barrier to their service access.	Thank you for your comment. The guideline has been amended to clarify that in the planned reconfiguration of gambling services after the introduction of the statutory levy, there is likely to be a move to more NHS-commissioned treatment services but that the services will be delivered by a range of providers, and some support services will be provided by the voluntary sector. In addition, a new section on referral and triage has been added to the guideline to enable people to reach the most appropriate level of support and treatment, and people will still be able to self-refer. The guideline already advises that services will need to support people with different need, for example women-only groups and culturally sensitive services.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	34	4	Refers to 'gambling addiction' - the guideline is not just focused on those with a gambling addiction, it is much broader. Suggest re-wording to say '…the stigma associate with their harmful gambling.'	Thank you for your comment. This wording is not present on this page of the guideline, so no changes have been made. In other places where addiction was mentioned the wording has been revised.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	34	7	Refers to 'gambling addiction' - the guideline is not just focused on those with a gambling addiction, it is much broader. Suggest re-wording to say '…co-ordinated manner alongside their harmful gambling.'	Thank you for your comment. This wording is not present on this page of the guideline, so no changes have been made. In other places where addiction was mentioned the wording has been revised.
GambleAware	Guideline	34	006 - 007	We are concerned that without appropriate reflection of the role of the NGSN and third sector, these recommendations will not increase access to and uptake of gambling treatment.	Thank you for your comment. The guideline has been changed considerably based on stakeholder feedback and so it is hoped that access will be improved when the guidelines are implemented.
GambleAware	Guideline	35	011 - 014	Competency criteria may be in development, but it is important to note that there is already a significant workforce of highly trained people, who are specialist gambling treatment practitioners working in services outside of the NHS. Their expertise must be retained in the future gambling harms treatment ecosystem, including if all treatment becomes commissioned by the NHS.	Thank you for your comment. The guideline has been amended to clarify that in the planned reconfiguration of gambling services after the introduction of the statutory levy, there is likely to be a move to more NHS-commissioned treatment services but that the services will be delivered by a range of providers, and so people already trained and competent may be retained where appropriate.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	36	2	Why the committee made the recommendations - Point 2- motivational interviewing is effective for addressing the underlying causes of offending or problematic behaviour. Staff who deliver accredited offending behaviours are trained in the principles and skills of MI. We need to ensure we are delivering a consistent narrative that MI is not about specific behaviours, but a way of working with people to understand their behavioural drivers and built rapport to support their desistance journey. Point 19- What is meant by behavioural therapy? Presumably not CBT as it is a separate point, and there is a wealth of evidence for CBT. Would be good to clarify what is meant here.	Thank you for your comment. The committee recommended motivational interviewing to be used in the way you suggest it is already used in the criminal justice system. Behavioural therapy is distinct from CBT. It usually includes some form of exposure, response prevention, and reinforcement, which might also be included in CBT but does not include the other elements of CBT, such as recognising negative thoughts and cognitive restructuring.

NECA (Charity Number 516516)	Guid eline	36	12	“Individual CBT is only cost effective in a public sector perspective.” This then says it could be offered. Surely this should be offered as this is patient choice or is the plan to restrict choice?	Thank you for your comment. We put a higher weight on the results of the economic analysis that adopted a public sector perspective when making recommendations (see also Evidence Review F, Appendix I, under Committee's discussion on 'Cost-effectiveness and resource use', where it is stated "The committee decided that economic results from a public sector perspective should be given a higher weight when formulating recommendations"). For this reason, there is a recommendation to offer individual CBT. Individual CBT is recommended when the person does not wish to join a group, or when group CBT is not possible or suitable, depending on individual needs, because group CBT was shown to be more cost-effective than individual CBT in the guideline economic analysis under both the NHS/PSS and the public sector perspective, and showed a higher effect versus no treatment in changing gambling symptom severity in the guideline NMA. We have now replaced ‘only’ by ‘also’ in the sentence to give a positive tone in the statement (as the previous statement might be misleading, implying that individual CBT should not be offered).

Royal College of Psychiatrists	Guideline	036 - 037	General	It was unclear what the extremely strong conclusions in this section were based on. If this is based on the network meta-analysis and/or health economic model it should be noted that it is not valid to compare studies with radically different control conditions, timelines, and methodologies, since this violates transitivity and other assumptions of network meta-analysis; and there have been virtually no independent high-quality health economic analyses of treatments in the UK. See points elsewhere about pervasive methodological issues with the included literature, which preclude any conclusions being drawn in this regard.	Thank you for your comment. Yes, the conclusions were based on the guideline NMA and economic analysis. This has now been clarified in the text. Moreover, we have now modified this section, to clarify that relative effects referred to the comparison of each active intervention versus no treatment. This is a valid comparison since the NMA adjusts for the different control conditions used in different studies. When conducting NMA, it is valid to include in the network studies with different control conditions, as long as these control conditions are not lumped together in one node but are classified in distinct homogeneous nodes. Indeed, one of the benefits of the NMA approach is that it can compare interventions that have not been directly compared with each other in head-to-head RCTs and/or have not all been compared against a common control condition. Including studies with different controls in a NMA does not violate the transitivity assumption, as long as the different controls are modelled as separate treatment nodes, because the different effects of different controls are then adjusted for in the analysis. We allocated controls to separate, clearly defined, homogeneous network nodes. Where the control was an active intervention, it was coded as such. Waiting list and no treatment were considered as separate controls, as they cannot be assumed to have the same effect (our analysis proved that, indeed, they do not have the same effect). Attention placebo was also assigned a separate node in the network. Regarding studies that used treatment as usual (TAU) as the control condition, when this involved an active intervention, then it was coded as such. There were only 3 studies in which the TAU control condition was coded as TAU in the network, forming an overall homogeneous group: 2 of them described TAU as information & referral to other services, and the other one described TAU (arm n=8) as ranging from no treatment to a variety of other treatments including counselling (see Table 3). Regarding timelines, NMA synthesised data collected at intended treatment endpoint (i.e. at the

					timepoint when treatment was completed) from all included RCTs, which ensured consistency and comparability of the data considered. All studies included in the NMA were RCTs assessing psychosocial therapies, and, overall, they adopted similar methodology. Therefore, the transitivity assumption was not violated regarding timelines and methodologies. We tried to minimise heterogeneity in the dataset by including a homogeneous population (adults with a clinical presentation of problem gambling according to DSM or a score on a commonly used symptom scale in all but one study, which included a population of adults at risk of or with probable problem gambling), classifying interventions (and controls) in distinct treatment classes according to common theoretical structure or hypothesized mechanism of action using the intervention descriptions in the papers, and selecting outcome data on frequency or on gambling symptom scale scores following the committee's expert advice. Regarding the economic evidence, due to very scarce published economic evidence, as part of the guideline development we constructed an (independent) economic model to assess the cost-effectiveness of psychosocial interventions for gambling that harms. Decision-analytic economic modelling is an entirely valid approach for assessing the cost-effectiveness of healthcare interventions (see, for example, Drummond et al., Methods for the Economic Evaluation of Health Care Programmes, 4th Edition, Oxford University Press 2015 (Chapter 9); Briggs et al., Decision Modelling for Health Economic Evaluation, Oxford University Press 2006). We have listed some of the benefits of economic modelling in our response to a related comment of yours. The guideline economic model was developed in consultation with the committee regarding the model structure, selection of clinical, epidemiological and cost data, and model assumptions. It incorporated cost data from two recent (2023) national reports (OHID and NIESR) (and therefore, in this aspect, it is directly applicable to the UK context) and used two different

					perspectives: NHS/PSS and public sector. Data were synthesised in a probabilistic analysis, which allowed for the uncertainty around model inputs to be considered and reflected in the results of the analysis. Further sensitivity analyses were conducted to explore the impact of the uncertainty around model inputs and assumptions and assumptions on the results. The guideline economic analysis had its strengths and limitations, which are reported within the economic modelling report (Evidence review F, Appendix I, Discussion). The cost-effectiveness results, the uncertainty around them, and the strengths and limitations of the model were considered by the committee when making recommendations, alongside effectiveness evidence and people's individual needs. Consideration of cost-effectiveness is a core element of NICE principles (please see https://www.nice.org.uk/about/who-we-are/our-principles Principle 7. Base our recommendations on an assessment of population benefits and value for money).

Royal College of Psychiatrists	Guideline	037 - 038	General	Naltrexone should also be available as a treatment option if a person does not wish for therapy or cannot tolerate it, and it is otherwise clinically indicated. At present the guideline would not allow naltrexone unless a person has been 'made' to do therapy, which goes against shared decision-making and patient choice.	Thank you for your comment. The committee decided that psychological therapy should be the preferred treatment and should always be offered first, in preference to an unlicensed medication with known side-effects. They therefore agreed to keep it as an alternative for certain groups but not to recommend it as an option for all people.
Royal College of Psychiatrists	Guideline	037 - 038	General	Nalmefene also has evidence of efficacy from available controlled studies. RCPsych would like to highlight recent evidence in support of nalmefene (with high confidence), based on network meta-analysis. See 'Pharmacological Management of Gambling Disorder: A Systematic Review and Network Meta-Analysis' by Ioannidis et al.: https://www.medrxiv.org/content/10.1101/2023.10.20.23297314v1	Thank you for your comment. You are correct that there was also evidence of benefit with nalmefene. However the doses used were far in excess of the licensed doses used in the UK, and the committee had no experience of its use and so decided not to include recommendations on its use in national guidance at this stage. The paper you reference includes all the evidence on nalmefene that the committee used to make the recommendations, and is also a pre-print that has not been reviewed yet and which includes the statement: 'This article is a preprint and has not been peer-reviewed. It reports new medical research that has yet to be evaluated and so should not be used to guide clinical practice.'

				As such it should be available as an option too, in addition to naltrexone being an option. Lack of prescribing experience on the NICE committee is not a reason to exclude this important medication since medics routinely learn to prescribe medications safely that they have not prescribed before. Similarly, a relatively higher dose than other conditions is not a prohibitive issue provided safety of those higher doses have been assessed in clinical trials – which they have been.	
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	39	16	Refers to Intervention for families and affected others. Family are usually included in the definition of affected others. Is there a specific reason why they have been mentioned explicitly?	Thank you for your comment. Discussions carried out as part of scoping for this guideline indicated that many people affected by other people's gambling may not understand the term 'affected other' and so the term was expanded to include families, to make this phrase understood by a wider audience.

NECA (Charity Number 516516)	Guideline & EIA	40	4 13	If elements re NHS are unchanged the document should state that the recommendations have the potential to de-stabilise the current treatment provision and potentially increase barriers to care and ease of access for individuals experiencing Gambling related harms. It would be most duplicitous not to accept that, as it stands, this guideline has the potential to cause harm. It is untested as it stands unless more inclusive of the current treatment process that accounts for 80-90% of the current individuals accessing care. Figure is out of date as we gather the figure is now 0.4%	Thank you for your comment. The guideline has been substantially amended based on stakeholder feedback and with the planned reconfiguration of gambling services and the introduction of NHS-commissioning from a number of providers, it is anticipated that the guideline will not cause harm, and that the planned implementation phase will not destabilise the service provision. The committee discussed that are a variety of figures available for the prevalence of harmful gambling but that the PHE (now OHID) figure of 0.5% quoted here agrees with the most recent Gambling Commission average from 2016 to 2023 (https://www.gamblingcommission.gov.uk/about-us/guide/page/gambling-behaviour-2015-to-2023-incidence-of-problem-gambling-short-form), so this has not been changed, although it has been noted that other pages on the Gambling Commission website quote figures of 0.4%.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	40	17	Insert text '…gambling with an elevated risk of harm …'	Thank you for your comment. This change to the wording has been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	40	19	Remove '' from around 'affected others' as they are referred to throughout the document	Thank you for your comment. This change to the punctuation has been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guid eline	40	20	Suggest adding additional statistics to this para given the 7% affected others figure covers both adults and children and young people (CYP). It seems odd not to include the figure of CYP who are experiencing harmful gambling. Suggested text - 'A 2022 study by the Gambling Commission estimated that 43,000 (0.9%) 11-16 year olds in Britain are experiencing 'problem gambling' with a further 114,000 (2.04%) gambling at levels of 'elevated risk' of harm.'	Thank you for your comment. As children and young people are not included in the scope of this guideline, more statistics about them have not been added.

Gambling with Lives	Guideline	40	024 - 025	It should be clarified that the 117 to 496 are additional suicides.	Thank you for your comment. The context states that these are deaths due to gambling. This seems a more meaningful way to express this statistic than 'additional suicides' as it may not be clear what this is in addition to.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	40	29	In reference to 'It may lead people into crime such as theft' it is important to note that it is debt that leads to the crime, not gambling itself. Suggest re-wording the sentence to 'gambling-related debt can lead people into crime such as theft.'	Thank you for your comment. Gambling may lead to theft to fund gambling activities, as well to deal with debt caused by gambling, so this sentence has been left open so it covers both these scenarios.
The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	41	003 - 004	This is not correct as most of the treatment for gambling harms currently remains outside the NHS.	Thank you for your comment. This has been corrected.

His Majesty's Prison and Probation Service (HMPPS)	Guid eline	41	6	7,8 & 9 There are also plans to move to a statutory levy on the gambling industry to fund research, prevention and treatment of gambling-related harm. This may result in an increase in the amount of NHS-provided and NHS commissioned services. This section will need to be updated to reflect the current situation re: funding that will go to NHS England to provide NHS commissioned services. HMPPS are working closely with NHS England, but it would also be helpful to set out here whether there will be a cross government board set up to decide what services need to be commissioned across the CJS. This will have a resource impact on HMPPS both in terms of staff time and the services to be commissioned and delivered. HMPPS would welcome this and use this to help inform the Gambling Operational framework that is currently in development.	Thank you for your comment. This section has been updated to reflect some recent planned changes following the introduction of the statutory levy. The detail of the commissioning arrangements are, however, not yet known, nor how this will impact on the criminal justice system.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	41	12	Amend sentence to read '…harmful gambling for treatment, with the majority of referrals into services being self-referrals.'	Thank you for your comment. This change has been made.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	41	14	Add in 'Treatment pathways are unclear and unknown by many, with limited, poor quality data to accurately assess outcomes. Current gaps in care include…'	Thank you for your comment. This has been added.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	41	025 - 027	This para is a little confusing and would benefit from some clarity. Suggested rewording '…takes an 'all harms approach' focussing on the needs of those participating in harmful gambling, as well as affected others impacted by gambling-related harms.'	Thank you for your comment. This sentence has been revised to make it clear.
Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	41	28	Clarity required around he term 'this group' as unclear who this refers to. Suggest ' …lack of evidence for interventions or support specifically for affected others' if this is correct.	Thank you for your comment. This sentence has been revised to make it clear.

NECA (Charity Number 516516)	Guideline	41	General	This document appears as a promotion of a new service and does not reflect existing provision or a reflection of how integration of existing Gambling Treatment and support services can bring a shared vision for reducing Gambling related Harms.	Thank you for your comment. The guideline has been amended based on stakeholder feedback to clarify that the proposed reconfiguration of gambling services is likely to include a move to more NHS-commissioned services but using a range of providers, and is likely to be implemented gradually so as to not de-stabilise the current support and treatment services.
NECA (Charity Number 516516)	Guideline	General	004 - General	Note: “People have the right to be involved in discussions and make informed decisions” (Does this needs to be reflected in the document? Treatment options should therefore be an informed choice for the individual)	Thank you for your comment. The guideline recommends that evidence-based treatments are 'offered' or 'considered' and people will always have the choice to accept or decline a treatment. The principles of discussing treatment options with people is accepted as good practice throughout the NHS and is not repeated in every guideline. However, links to the NICE guidelines on patient experience in adult NHS services, shared decision-making and service user experience in adult mental health where this is explained have now been included in the guideline.

Betknowmore UK	Guideline	General	General	Currently support for people experiencing gambling harms is provided through an integrated model of National Gambling Support Network (NGSN) providers and NHS clinics (plus Gamblers Anonymous). NGSN providers hold many decades of experience providing tailored, effective support for people, including people with complex and acute support needs. The NGSN is the largest scale provider of specialist services whose staff and volunteers, many with lived experience, hold considerable professional expertise, including certified therapists and counsellors, clinical supervisors and certified peer supporters. NGSN providers have learnt that one model does not fit all. The providers have innovated to provide evidence-based and effective clinical support, peer support, aftercare provision, support for affected others, and support for specific communities that would otherwise be reluctant to enter mainstream services. NGSN services have developed on the basis of academic research evidence (e.g. https://www.researchgate.net/publication/326331882_) and client outcomes data to provide holistic support that recognises the diverse and enduring harms gambling can cause. CBT approaches focus upon a client gaining control of gambling thoughts and behaviours, but NGSN providers know that this is just the beginning and they support clients to rebuild their relationships, careers, physical and mental health. Betknowmore UK was the first organisation in the	Thank you for your comment and for the information about current NGSN services and how they interact with other services. The guideline has been amended based on stakeholder feedback to clarify that the proposed reconfiguration of gambling services is likely to include a move to more NHS-commissioned services but using a range of providers, and is likely to be implemented gradually so as to not de-stabilise the current support and treatment services.

				UK to provide accredited Gambling Peer Support training to people with lived experience, first by NVQ and now assured by City & Guilds. Some NGSN organisations have been in operation since the 1970s, while the first NHS treatment clinic was only established in 2008. Despite this considerable wealth of experience and proven outcomes of reducing gambling harms, the Guideline makes no reference to the NGSN and its specialist services. The track record of the NGSN places it in an ideal position to remain a first point of contact, support and treatment, with high-risk clients with complex needs referred into NHS clinical services.	

Betknowmore UK	Guideline	General	General	The Guideline recommends that people with a PGSI score of 8 and above be directed to NHS specialist services. This is predicated on the assumption that the PGSI is a sufficient means to assess a client's level of gambling harms. The PGSI is not a robust clinical tool. It is currently used by the NGSN to largely assess the extent of a person's recovery, and it does not determine their support pathway. A person's PGSI, due to the nature of gambling highs and lows, can vary considerably from one week to another. The PGSI survey questions were designed to capture gambling harms over a 12 month period and their validity for shorter periods of time has not been tested. The tool also contains questions that can heighten feelings of stigma, contains self-report bias, was designed as a survey question in 2001 when gambling and gamblers were very different, is not appropriate for use with some minority groups, and cannot be applied to 'affected others'. Research by Samuelsson et al found "Several answers to the PGSI items contained ambiguities and misinterpretations, making it difficult to assess to what extent their answers actually indicated any problematic gambling over time" (https://doi.org/10.1177/1455072519829407). Members of our staff with lived experience have told us that even though they no longer gamble, they would still score above 8 on the PGSI because the questions are ambiguous. A more comprehensive way to establish the appropriate treatment pathway is by assessing risk, using a	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

				range of tools, including the Core-10, GAD-7 etc., and by explaining the range of support options available, thus respecting client choice. Betknowmore UK takes a minimum of an hour to comprehensively assess the gambling harms and support needs of clients, including an assessment of co-morbidities, safeguarding concerns and family/relationship context. The time that primary care and social services staff can spend with clients is severely restricted, and over reliance on the PGSI will lead to poorly tailored treatment and support, risking increased levels of drop-out and relapse. The reliance on the PGSI to classify clients also risks over-pathologising people experiencing gambling harms, further increasing the shame and stigma they feel. Led by the lived experience community, over recent years there has been a significant and hard-won shift away from labelling people as 'problem gamblers'. The Guideline risks reversing this progress.	

Betknowmore UK	Guideline	General	General	Our service users tell us that they want the freedom and information to choose between NGSN services, NHS services and organisations such as Gamblers Anonymous. All these services offer considerable expertise that should not be undervalued or lost. One of our volunteers with lived experience commented: “Third sector also use lived experience, there is nothing more powerful than being around individuals who have walked in your shoes and get you with true empathy! This allowed me to build up trust quicker, open up and learn! Therapist can learn from a textbook but life experience far outweighs this. I was offered multiple pathways to recovery, not a one size fits all approach, and having choices and options worked a lot better for me than being told where to go”. Patient/client choice should be protected and enhanced, rather than diminished. The Guideline as it is currently drafted will reduce client choice and risks people avoiding treatment services altogether rather than being stigmatised as ‘problem gamblers’ and referred to NHS clinics. Community-based treatment and support can act to reduce barriers to accessing services, as well as enhancing client choice. A service user told us that if she had been referred to NHS services “I would have been very anxious and worried this possibly made me want to avoid any help whilst in active addiction, in the early days I was very aware that I needed to be careful who I trusted”. The Guideline also ignores the high relapse rates evident across all addictions	Thank you for your comment. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will be delivered by a variety of providers. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition. Self-referral will remain an option.

				and that people experiencing gambling harms may require numerous periods of varying types of support over many years. Flexibility, choice and short waiting times are key to ensuring effective treatment, support and prevention.	

Betknowmore UK	Guideline	General	General	The Guideline is not sufficiently evidence based with regard to outcomes. There is no evidence that CBT is sufficient or effective in treating complex cases where harms are multiple and persistent. CBT focuses upon control of gambling thoughts and behaviours and does not address the diverse, enduring harms that gambling can cause. One model does not fit all. One of our volunteers with lived experience told us: “I was 8+ but had no immediate clinical need, my need was criminal justice support, debt, connection, not feeling isolated, family advice and rebuilding relationships - this was not a clinical diagnosis [that was] required, it was more long term ongoing support as opposed to 6 sessions (gambling harm doesn't stop when you've stopped gambling)”. Increasingly trauma-informed approached are being recognised as having the potential to reduce harms. Many of our clients, including those with PGSI scores of 8+, tell is that the most effective support they received was provided by other people with lived experience, diminishing their shame and building their hope. Betknowmore UK provides City & Guilds assured training to people with lived experience so that they can provide this peer support, and our outcomes data prove how effective peer support can be, including to those who initially had high PGSI scores.	Thank you for your comment. The committee decided that a wide range of support and advice is needed and this is recommended in the guideline, including advice on the topics you have mentioned, including peer support. However, the most cost-effective intervention for reducing gambling severity was group CBT, with individual CBT as an alternative. When delivering this, a competent practitioner would adapt the content to meet the specific background and needs of the person. The use of PGSI as a cut off score as the sole determinant of treatment has been removed and replaced with a new section on referral and triage.

Betknowmore UK	Guideline	General	General	The Guideline ignores the existing waiting times to access treatment NHS gambling treatment services and an average 2 week wait time to even see a GP. Currently clients referred to Betknowmore UK will be seen within 2 days, and wait times across the NGSN are low, compared to those of NHS services. Should all those people with PGSI scores of 8 and above be referred to NHS specialist clinics, waiting lists can be expected to grow rapidly and levels of risk will become unacceptable. The Guideline also ignores that the NHS is a strong and much-loved brand and yet the service is widely recognised to be in crisis with long waiting times for GPs, at A&E, for ambulances, tests, results, surgical procedures etc. The Guideline risks people avoiding seeking support for fear of putting more pressure on NHS services, as well as fearing long waiting times. Our service users commented: “I view gambling specific charities as experts in their field, whereas the NHS already have a negative reputation in terms of waiting times and inability to manage current work load etc.”; “I would have worried about waiting times and booking holiday off work, worried about what people thought as they wouldn't understand if they didn't have lived experience”; “I would be okay if that support was available to me, but my concern initially would be how long do I have to wait for treatment to begin, NHS waiting times are long and what capacity can they have, who would support me during the waiting period”; “My first thought would be what is	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. Following the planned reconfiguration of services after the introduction of the statutory levy there will be a move to NHS-commissioned gambling treatment services but it is likely that these will be delivered by a range of providers. In addition, a new section on referral and triage has been added to the guideline to enable people to reach the most appropriate level of support and treatment, and people will still be able to self-refer, so services will not only be accessible via a GP or other practitioner referral.

				the NHS going to do with this information and how would they be able to support me when they are so busy. I also think I could feel let down if they had a ridiculously long waiting list"; and "I might have been concerned with the fact the NHS is viewed as a health organisation, I don't think at the time I saw it as a "health" problem, which may have scared me off".	

Betknowmore UK	Guideline	General	General	NICE is required to ensure that all its guidelines consider value for money. This has not been considered in the current Guideline and its recommendations are not based on the evidence. NHS treatment clinics offer less cost-effective services than NGSN providers. The NHS gambling clinics are due to cost at least £2000 per referral. https://hansard.parliament.uk/lords/2022-03-28/debates/8769891E-1F28-4D3B-9596-B930877F8B1A/NHSGamblingTreatmentServices says their running costs will be £6 million/year (excluding set up costs), and the clinics plan to treat up to 3000 people per year. In comparison, NGSN provider costs are much lower. The average cost of Betknowmore UK's support provision per client is half that of the NHS and is expected to fall rapidly as our services expand. For the overwhelming majority, the NHS core treatment option is 8-10 hours of group CBT. Depending on which part of the country you're in, £2,000/head for group CBT, is between 200% and 400% of the cost that you can buy group CBT for privately. Even in London it would cost less to buy everyone 8-10 hours of individual CBT or even full individual psychotherapy privately. The Guideline recommendations do not present value for money, indeed they are hugely cost inefficient, and thus will mean fewer people are treated and fewer people recover.	Thank you for your comment. We have considered the value for money of the NHS commissioned services when developing the guideline; these services may be provided by a number of different providers. A cost-effective service is not necessarily the least costly service, but a service where additional benefits (and potential future cost-savings) outweigh additional provision costs, compared with current care according to the NICE cost-effectiveness thresholds. The figure of £2,000 per referral has been an estimate calculated by dividing the current annual funding of £6 million allocated to the NHS specialist gambling clinics by the number of 3,000 patients a year that are planned by NHS to be treated across these clinics. The committee were aware that there will be a transition period as services for gambling treatment and support are reconfigured. The running costs will cover assessment as well as provision of ongoing treatment and support for people experiencing gambling that harms and affected others, and not solely the cost of a group CBT course. The estimated average cost per person receiving group CBT has not taken into account other aspects of care including assessment, treatment and support as well as follow-up and aftercare, and the fact that some people will require alternative or additional treatment with motivational interviewing, individual CBT, or medication. The comparison between NHS clinics and the NGSN provider costs do not take into account what type of care is provided in each setting (including assessment, support, treatment and aftercare), by whom (specialist or not), and the outcomes expected to be achieved in each setting. Moreover, the cost estimate of £2000 per referral is based on current NHS provision of 15 specialist gambling clinics and does not take into account the fact that NHS is planned to commission gambling treatment and gambling support services, which may be provided by a range of providers, including the NHS or the voluntary and charity sector. The introduction of the statutory levy (which is expected to raise approximately £90-100 million annually by 2027 –

					see Government response to the consultation on the structure, distribution and governance of the statutory levy on gambling operators - GOV.UK) is likely to increase the funding available to spend on gambling support and treatment services commissioned by the NHS and a significant reconfiguration of services is expected, to meet different levels of need. It is anticipated that the guideline will take a period of time to implement fully. As there is currently largely unmet need for these services (according to OHID figures on treatment needs: https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates/gambling-treatment-need-and-support-in-england-main-findings-and-methodology) and the financial and social costs associated with gambling-related harms are very high (according to OHID figures https://assets.publishing.service.gov.uk/media/63bc25b4d3bf7f262c5ad31f/The-economic-cost-of-gambling-related-harm-in-England_evidence-update-2023.pdf and NIESR figures https://www.niesr.ac.uk/wp-content/uploads/2023/04/The-Fiscal-Costs-and-Benefits-of-Problem-Gambling.pdf), it is anticipated that expanded, NHS commissioned, gambling treatment and gambling support services will gradually cover a larger part of the population needs, resulting in benefits and cost-savings that are likely to offset, at least partially, the high costs associated with gambling-related harms. The resource implications of the guideline are being considered, and are likely to be substantial, involving setting up new services, reconfiguring existing services and transferring current staff or services from other providers into NHS-commissioned services.

Betknowmore UK	Guideline	General	General	The Guideline ignores the poor health outcomes that some population groups achieve through NHS services. Some minority communities have poor levels of trust in NHS services and, when combined with high levels of shame and stigma associated with gambling harms, they are unlikely to seek NHS help for gambling harms due to such barriers. Women with lived experience have told us of their poor health outcomes from NHS services, causing them stress and anxiety that have contributed to the development of their gambling harms. These women would not be willing to access NHS gambling treatment services. In contrast NGSN providers are embedded in their local communities and conduct outreach activities to make their services as accessible as possible. One service user commented: “Both of the community-based sessions have been really beneficial to me, both of the people I have spoken to have been really helpful in getting me to understand my addiction and ways to manage and control my urges”.	Thank you for your comment. The guideline has been amended based on stakeholder feedback to clarify that the proposed reconfiguration of gambling services is likely to include a move to more NHS-commissioned services but using a range of providers. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition. Self-referral will remain an option. . Women have already been highlighted in guideline as a group who may need particular support to access services.

Betknowmore UK	Guideline	General	General	While acknowledging that gambling harms impact on people other than the person gambling, the support needs of these 'affected others' are not addressed in sufficient depth in the Guideline. Affected others tell us that they feel that their needs are an afterthought, and this impression is reinforced by the Guideline.	Thank you for your comment. The recommendations in the majority of the guideline apply to all people experiencing gambling-related harms, whether they are gambling themselves or as an affected other, and this is stated in the recommendations for affected others. There was no evidence that met the protocol criteria for specific interventions to reduce gambling-related harms for affected others and so the committee made a research recommendation.

The Hurley NHS GP Partnership (Primary Care Gambling Service)	Guideline	General	General	The Primary Gambling Service led by Dame Professor Clare Gerada is in a very different position to that of the NHS Specialist Clinics inasmuch we are an NHS GP Partnership and our funding comes directly from GambleAware. We are an active member of the National Gambling Support Network (NGSN) and support this system wide approach. As such we have concern as to direction these guidelines are taking. Throughout these guidelines it reads that the care for people experiencing gambling harms is predominantly through the lens of the specialist NHS services with no real definition around what NHS commissioned services means, particularly, in relation to well established third sector organisations.	Thank you for your comment. The guideline has been amended based on stakeholder feedback to clarify that the proposed reconfiguration of gambling services is likely to include a move to more NHS-commissioned services but using a range of providers, and there will therefore be a choice of services for people to access, including the voluntary sector. A new section on referral and triage has been added to help ensure that people are directed to the appropriate level of service and this may include the NHS gambling clinics.

				There is a sense that this guidance has been written to ensure that patients reach the 15 NHS specialist clinics, but it does not help the users of the guideline or the patients themselves to understand how they will get there. The "currency" in the guideline should be the patients, not the clinics.	
				There needs to be some reflection on how important the third sector and the community is to those experiencing gambling harms and the important role it plays in connecting with patients who initially do not see they are even ill. If we expect the patient to reach these treatment clinics it must be recognised that their journey begins in the community via providers that are accessible in their local communities and have the relatable "lived experience" voice within them. This is the first step into the treatment pathway. For the guidelines to be of benefit to those experiencing gambling harms the aim should be for them to encompass the use of the whole system. There must be a focus on collaboration between healthcare professionals, people with	

				lived experience and their families and the statutory and voluntary sector providers. Only then will we see an improvement in the delivery of gambling treatment in this country.	

Gambling with Lives	Guideline	General	General		This comment has been redacted. The subject of the comment (Composition of the committee – conflicts of interest) is addressed in our response to a comment on the same subject from another stakeholder (Royal College of Psychiatrists).

Gambling with Lives	Guideline	General	General	Stigmatising Language At Gambling with Lives (GwL) we are very concerned about how language is used in the guideline. Descriptors of gambling in themselves both reflect and reinforce stigmatising attitudes. GwL beneficiaries who are bereaved by gambling related suicide provide testimony that the stigmatisation of people experiencing gambling harms was a significant factor in the completed suicides of their family members.	Thank you for your comment which has been edited. The committee has worked hard to avoid stigmatising language throughout the guideline and uses language such as 'people experiencing gambling that harms or gambling-related harms' instead of language such as 'problem gambler'. This was agreed by the committee to define a level of gambling that is causing harm and so define the population of the guideline, and is also used to define those who are affected others. However, the guideline has been reviewed and in a number of places language has been modified to use just 'gambling' or 'gambling harm' as you suggest to try and reduce any inference of blame or stigma, including in the recommendations you give as examples. The guideline also has specific recommendations to raise awareness of potential stigma and the need to avoid it. The recommendations on information advise the provision of information on the harms of gambling products.

				Suicide notes also provide evidence that suicidal ideation is partly a result of lack of understanding that harm from gambling is primarily caused by wide availability and marketing of dangerous products that harm mental health. There is a danger that the guidelines reinforce the attitude that the individual alone is responsible for the harm that is suffered both to themselves and to others. We note that the importance of language is acknowledged in the guideline (1.4.3): “To lessen the impact of stigma and to support access to treatment: use a person-centred, empathetic, non-judgemental approach” and we welcome the well-meaning attempts to mitigate stigma. However, the use of terms noted below to describe gambling that harms is both stigmatising and inconsistent and there is a danger that the opportunity to guide healthcare professionals (HCPs) and others to use language that does not reinforce harm could be missed.	

				The term “harmful gambling” is very similar to “problem gambling” and is used 123 times throughout the guideline. The term “harmful gambling” can easily be transferred to “harmful gambler” and applied to the individual rather than harmful gambling products and prolonged use encouraged by predatory marketing. In the guideline the rationale for interchanging “people experiencing harmful gambling” and “people experiencing gambling harm” is unclear and inconsistent and often locates responsibility for the harm caused in the person gambling as opposed to understanding that products and marketing cause addiction, increased activity, and relapse. For example, the use of the term “harmful gambling” in: 1.2.3 “Provide unbiased information to people who are affected by the harmful gambling of family members” 1.7.2 “Harmful gambling of someone close [to an affected other]”	

				The use of the term in these instances reinforces the idea that the harm to an affected other is being caused by the family member. Given the high rates of suicidal ideation, attempts and completion this is particularly dangerous and could give rise to stigmatising comments by HCPs that increase stigma, guilt and inappropriate sense of responsibility and may lead to completed suicide.	

				We recommend that all instances of “harmful gambling” are replaced by “gambling” or “gambling harm”, depending on the context, and that neutral, people centred language such as “person/ persons harmed by gambling” is used throughout the guideline.	
Gambling with Lives	Guideline	General	General	Failure to include adequate recommendations on the provision of complete information We are concerned that the recommendations on the provision of information are limited and may be inconsistent with the qualitative evidence provided on the information valued by people experiencing gambling harm and affected others.	Thank you for your comment. The recommendations on the provision of information already include advice on how different gambling products may be more addictive than others, and they have been amended based on stakeholder feedback to include more detail on the activities of the gambling industry. You have referred to lack of inclusive information throughout the guideline but the guideline aims not to be repetitive so we would not repeat the information about products or gambling industry activities in multiple places. This section of the guideline on information is for all providers of gambling treatment and support services so it is not just for specialised services as you suggest. The recommendation on initial support does already suggest that advice on gambling-related harms is given to people and includes a cross-reference to the more detailed section

				We welcome and below quote at length below the section on why the Committee made the recommendations on 1.2.1 to 1.2.5 and but we are concerned that this evidence is not reflected adequately in the guideline recommendations. We are concerned that the omission of many references to the provision of information about a serious health condition may result from untested assumptions in both the Committee and in NICE. It is possible that the lack of reference to inclusive information throughout the guideline is a result of the failure in the industry-funded organisations referenced in our first comment to provide information on gambling products and predatory commercial marketing to patients and clients. It is also possible that this kind of information is perceived by the NICE organisation as only relevant to public health prevention interventions designed to reduce the uptake of gambling and therefore not in scope within a diagnostic and treatment guideline (as referenced in the context section).	on information, again to avoid large sections of the guideline being repetitive. The recommendations on suicide risk have been amended to advise that people should be told about the link between gambling and suicide. However, as stated before, NICE guidelines aim to be concise documents that are considered as a whole, and therefore the risk of suicide would be stated once but not repeated throughout the guideline.

				We suggest that it is normal medical practice to provide patients with clear complete up to date information about a health condition, related dangers, and possible remedies, indeed it is considered unethical not to do so. Therefore, we suggest that the mention of complete information in only one section of the guideline and restricted only to specialist treatment providers is subject to question. For example, it is normal ethical practice to provide information to a patient presenting to an HCP with a cough about tobacco, harm to health and addiction and the possible link between smoking and presenting symptoms. We suggest that ethical practice demands that on presentation of symptoms possibly caused by gambling (e.g., insomnia and anxiety) HCPs should not only screen for gambling but also provide information that gambling is addictive, some forms of gambling are more addictive than others and that there can be harm to mental health including suicidal ideation.	

				There is widespread public lack of information and misunderstanding of the addictive qualities of gambling, differences in gambling products and the effect of intensive gambling on the brain. This is partly driven by the normalisation of gambling through massive spend on advertising and personal marketing but also by stigmatising tropes promoted by the gambling industry to limit responsibility for promotion of products causing harm to health. Given the strength of the evidence below in a guideline where evidence is very limited, it is inconsistent to restrict recommendations on information provision to specialist gambling providers. It is also not clear why information on products and causes of gambling harms is not included in 1.1.7. 1.2.1 – 1.2.5 why the Committee made the recommendations:	

				"There was evidence from the qualitative reviews on access and what works best that people who experience gambling-related harms were not always aware of the addictive nature of gambling and what induced them to gamble. Nor did they understand the different types of gambling and the harm they caused … This information would help people understand that the harms they are experiencing due to gambling are not their fault, and that help and support is available to reduce these harm" "People experiencing gambling-related harms expressed a preference for accessing information in a variety of ways … They also valued access to information through other routes in the community, such as their workplace … [and] that it needs to be more widely promoted by providers of gambling treatment services through a variety of health and social care services and in the community [including] in all health and social care settings, in the criminal justice system and through other external institutions."	

				Considering the strength of evidence of need, normal ethical practice, widespread misinformation and consequent stigmatisation and prejudice, it seems extremely inappropriate not to reference the provision of complete health information (including harmful products) connected to a serious life-threatening condition throughout the guideline.	

				We also suggest that the risk of suicide connected to gambling is well documented and is identified in the recent National Suicide Prevention Strategy as a dominant risk factor "without which the suicide may not have occurred". While we welcome the mention of suicides in the guidelines, it is essential that HCPs and the public are provided with full information about the link between suicidal ideation and gambling to promote an understanding that suicidal ideation can be caused by gambling and is not necessarily a separate co-morbidity. It is the experience of Gambling with Lives, through our engagement with bereaved families and hundreds of gamblers in recovery, that most people with gambling disorder have had serious suicidal thoughts and many have attempted suicide. This is further supported by numerous research studies (1).	

				Following the inquest into the death of GwL co-founders' son Jack Ritchie, who died in 2017, the coroner stated that the provision of information at the time of Jack's death was "woefully inadequate" and issued a prevention of future deaths report to multiple government departments. In the report, he stated: "That in the time since Jack's death, whilst there have been improvements made in the areas of warnings, information, training and treatment, the evidence showed there were still significant gaps in these areas. "One notable gap was the fact that evidence suggested GPs currently have insufficient training and knowledge to deal effectively with gambling problems. This was of particular concern given many gamblers affected are likely to contact a GP as their first attempt to seek help." We recommend that a requirement for information about the harm to mental health from addictive gambling products and information about addictive qualities of different gambling products should be provided throughout the guideline.	

				We also recommend that information about the link between gambling and suicidal ideation is given as essential information in section 1.1.10 and that the risk of suicide is included throughout the guideline. References https://pubmed.ncbi.nlm.nih.gov/36387006/	
Gambling with Lives	Guideline	General	General	Severity Throughout the guidelines (see 1.1.6 for example), it is recommended that people scoring 8 or above on the Problem Gambling Severity Index (PGSI) may need specialist treatment. We understand that the PGSI is used as an indicator as part of a holistic health assessment by HCPs. However, we are concerned that 8 may be too high and too crude a marker for this purpose.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

				There is a risk therefore that if the PGSI is administered to determine if somebody requires treatment, it could mis-diagnose someone if it is conducted during a period of low gambling activity or an attempt at abstinence.	
				Lived experience also provides examples of very rapid onset of gambling disorder. For most families, gambling disorder set in after weeks and months, rather than years, with some cases much more rapid. For example – one young man known to GwL who died by gambling-related suicide died just 12 days after placing his first bet. References https://www.ncpgambling.org/wp-content/uploads/2014/08/DSM-5-Diagnostic-Criteria-Gambling-Disorder.pdf	

Gambling with Lives	Guideline	General	General	Training We welcome the inclusion of training requirements for staff offering support and treatment for gambling harms. However, given the widespread lack of understanding of the effects on the brain and differential addictive qualities of different gambling products we suggest that it is essential to specify that HCPs are provided with adequate information on gambling products so that they can both understand the causes of addiction and provide information and help to people seeking to recover and prevent relapse.	Thank you for your comment. NICE guidelines do not generally provide detailed recommendations on the training needed to implement guidelines but instead advise what level of service should be provided, and that this should be provided by competent staff. However we will pass this suggestion to the NICE implementation team to consider when support activity is being planned. The link between gambling and suicide has now been added to the guideline where you suggest but this would not be repeated multiple times throughout the guideline.

				The risk of suicide connected to gambling is well documented and is identified in the recent National Suicide Prevention Strategy as a dominant risk factor “without which the suicide may not have occurred”. Considering this, we are also concerned that there are only 12 references in the draft guidelines. It is essential that HCPs and the public are provided with information about the link between suicidal ideation and gambling to promote an understanding that suicidal ideation can be caused by gambling and is not necessarily the result of a concurrent co-morbidity. It is our recommendation that information about the link between gambling and suicidal ideation is given as essential information in section 1.1.10 and that the risk of suicide is included more pertinently throughout the guideline.	

Gambling with Lives	Guideline	General	General	Separation of clinical and public health guidelines We understand that this is a policy decision by NICE which may prove useful for many health conditions. However, it creates significant drawbacks when delivering a comprehensive guideline for health conditions created by largescale health harming industries marketing products that pose a significant danger to health. The exclusion of a public health framework inevitably leads to a focus on purely individual remedial action (1). There is a danger therefore that the guideline itself reinforces the individual responsibility narrative promoted by the very industry creating and benefiting from the harm. We recognise the attempts to mitigate this problem but in the absence of a public health guideline for gambling harms we believe that the danger should be recognised within the guideline.	Thank you for your comment. Public health interventions to reduce gambling were, as you state, not within the scope of this guideline which focuses on the treatment of people who are affected by gambling-related harms. There are likely to be people who need support and treatment even if (or when) comprehensive public health initiatives are in place and so this guideline still has a valuable role to play in ensuring people have help, support and treatment and so do not reach crisis point. The commercial determinants of harm were therefore also not included in the scope, and so no evidence review was carried out to identify them, but the committee did make recommendations on the activities of the gambling industry, the addictive nature of their products, and the use of money management, blocking tools and the role of advertising and marketing, based on their knowledge and experience. However, these would not be repeated throughout the guideline. As the committee did not look for evidence on the role of commercial determinants it was not possible to make a research recommendation.

				We note that here is nothing about the commercial determinants of harm and the impact on an individual's health of the social and economic factors of business practices. This is particularly unhelpful when considering the risk of relapse – for example, there is no research or mention of the role of marketing and advertising in triggering relapse or use of tools to prevent relapse. Even though these may be seen as public health issues, we suggest that clinicians often provide advice based on public health prevention measures about changes to habit including money management, avoiding advertising/marketing, implementing blocking. We welcome the brief mention in sections 1.6.2 and 1.7 and suggest a research recommendation to improve knowledge and subsequent advice. References HYPERLINK "https://www.sciencedirect.com/science/article/abs/pii/S0140673623000120"https://www.sciencedirect.com/science/article/abs/pii/S0140673623000120	

Gambling with Lives	Guideline	General	General	Churn We are concerned that the presentation of gambling disorder throughout the guidelines is fairly static, particularly in relation to research. For example, on page 40 it is not acknowledged that statistics represent evidence taken at a snapshot in time: there is good evidence that there is a 'churn' between categories – today's "medium risk" gamblers are tomorrow's "problem gamblers" (1). Therefore, we recommend that, as a minimum, the guidelines suggest that clinicians should be aware that presentation of people is not static but subject to frequent change and that presentation may be more frequent than the static position might suggest. The references to "relapse" appear to exclude understanding that the state of being in "remission" is still potentially a clinically significant position. https://www.bmj.com/content/365/bmj.l1807	Thank you for your comment. The statistics on page 40 refer to data taken from a particular public health report so it is clear that these relate (as do most statistics like this) to a snapshot in time, so this has not been added. Additional wording has been added to the new section on referral and triage to clarify that the severity of gambling harms and the level of need may change over time. The section on relapse already acknowledges that relapse in people 'in remission' is a particularly distressing and potentially dangerous time.

Gambling with Lives	Guideline	General	General	Practical tools Although they are mentioned at points, which we welcome, we believe that blocking tools and other practical measures should feature more prominently throughout the guidelines – see page 28 of the draft guidelines for example, and our comment numbers 22 and 23.	Thank you for your comment. The blocking tools are mentioned in the sections of the guideline on initial support and relapse so these would not be repeated multiple times throughout the guideline.

Parkinson's UK	Guideline	General	General	We welcome these guidelines for the identification, assessment and management of harmful gambling. We also welcome the recognition that people with Parkinson's are at risk of harmful gambling due to the medications that they take. However, due to potential differences in how people with Parkinson's who experience harmful gambling are managed in clinical practice, we would recommend that there is a dedicated section within the guidelines that is specific to harmful gambling in people with Parkinson's. In this respect, the recommendations (Skelly, R. (2020). Gambling Addiction and Parkinson's disease - supporting better patient care. Royal College of Physicians. Accessed online 15 Nov 23 at https://www.rcplondon.ac.uk/news/gambling-addiction-and-parkinson-s-disease-supporting-better-patient-care) may include Undertaking a careful risk assessment with an understanding of the risk factors present in Parkinson's: Young age at onset Male Sex Smoking	Thank you for your comment. The committee have included a link to the NICE guideline on Parkinson's disease which includes advice on managing and monitoring impulse control disorders as an adverse effect of dopaminergic therapy. However, the committee did not look at the evidence for risk assessment or management in the specific population of people with Parkinson's disease, and so have not been able to include separate recommendations for this group.

				Family or personal history of alcohol misuse Family history of problem gambling, novelty seeking behaviour and drug-induced mania Review of medication by a clinician if problem gambling is detected. Use of nurse-therapist (psychotherapist nurses who specialise in addressing mental health issues) led cognitive behaviour therapy. Follow-up with continued screening using validated screening tools such as the questionnaire for impulsive compulsive disorders in Parkinson's disease (QUIP) (Weintraub, D., Hoops, S., Shea, J. A., Lyons, K. E., Pahwa, R., Driver-Dunckley, E. D., Adler, C. H., Potenza, M. N., Miyasaki, J., Siderowf, A. D., Duda, J. E., Hurtig, H. I., Colcher, A., Horn, S. S., Stern, M. B., & Voon, V. (2009). Validation of the questionnaire for impulsive-compulsive disorders in Parkinson's disease. Movement disorders: Official Journal of the Movement Disorder Society, 24(10), 1461–1467. https://doi.org/10.1002/mds.22571).	

				Provision of written information on impulse control disorders. Dissemination of oral advice to a person with Parkinson's in the presence of a family member who can monitor the emergence of abnormal behaviours. Written advice to the patient with a copy sent to the GP. Emphasis on support and reduction of stigma. Information on stimulus control and environmental protections.	
Gordon Moody	Guideline	General	General	We understand that the NICE guidelines are designed mainly to guide the NHS-commissioned services practice, but in a sector where the vast majority of services are not delivered or commissioned by NHS, the guidelines fall short of offering a platform for developing an inclusive approach to identification, assessment and management of gambling related harms.	Thank you for your comment. The planned reconfiguration of gambling services following the introduction of the statutory levy is likely to move commissioning to the NHS but the services will be delivered by a variety of providers, to ensure there is an inclusive approach to treatment.

Gordon Moody	Guideline	General	General	We believe that in the absence of research evidence-base to inform recommendations, more emphasis could have been placed on introducing practice-based evidence offered through more than 50 years of experience of both NHS services and third-sector treatment providers as well as showcasing the voice of people with lived experience.	Thank you for your comment. The majority of committee members have experience of delivering gambling treatment services in a variety of settings, as well as lay members with lived experience so their views were taken into account in the development of the guideline. However, the committee were disappointed, as you state, with the lack of peer-reviewed published evidence available on the outcomes of treatments or the methods of delivering services. In addition to the committee the consultation of this guideline has taken into account a large number of suggestions from those currently involved in delivering services.
Gordon Moody	Guideline	General	General	No recommendation was made in regard to independent regulation of the treatment services (such as CQC), which can leave the system vulnerable in terms of quality assurance processes	Thank you for your comment. Following the planned reconfiguration of services and the move to NHS-commissioning, services will be subject to the same clinical governance requirements as other NHS commissioned services.

Gordon Moody	Guideline	General	General	Throughout the consultation document, the NHS-commissioned services are described as the specialist gambling services. We would like to mention that the third sector services have significant experience in delivering gambling specific services and should also be considered “specialist services”.	Thank you for your comment. The guideline has been amended based on stakeholder feedback to clarify that treatment services will not just be delivered by the NHS gambling clinics. Following the introduction of the statutory levy and the planned reconfiguration of gambling treatment services is it likely that more services will be NHS-commissioned but that they will be delivered by a range of providers, including the third sector. A new section on referral and triage has also been added to the guideline to help ensure people reach the appropriate level of service dependent on their needs.
				The formulation implies a unidirectional referral pathway with NHS supporting those most affected by gambling related harm. This is hardly the case, with referrals usually going in both directions, evermore so as NHS is not delivering Tier 4 residential gambling services.	

Gordon Moody	Guideline	General	General	We support all of the research recommendations made by the committee but would like to add further recommendations based on our experience working directly with those most affected by gambling harm. We recognise that populations who may be particularly vulnerable to gambling harm are those who also experience the greatest barriers to treatment. Therefore, research into how to reduce barriers for those from BAME and LGBTQ+ communities in accessing treatment is vital. Furthermore, experiences that may shape the development of gambling harm are under-researched. We suggest that the role of trauma and adverse childhood experiences may be a key factor in the development of gambling addiction, much like the development of alcohol and drug addictions.	Thank you for your comment. There is already a research recommendation exactly as you describe: 'What is the effectiveness and cost-effectiveness of interventions or approaches designed to improve access to gambling treatment services for people from under-represented groups who are experiencing gambling-related harms?' as no evidence was identified on improving access for people from the LGBTQ+ community. This research could also include improving access for BAME communities, as you also suggest. The committee looked for evidence for factors that increase the risk of harmful gambling and identified a number of risk factors including PTSD and other mental health conditions, so they did not make a research recommendation on the role of trauma and adverse childhood experiences. Thank you for telling us about your forthcoming research into residential treatment. As the committee found no evidence for residential treatment they have already included this in their research recommendations on psychological treatments (see appendix K of evidence review F). There are also already research recommendations on treatment for affected others and tools for measuring gambling harms. The committee did not look for evidence on the other topics you list in your comment, such as epidemiological and prevalence studies, gaming, loot boxes or social media research so have not been able to make research recommendations on these topics.

				We also believe that more research is needed in evaluating the efficacy of residential treatment. We are evaluating our treatment services and plan to publish these in 2024, but further research showing the benefit of these treatment services for people suffering from gambling harm as well as randomised controlled trials evidencing the most effective length and structure of residential treatment would be highly valuable. Other research recommendations: How to encourage people from BAME communities, who are at higher risk of gambling harm (Levy, O'Driscoll & Sweet, 2021), to access treatment. The role of trauma and adverse childhood experiences in the development of gambling addiction. Many people who suffer from gambling harm, particularly women, have experienced childhood trauma and/or adverse childhood experiences (including poverty, domestic violence and racism). The role of trauma and adverse childhood events in developing gambling addiction is not clear and requires further research.	

				Research is poor in the UK regarding affected others. At Gordon Moody we are committed to delivering our initiatives and services with a foundation of knowledge from research and evidence-based data. We would like to see more specific recommendations regarding affected others specific research. Epidemiological and prevalence studies to fully understand the extent of the impact of gambling related harms and the need for support and treatment Methods and tools for measuring gambling harm impact and societal costs Public health studies Game design and patterns of play impact of advertising Social media research using machine learning Loot boxes and their relationship with gambling Gaming and its relationship with gambling The emergence of e-sports and its impact of gambling related harms	

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	General	General	Language relating to drug and alcohol dependence is inconsistent throughout the document, and on occasion could be seen as stigmatising by the drug and alcohol treatment community, as well as public health stakeholders. Examples of reference to '[drug and alcohol] addictions' (page 4 ,27, 35), 'alcohol misuse' or 'substance misuse' (page 4, 11) and 'alcohol and drug abuse' (page 16). The terms abuse, misuse, abuser, misuser, and addict are regarded as judgemental, stigmatising and pejorative and should not be used. Whilst reference to 'alcohol and substance use' (page 31) is fine, but generally and for consistency we would prefer the use of 'alcohol or substance dependence'	Thank you for your comment. This has been standardised to alcohol or substance dependence throughout, as you suggest.
Gambling Harm UK	Guideline	General	General	Gambling harm disproportionately affects some minority groups where English may not be a first language. Interventions and signposting in non-English languages should be considered.	Thank you for your comment. The need to adapt services for people where English is not their first language is covered in the NICE guideline on patient experience, which is cross-referenced from this guideline, and so this is not described separately in all NICE guidelines.

Breakeven (Charity no 1158156)	Guideline	General	General	A Stepped care approach is the optimum model for individuals presenting with gambling-related problems. In this model, rather than immediately referring individuals to clinical interventions within the National Health Service (NHS), they would first be referred to a gambling harms practitioner within a local NGSN (National Gambling Support Network) provider. This approach aims to establish a positive therapeutic alliance and address initial needs in a way that suits the individual's circumstances and urgency of their needs. Once engaged, individuals would undergo a comprehensive assessment to gain a thorough understanding of their situation, including additional support needs, co-morbidities, clinical risk, safeguarding, and other potential complexities. This assessment is already a standard practice within the NGSN.	Thank you for your comment. Based on stakeholder feedback the guideline has been amended and a new section on referral and triage has been added, to ensure that people are assessed and receive the appropriate level of support and treatment. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. However, there is a planned reconfiguration of gambling treatment services following the introduction of the statutory levy and this is likely to include a move to more NHS-commissioned services, although these may be delivered by a range of providers. There is also likely to be a long implementation phase for these changes so that joined up collaborative services can continue to be provided.

				Based on the comprehensive assessment, the practitioner, in collaboration with the individual, would decide on the most appropriate support pathway, leveraging the NGSN provider's knowledge of community-based assets in the area. This could involve partnering with mutual aid groups, debt services, criminal justice agencies, and mental health providers. Regional NGSN leads have well-established pathways to local services, which have been developed over many years. For example, services like Breakeven have engaged with and continue to engage with a plethora of local and regional Stakeholders and are continually developing new Treatment pathways etc., that assist in facilitating these routes to support. This comprehensive approach ensures that support is not only focused on gambling-related issues but also addresses co-occurring problems such as debt, housing, relationships, and involvement with the justice system.	

				The use of a Stepped model not only encourages a person-centric approach, but also fosters the development of peer coaching within the local community, thereby generating new capacity and expertise. In line with its name, person-cantered care places the individual at the core of their own care. This stratification model, which has been continuously developed in collaboration with our service-user/lived experience groups over the years, adapts our services to align with the expectations and preferences of the community, rather than the other way around. Consequently, we can claim that our services are user-led.	

				Instead of employing a disempowering approach that automatically refers people to the NHS, individuals are given support choices within their own community. However, an NHS referral remains an available option when discussing and evaluating an appropriate pathway, which can be promptly acted upon if there is immediate evidence of harm. The skills and networks we provide, including recovery-oriented and peer-based support, facilitate relationship building at the very core of the screening and assessment process. This builds trust and ultimately enhances retention and engagement, particularly for individuals who are likely to face high levels of stigma, shame, and distress. This inclusive approach is especially crucial for a group that evidence suggests encounters significant barriers when seeking help due to the stigma associated with mental health.	

				By embracing this approach, those who access our services feel more comfortable and confident in the delivery of our support, while also meeting their clinical, emotional, social, and practical needs. In addition, peers can actively connect them with community resources. In our argument, we propose that adopting the Stepped care, community-based model for gambling support and general support services, is the safest and most effective approach. It not only offers the best value for public funding but also prioritises the best interests of service users. Breakeven and the wider NGSN have already embraced this working method and are proven providers of specialist gambling harms education, early intervention, treatment, and recovery support. Their approach is based in the community, timely, preferred by service users, and offers a clear and robust referral pathway into the NHS. To demonstrate the success of this model, Breakeven's latest data from the previous quarter shows: The average change in PGSI score for discharged service users was 16.1 (from 20.6 to 4.5). 100% of our beneficiaries stated that they were satisfied with the service and 100% stated they would recommend Breakeven's gambling services.	

				The average change in CORE-10 score was 11.9 (from 18.2-6.3). The average waiting time from initial referral to first contact was 0.5 days, and the average wait from contact to assessment for treatment was 1.8 days. Average waiting time for Treatment following assessment was 3 days. The proposed guidelines recommend a significant change to the current system, which has proven to be effective over the years in engaging with service users at various levels. We assert that such a substantial change should be supported by pilot data or other evidence to demonstrate its viability at a systems level.	

				Our concern is that to name a specific provider for treatment i.e. the NHS , unheard of in Nice guidelines construct, has the potential to create a barrier to limit help seeking, and cause significant harm to the patient , as a direct result of constraining service user choice by excluding local community based 3rd sector services (in particularly culturally appropriate and trusted services) consequently losing an opportunity for early intervention, a model that engages currently with thousands of patients in this country and which to dismantle by these intended guidelines would most certainly have the potential to be extremely damaging to this Client Group.	

Royal College of General Practitioners	Guideline	General	General	We are concerned that patient choice is being taken away, and a PGSI >8 is being used to mandate that patients should be directed to specialist NHS commissioners' services. This approach does not align with patient-cantered care or involving patients and carers in their health related decisions. It is important that patients are provided with some level of care rather than losing them to treatment simply because they are directed to a service not of their choice.	Thank you for your comment. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. There is also a planned reconfiguration of gambling treatment services following the introduction of the statutory levy and this is likely to include a move to more NHS-commissioned services, although these may be delivered by a range of providers. and there will therefore be a choice of services.

RCA Trust	Guideline	General	General	A Stepped care approach is the optimum model for individuals presenting with gambling-related problems. In this model, rather than immediately referring individuals to clinical interventions within the National Health Service (NHS), they would first be referred to a gambling harms practitioner within a local NGSN (National Gambling Support Network) provider. This approach aims to establish a positive therapeutic alliance and address initial needs in a way that suits the individual's circumstances and urgency of their needs. Once engaged, individuals would undergo a comprehensive assessment to gain a thorough understanding of their situation, including additional support needs, co-morbidities, clinical risk, safeguarding, and other potential complexities. This assessment is already a standard practice within the NGSN.	Thank you for your comment. Based on stakeholder feedback the guideline has been amended and a new section on referral and triage has been added, to ensure that people are assessed and receive the appropriate level of support and treatment. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. However, there is a planned reconfiguration of gambling treatment services following the introduction of the statutory levy and this is likely to include a move to more NHS-commissioned services, although these may be delivered by a range of providers. There is also likely to be a long implementation phase for these changes so that joined up collaborative services can continue to be provided.

				Based on the comprehensive assessment, the practitioner, in collaboration with the individual, would decide on the most appropriate care pathway, leveraging the NGSN provider's knowledge of community-based assets in the area. This could involve partnering with mutual aid groups, debt services, criminal justice agencies, and mental health providers. Regional NGSN leads well-established pathways to local services, which have been developed over many years. For example, services like the RCA Trust offer a holistic approach that offer a wide range of interventions to support an individual utilising a wide range of partners across money advice, housing, family and relationships and criminal justice. We have a proven record in delivering early intervention, prevention, and community-based treatment options.	

				The use of a Stepped model not only encourages a person-centric approach, but also fosters the development of peer coaching within the local community, thereby generating new capacity and expertise. In line with its name, person-centred care places the individual at the core of their own care. This stratification model, which has been continuously developed in collaboration with our service-user/lived experience groups over the years, adapts our services to align with the expectations and preferences of the community, rather than the other way around. Consequently, we can claim that our services are user-led. The skills and networks we provide, including recovery-oriented and peer-based support, facilitate relationship building at the very core of the screening and assessment process. This builds trust and ultimately enhances retention and engagement, particularly for individuals who are likely to face elevated levels of stigma, shame, and distress. This inclusive approach is especially crucial for a group that evidence suggests encounters significant barriers when seeking help due to the stigma associated with mental health.	

				By embracing this approach, those who access our services feel more comfortable and confident in the delivery of our support, while also meeting their clinical, emotional, social, and practical needs. In addition, peers can actively connect them with community resources. In our argument, we propose that adopting the Stepped care, community-based model for gambling support and general support services, is the safest and most effective approach. It not only offers the best value for public funding but also prioritises the best interests of service users. The RCA Trust along with the wider NGSN have already embraced this working method and are proven providers of specialist gambling harms education, early intervention, treatment, and recovery support. Their approach is based in the community, timely, preferred by service users, and offers a clear and robust referral pathway into the NHS.	

GamCare	Guideline	General	General	Following the upcoming changes in commissioning of treatment for gambling harms set out in a consultation by the Department for Culture Media and Sport on a 'statutory levy', the guideline must urgently clarify the meaning of "NHS commissioned specialist services". The guideline in their current format seem to imply that this would include NHS providers. Furthermore, it is not clear which organisations are the 'NHS commissioners' or specialist services. NHS England Specialist Commissioning has significantly reduced in recent year with these functions being passed to local NHS Provider Collaboratives (such as for Forensic Mental Health Services). In addition, Integrated Care Boards and Integrated Care Systems, are increasingly reducing their competitive tendering for services, rather than working with partners in a local area to deliver services. The recent changes in procurement of NHS services further supports this move. This potentially further excludes the third sector which is already delivering effective treatment.	Thank you for your comment. Based on stakeholder feedback the guideline has been amended and a new section on referral and triage has been added, to ensure that people are assessed and receive the appropriate level of support and treatment. The definitions of gambling treatment and support services have also been defined, and the term 'specialist services' is no longer used. However, there is a planned reconfiguration of gambling treatment services following the introduction of the statutory levy as you state, and this is likely to include a move to more NHS-commissioned services, although these may be delivered by a range of providers. This will remove any possible influence or perception of influence on services such as GamCare from the gambling industry. There is likely to be a long implementation phase for these changes so that joined up collaborative services can continue to be provided. The details of the new commissioning arrangements are not yet known by NICE.

				Throughout the guideline, there is an emphasis on who delivers the services ('NHS commissioned specialist treatment services'). This is unusual as NICE guidelines usually refer to service delivery, based on competences, evidence, knowledge and skills, irrespective of the organisation that commissions or delivers the service. Moreover, other NICE guidelines tend to use the term 'staff' rather than NHS or voluntary sector providers. We know that NHS treatments are often provided by private healthcare providers and voluntary sector organisations – provided they have the skills and expertise, to deliver this care safely and according to NICE standards. We would like clarity about the discrepancy of this choice of language. The guideline also sets out that gambling services should be commissioned and provided without influence or involvements from the gambling industry (see comment 17). GamCare is conscious about the image of the third sector and 'industry money' and we are aware that this could have fed into the development of these guideline.	

				However, GamCare and other voluntary sector organisations have for many years had to rely on indirect and direct industry funding to support problem gambling intervention, in the absence of any government funding to do so. 85% of our audiences told us they feel larger gambling companies should meet the costs of supporting those affected. There is evidence that treatment and services delivered by GamCare and the third sector are effective and there is no evidence to show that our funding streams are causing harm. Moreover, GamCare have been seeking a national evidence base for treatment interventions for many years and work to embed lived experience and coproduction in all the work that we do. We also work very closely with layered gambling prevention services and tools to support people to put in immediate exclusion software on their bank accounts to prevent them from further gambling.	

NHS England	Guideline	General	General	General comment, really interesting reading, thank you. For me the key is 'identification' of these people and from a primary care point of view I don't think this is high on our radar. I have just reviewed our GP system (TPP system one) and also Ardens templates and I can't find any reference to gambling on any templates including mental health and alcohol templates. There is no PGSI screening tool embedded in the system either.	Thank you for your comment. The committee agreed that identification was key and that implementation of this guideline will hopefully lead to changes in GP systems and templates, as well as inclusion of the PGSI or a similar scoring tool. This comment has been passed to the NICE implementation team to consider when support activity is planned.
NHS England	Guideline	General	General	Another general comment from a primary care point of view in terms of treatment / support would be to link this to social prescribing both in terms of screening but also support and sign posting to other services. It might be that the cohort of patients they see are more prone to gambling.	Thank you for your comment. The committee decided that social prescribers would fall within the categories of 'healthcare professionals in any setting' who were encouraged to ask about gambling and provide initial support, and so did not add social prescribers as a separate group.
Haringey Public Health Department	Guideline	General	General	Service coordination needs to be built and recommendations around setting this up would be helpful	Thank you for your comment. Service coordination is indeed important and is already highlighted in these recommendations as something that should be included when commissioning services.

Haringey Public Health Department	Guideline	General	General	Training for clinicians at primary care level on gambling harms and screening is available and should be mentioned in the guideline as a helpful adjunct, particularly in areas where harmful gambling is prevalent.	Thank you for your comment. NICE guidelines do not generally provide detailed recommendations on the training needed to implement guidelines but instead advise what level of service should be provided, and that this should be provided by competent staff.
Haringey Public Health Department	Guideline	General	General	There are no recommendations specific to children, especially around gaming and gambling. This is essential to future proof the guidelines and capture a highly vulnerable group.	Thank you for your comment. Children were not included in the scope of this guideline which relates to adults only.
Haringey Public Health Department	Guideline	General	General	It may also be helpful to consider certain groups who may benefit from other interventions, like for women, LGBTQ+, elderly persons etc.	Thank you for your comment. The guideline has already identified certain groups who may need specific support to access services such as women and people from some cultural backgrounds, and made recommendations relating to these groups. The guideline found very little evidence for interventions to improve access or deliver treatments for under-represented groups and so made research recommendations for these groups.

Haringey Public Health Department	Guideline	General	General	MDT members should be explicit – whilst services around drugs/alcohol are important, health visitors and school nurses would also be important for CYP with gambling harms, and for the CYP of parents/carers who are experiencing gambling harms.	Thank you for your comment. The exact composition of multi-disciplinary teams may vary across different settings and so have not been specified. Children were not included in the scope of this guideline which relates to adults only.
Haringey Public Health Department	Guideline	General	General	In terms of embedding data, it would be helpful to provide specific clinical coding's. This would ensure appropriate and consistent coding of gambling diagnoses to ensure high quality data are available and so that individuals are appropriately flagged when accessing different services.	Thank you for your comment. The guideline recommends that standardised data is collected and it would be the decision of commissioners exactly what this data should include, including clinical codes.
Haringey Public Health Department	Guideline	General	General	Overall, we are hugely supportive of the development of this guideline and commend the authors for the considerable efforts in evidence gathering and interpretation to put this together. It is very important emerging public health issue, and we welcome this as an important step forward.	Thank you for your comment

Ara recovery for all (Addiction Recovery Agency Ltd. Charity Number 1002224)	Guideline	General	General	A Stepped care approach is the optimum model for individuals presenting with gambling-related problems. In this model, rather than immediately referring individuals to clinical interventions within the National Health Service (NHS), they would first be referred to a gambling harms practitioner within a local NGSN (National Gambling Support Network) provider. This approach aims to establish a positive therapeutic alliance and address initial needs in a way that suits the individual's circumstances and urgency of their needs. Once engaged, individuals would undergo a comprehensive assessment to gain a thorough understanding of their situation, including additional support needs, co-morbidities, clinical risk, safeguarding, and other potential complexities. This assessment is already a standard practice within the NGSN.	Thank you for your comment. Based on stakeholder feedback the guideline has been amended and a new section on referral and triage has been added, to ensure that people are assessed and receive the appropriate level of support and treatment. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. However, there is a planned reconfiguration of gambling treatment services following the introduction of the statutory levy and this is likely to include a move to more NHS-commissioned services, although these may be delivered by a range of providers. There is also likely to be a long implementation phase for these changes so that joined up collaborative services can continue to be provided.

				Based on the comprehensive assessment, the practitioner, in collaboration with the individual, would decide on the most appropriate support pathway, leveraging the NGSN provider's knowledge of community-based assets in the area. This could involve partnering with mutual aid groups, debt services, criminal justice agencies, and mental health providers. Regional NGSN leads well-established pathways to local services, which have been developed over many years. For example, services like Ara Recovery for All could assist in facilitating these routes to support. This comprehensive approach ensures that support is not only focused on gambling-related issues but also addresses co-occurring problems such as debt, housing, relationships, and involvement with the justice system.	

				The use of a Stepped model not only encourages a person-centric approach, but also fosters the development of peer coaching within the local community, thereby generating new capacity and expertise. In line with its name, person-centred care places the individual at the core of their own care. This stratification model, which has been continuously developed in collaboration with our service-user/lived experience groups over the years, adapts our services to align with the expectations and preferences of the community, rather than the other way around. Consequently, we can claim that our services are user-led.	

				Instead of employing a disempowering approach that automatically refers people to the NHS, individuals are given support choices within their own community. However, an NHS referral remains an available option when discussing and evaluating an appropriate pathway, which can be promptly acted upon if there is immediate evidence of harm. The skills and networks we provide, including recovery-oriented and peer-based support, facilitate relationship building at the very core of the screening and assessment process. This builds trust and ultimately enhances retention and engagement, particularly for individuals who are likely to face elevated levels of stigma, shame, and distress. This inclusive approach is especially crucial for a group that evidence suggests encounters significant barriers when seeking help due to the stigma associated with mental health.	

				By embracing this approach, those who access our services feel more comfortable and confident in the delivery of our support, while also meeting their clinical, emotional, social, and practical needs. In addition, peers can actively connect them with community resources. In our argument, we propose that adopting the Stepped care, community-based model for gambling support and general support services, is the safest and most effective approach. It not only offers the best value for public funding but also prioritises the best interests of service users. Ara recovery for all and the wider NGSN have already embraced this working method and are proven providers of specialist gambling harms education, early intervention, treatment, and recovery support. Their approach is based in the community, timely, preferred by service users, and offers a clear and robust referral pathway into the NHS. To demonstrate the success of this model, Ara's latest data from the previous quarter shows:	

				The average change in PGSI score for discharged service users was 17.8 (from 21 to 3.2). 100% of our beneficiaries stated that they were satisfied with the service and 100% stated they would recommend Ara's gambling services. The average change in CORE-10 score was 16.1 (from 23.7 to 7.6). The average waiting time from initial referral to first contact was 1.5 days, and the average wait from contact to assessment for treatment was 9 days. The proposed guidelines recommend a significant change to the current system, which has proven to be effective over the years in engaging with service users at various levels. We assert that such a substantial change should be supported by pilot data or other evidence to demonstrate its viability at a systems level.	

				Our concern is that to name a specific provider for treatment i.e. the NHS , unheard of in Nice guidelines construct, has the potential to create a barrier to limit help seeking, and cause significant harm to the patient , as a direct result of constraining service user choice by excluding local community based 3rd sector services (in particularly culturally appropriate and trusted services) consequently losing an opportunity for early intervention, a model that engages currently with thousands of patients in this country and which to dismantle by these intended guidelines would most certainly create	

Royal College of Psychiatrists	Guideline	General	General	The Royal College of Psychiatrists (RCPsych) welcomes the NICE guidelines on gambling related harms, which will help to address stigma, raise awareness of gambling harms (including gambling disorder), and help to ensure quality of care provision. We thank all members of the Committee for their contribution to the guidelines, which occur at a crucial time when treatment of gambling disorder is now a national NHS priority, and independent NHS clinics are opening around the country.	Thank you for your comment.

Royal College of Psychiatrists	Guideline	General	General	In the area of addictions (tobacco, alcohol, gambling) it is vital that rigorous safeguards are in place to protect policy, research, education, and practice from inappropriate influence from such commodity industries. RCPsych notes that several members of the NICE Committee disclosed that they work for (or have direct links with) organisation(s) that take (and/or have recently taken) many millions of pounds from the gambling industry in voluntary donations. RCPsych asks why such profound direct conflicts of interest were not exclusionary, in terms of NICE Committee Membership? Would members of organisations with direct and large pecuniary links with 'big tobacco' be permitted to sit on development of NICE guidelines for smoking related harms? If the latter would be unacceptable, why is it permitted in relation to gambling? There is a risk that this will reduce patient and public confidence in this guideline, and indeed, in NICE.	Thank you for your comment. The committee constitution was defined on the basis of the professional roles (psychiatrist, psychologist, mental health nurse, commissioner, lay member etc) and the people appointed to those roles were appointed through a standard selection procedure to identify the best people from the pool of applicants for each role. As the majority of current services are provided by organisations that are funded through the voluntary levy and are commissioned by GambleAware it was not surprising that some applicants, and therefore appointees, came from these organisations. This was declared on recruitment and NICE are confident that their open and transparent process for declaring and recording interests was adhered to. The committee members are on the committee as individuals and they do not represent their employing organisation and therefore it cannot be assumed that all members of the committee who work for a service currently commissioned by GambleAware or that receives gambling industry funding are personally conflicted in their everyday practice. However, people bring to the committee their experience of services they have worked in, experiences they have had and so all committees will encompass a wide range of views and viewpoints. The committee has been aware of the need to avoid the influence of the gambling industry on their recommendations right from the start - for example all evidence was, at the committee's request, sub-grouped by its source of funding. NICE has a specific duty to adhere to WHO recommendations on working with the tobacco industry but such guidance does not currently exist for the gambling industry.

Royal College of Psychiatrists	Guideline	General	General	Relatedly, RCPsych was extremely surprised that people were invited to comment on the draft guidelines without any need to disclose any conflicts of interest they may have in relation to the gambling industry.	Thank you for your comment. Stakeholder consultation on NICE guidelines is open to all registered stakeholders, and individuals may also comment. This process is open and transparent and replies to all comments from registered stakeholders are published on the NICE website. Declarations of interest are therefore not collected.
Royal College of Psychiatrists	Guideline	General	General	RCPsych welcomes the presence of some independent experts on gambling related harms and neuroscience on the NICE Committee (of national/international repute) but would have liked to see more such independent gambling harms experts on the Committee.	Thank you for your comment. The committee composition was designed to provide a broad range of views and opinions from across the gambling treatment community but in order to keep the committee to a manageable size a single representative for each committee role was chosen.

Royal College of Psychiatrists	Guideline	General	General	The guidelines should highlight the importance of NHS gambling services having a suitably skilled multidisciplinary workforce, explicitly including both psychiatrists and clinical psychologists. There is an urgent need to build these workforces and to make them sustainable – such as through training and education. This work is urgently needed to avoid issues that happened in care provision for other addictions, such as the catastrophic issues highlighted in Dame Carol Black's report relating to a lack of training and a lack of sufficiently trained clinical staff in addiction services.	Thank you for your comment. The committee agree that services for gambling support and treatment should be delivered by a trained and competent workforce and have highlighted this in their recommendations in several places.
Adferiad	Guideline	General	General	Case identification, assessment and initial support. 1.1	Thank you for your comment. No action appears to be required in relation to this comment.

Adferiad	Guideline	General	General	The guidelines fail to provide a clear definition of what constitutes “harmful Gambling. No specific guidance has been given on how healthcare professionals should be trained to recognise signs and symptoms of harmful gambling.	Thank you for your comment. The definitions of gambling that harms and gambling-related harms have now been added to the 'terms used' section of the guideline. The section of the guideline on case identification and assessment provides advice on the identifying gambling by asking direct questions, and on the risk factors and signs which indicate that gambling-related harms may be present.
				Summary	

Beacon Counselling Trust	Guideline	General	General	By NICE adopting the stratified, community-based model described above, within gambling support and general support services, we would argue is the most safe and effective model to adopt, and also provides best value for public funding, and more importantly delivers the service-user's best interests. BCT and the wider NGSN have already adopted this way of working and are a safe and effective provider of specialist gambling harms education, early intervention, treatment and recovery support, which is community based, timely, service-user preferred, and has a clear and robust referral pathway into the NHS. To evidence this, in the previous quarter BCT had: Average change in PGSI score for discharged service users: 15.6 (from 19.4 to 3.8) 97.5% of service-users feel the treatment received has brought about a positive change in circumstances, and that they were given enough appointments Average change in CORE-10 score: 9.3 (from 16.1 to 6.8)	Thank you for your comment. The guideline has been amended based on stakeholder feedback to clarify that the planned service reconfiguration following the introduction of the statutory levy will lead to the commissioning of treatment services by the NHS, but these are likely to be delivered by a range of providers, and will include community based services as you describe. It is anticipated that the implementation of these changes will take some time, and so changes can be evaluated as they are implemented.

				Average waiting time from initial referral to first contact: 1.5 days and 6 days average wait from contact to assessment for treatment The model recommended within the current proposed guidelines would be a huge change to the current system which has been working well for many years now at engaging with service-users from an early intervention and education level, through to the most complex, clinical presentations. We would argue that a change as significant as the one proposed, would need to be evidenced using, at the very least, pilot data, to demonstrate that this change of modelling can work at a systems level.	
Royal College of Nursing	Guideline	General	General	Thank you for the opportunity to contribute to the above consultation, we received no member comments this time.	Thank you for letting us know that you received no comments from your members.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	General	General	Throughout the document the terms gambling / gambling-related harms / harmful gambling seem to be used interchangeably. The document may benefit from a clear definition of each term at the beginning. Harmful gambling is the activity/action, gambling-related harm is the result of harmful gambling experienced by both those who gamble and those around them. Treatment can be used to reduce/stop someone from participating in harmful gambling (addressing motivation /craving etc) or it can be used to treat the harms they have experienced as a result of harmful gambling (e.g. poor mental health etc) Would recommend that the terminology throughout the doc is checked for consistency.	Thank you for your comment. The definitions of gambling that harms and gambling-related harms have now been added to the 'terms used' section of the guideline. As you state both terms (as well as 'gambling') are used in the guideline and these have been checked to ensure that all these terms are used appropriately, as people who gamble and affected others may experience harms.

Adferiad	Guideline	General	General	There is a lack of evidence underpinning the recommendations throughout. There is a lack of guidance on how to support people with complex comorbidities or dual diagnosis.	Thank you for your comment. The committee were disappointed that there was a lack of evidence to underpin some sections of the guideline, but used evidence where it was available and used their knowledge and experience to make consensus recommendations in other areas. The committee made recommendations emphasising the need to consider the complexity of people's diagnosis and comorbidities when referring people and planning and delivering care, including coordinating with mental health and substance dependency services and whether sequential or concomitant treatment of gambling harms and other comorbidities is optimal.
GamCare	Guideline	General	General	The Guideline fails to address existing waiting times to access NHS gambling treatment services and an average 2 week wait to for a GP appointment. There needs to be clarity over whether these services will only be accessible via a GP referral, as many NHS services are. Last year, on average it took just five days from assessment to the offer of a first support session at GamCare.	Thank you for your comment. There is no suggestion in the guideline that access to services will only be via a GP referral, as a referral could be made by a range of professionals and practitioners, or via self-referral, and a new section has been added to the guideline on referral and triage and directing people to the correct level of service. The recommendations have been amended to clarify what gambling treatment services deliver and that a number of services will be NHS-commissioned gambling treatment services, not just the NHS specialist clinics. The exact provision of services may alter when the planned reconfiguration of services and new commissioning arrangements come into place when the compulsory levy is introduced.

				Specifically, if the guideline's reference to 'NHS commissioned specialist services' means the exclusion of any providers with industry related funding, this excludes many effective, third sector providers. We are worried for future feasibility of these organisations, and ultimately, how the vast number of people who need support will be able to access this support in a timely manner. GamCare and the National Gambling Support Network have established and effective infrastructure for referrals, to both national providers and local providers, offering people a menu of treatment options that best suit their needs, and with quick access to treatment.	
GamCare	Guideline	General	General	GamCare would like to raise that the guideline proposed will have a real and detrimental impact on people are experiencing gambling harm. It will affect service-users lives and has the potential to ultimately harm people.	Thank you for your comment. Substantial changes have been made to the guideline based on stakeholder comments and the committee do not agree that the final guideline will have a detrimental effect on care.

Midlands Partnership University NHS Foundation Trust (MPFT).	Guideline	General	General	We welcome the development of the NICE guideline and consider that the majority of recommendations for harmful gambling: identification, assessment and management accord with the standards we have set for ourselves at the WMGHC. In particular, we commend committee members for their diligence and efforts in reviewing the evidence base to support their recommendations. Given the current investment in NHS treatment for gambling harms, and anticipated expansion in training and education and research in this area, we strongly recommend setting a date for review and updating of the guidance. This would allow us to build on the progress we have achieved, and respond to new and emerging concerns and a rapidly developing evidence base.	Thank you for your comment and support for the guideline. NICE undertakes a planned programme of surveillance to ensure guidelines remain up to date.

Department of Health and Social Care – Office for Health Improvement and Disparities	Guideline	General	General	NICE may wish to consider dependent drinking as a transient state with people moving in and out of dependent patterns of drinking, although less common among severely dependent drinkers. Given this there are times when it is most appropriate to use a term such as 'people who are drinking alcohol in dependent way'. NICE recently amended the title of their alcohol guidance to 'Alcohol-use disorder: diagnosis, assessment of harmful drinking and alcohol dependence' suggesting these are the most appropriate terms to use	Thank you for your comment. The term alcohol dependence has now been used throughout the guideline in accordance with your advice here and in another of your comments.
GambleAware	Guideline	General	General	This guideline is an important and welcome development in treatment and support for gambling harms. We address specific points in the relevant sections below, but would like to make some comments in this section about the draft guideline as a whole. We have a number of overarching concerns about the current guideline that must be addressed:	Thank you for your comment. The committee members provided knowledge and expertise on the current management of gambling harms delivered by a range of providers. Based on stakeholder feedback the guideline has been amended and now recognises that, following the planned service reconfiguration with the introduction of the statutory levy, treatment services will be commissioned by the NHS but are likely to be delivered by a range of providers. This is therefore likely to utilise the existing knowledge and experience of many current providers. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services

				The expertise of the National Gambling Support Network (NGSN) has been overlooked. This omission will have significant implications for the whole gambling harms system, impacting critical and effective support networks that are successfully tackling gambling harms. Through the NGSN, the third sector delivers the majority of gambling harms treatment. However, this is not reflected in the current draft guideline. The NGSN is a diverse group of third sector specialist treatment providers, with expertise and capability to deliver all levels of prevention and treatment, working as a system and adopting a regional first approach. It is underpinned by an Outcomes Framework and Service Blueprint that were informed through extensive stakeholder engagement, including those with lived experience. The NGSN delivers quality services and outcomes: 92% of people who completed their treatment showed improvement on their Problem Gambling Severity Index (PGSI) score.	and gambling treatment services to clarify what different levels of services will provide. Comparison of costs needs also to take into account what type of care is provided in each setting (including assessment, support, treatment and aftercare), by whom (specialist or not), and the outcomes expected to be achieved in each setting. The cost estimate of £2000 per referral is based on current NHS provision of 15 specialist gambling clinics and does not take into account the fact that NHS is planning to commission gambling treatment and gambling support services, which may be provided by a range of providers, including the NHS or the voluntary and charity sector. The introduction of the statutory levy (which is expected to raise approximately £90-100 million annually by 2027) is likely to increase the funding available to spend on gambling support and treatment services commissioned by the NHS and a significant reconfiguration of services is expected, to meet different levels of need. The recommendation to refer every person scoring 8+ on PGSI to NHS commissioned specialist gambling treatment services has been removed.

				86% of people who completed their treatment also reduced their psychological distress around their gambling behaviour. The rate of 'problem gambling' among service users fell from 90% to 28% between their first and last appointments. Furthermore, among users who completed treatment, the rate of 'problem gambling' was only 13% by the end of treatment. The draft guideline's sole focus on NHS delivery and lack of recognition of the third sector's expertise in providing more complex treatment alongside the NHS may have detrimental repercussions. It may discourage healthcare professionals from referring to these services in place of more costly NHS treatment, and may also turn people experiencing harms away from self-referring. The NGSN has unrivalled ability to adapt and respond to the needs of service users and its capacity exceeds that of the NHS.	

				People can also access services much faster in the NGSN than the NHS. The current NHS waiting time reported by NGSN provision is 4-7 weeks compared to an average of 5 days for NGSN provision. As well as potentially limiting or delaying access to treatment, a sole focus on the NHS also has cost implications. Internal GambleAware contract monitoring data from 2021/22 indicates an overall unit cost of £2,094 for the London NHS clinic and £1,788 for the Northern NHS clinic. In contrast, independent economic modelling conducted by the NHS Health Economics Unit (available upon request) has estimated a unit cost of £840 for NGSN Tier 3 treatment. This is further supported by the fact that the NHS clinics aim to see 3,000 patients in 2023/24 at a cost of £6 million. The draft guideline focuses primarily on the use of the PGSI to determine appropriate treatment, and inaccurately states a score of 8 or above indicates a need for specialist NHS treatment.	

				The PGSI is a survey tool for understanding the scale of problematic gambling behaviour and was not designed to provide a comprehensive assessment of individual clinical need for treatment purposes. Some helpful information about the use of PGSI can be found in this summary report conducted by IPSOS, UK 2023. While someone presenting with PGSI 8+ should clearly be flagged as requiring further support, PGSI score alone should not lead to a direct referral to an NHS clinic. Not all people within a PGSI classification group are at the same risk of harm on wellbeing measures (IPSOS,UK 2023). Consideration should be made of local community support, other options, and discussion of service user choice. In many cases needs can be met by third sector providers, which are also able to provide more complex treatment than is suggested in this narrative.	

				To determine someone's full clinical presentation, and whether there is a need for stepped-up care, a full assessment of their needs is required, including to understand the patient's mental and emotional wellbeing. The guideline must set out how this can be accessed and undertaken. It is vital the final guideline acknowledges the critical role and expertise of the NGSN and third sector providers across all tiers of treatment and prevention and makes clear to commissioners and healthcare professionals that this is an important referral option for patients. This should include clarity that those at PGSI 8+ should not necessarily be directed straight to the NHS as the default treatment approach, and that a full assessment of needs that is not reliant on the PGSI must be made.	

				At a time when NHS capacity is stretched, it is even more important to lean on the established systems and capacity of the NGSN. The GB-wide approach that the NGSN supports ensures provision in all parts of GB. A smooth transition to the future levy system should lean on the third sector to ensure the continued provision of a public health approach to gambling harms.	

Royal College of General Practitioners	Guideline	General	General	We acknowledge and appreciate that the definition of “specialist” now includes “GP-Led”. However, we are concerned that this is not apparent throughout the guideline. A “specialist gambling treatment service” can have several interpretations, including consultant addiction psychiatry-led. Furthermore, the guidelines do not consider the important role that GPs can play in early identification and intervention. GPs often have a holistic view of patients' health and well-being, and by focusing primarily on specialist services, the guidelines might overlook the broader context of an individual's health. We are concerned that this could also result in a disconnect between the guidelines and the day-to-day activities of GPs, who often serve as the first point of contact for individuals with various health concerns.	Thank you for your comment. The guideline has been amended and the use of the terminology 'specialist gambling services' has been removed. Instead the difference between treatment services and support services has been clarified and a new section on referral and triage has been introduced to help guide people to the right level of services. The committee agreed that while GPs do have a holistic view of people's healthcare the role of the GP in most practices that do not operate as a primary care gambling service could not be extended beyond identification, signposting, initial support and referring due to a lack of GP capacity.

GamCare	Guideline	General	General	The guideline sets out just one model of care, which will not fit all. It is vital that service-users are given choice in their treatment. Referring those with a PGSI over 8 into one model of 'specialist' treatment, risks over-pathologising their experience, and discourage people for moving forward with treatment. This move could also risk increasing stigma, when we know from our lived experience community how entrenched this issue already is. The guideline should support a 'no wrong door' approach to people wishing to access treatment and support.	Thank you for your comment. The term 'specialist setting' has been removed from this heading as it applies to all gambling treatment services. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The guideline has been revised and services for people with gambling-related harms have been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide. It is specified that gambling treatment services should be commissioned by the NHS, but they may be delivered by a number of different providers, and the committee were aware that there will be a transition period as services for gambling treatment are reconfigured. The guideline will therefore advise the provision of a wide range of services commissioned by the NHS but does not simply replicate the current provision.

				It is not clear which organisations the NHS will commission to provide treatment services, and the possible exclusion of any organisation that has accessed gambling industry funding implies that this will largely be NHS provider services. A single or predominately NHS model of care could potentially create further barriers to accessing treatment. We hear from our lived experience community that many people simply do not want to speak to their GP about a gambling problem or have it on their NHS health record. Some people, mentioned within this guideline, such as people experiencing homelessness or in contact with the criminal justice system, may not have a registered GP. We also know that some groups are less likely to access and have lower levels of trust in NHS health and care services.	

NECA (Charity Number 516516)	Guideline	General	General	This document is for providers of gambling treatment services, therefore should it be inclusive and not recommend a particular service. Acknowledging services should be mindful of the needs of the individual and the expertise of the service referring to as appropriate to other services.	Thank you for your comment. The guideline has been amended based on stakeholder feedback to clarify that the planned service reconfiguration following the introduction of the statutory levy will lead to the commissioning of treatment services by the NHS, but that they are likely to be delivered by a range of providers. A new section on referral and has also been introduced to guide referral to the appropriate level of service.

NECA (Charity Number 516516)	Guideline	General	General	The service promoted in the document is non-evidential in terms of impact and in our opinion is aspirational. In its current form is it appropriate for guidelines? Does it follow the NICE principles? In summary, one major concern in relation to the current content of the draft guidelines is this does not appear to represent the purpose of creating a collaborative working framework to reduce Gambling related harm for either individuals or communities.	Thank you for your comment. The guideline has been amended based on stakeholder feedback to clarify that the planned service reconfiguration following the introduction of the statutory levy will lead to the commissioning of treatment services by the NHS, but that they are likely to be delivered by a range of providers. The guideline is aspirational, and recognises that this reconfiguration is likely to take time to implement. A new section on referral and triage has also been introduced to guide referral to the appropriate level of service, and there are also recommendations relating to collaboration between services, with the aim, as you state, of reducing gambling-related harms for all.

GamCare	Guideline	General	General	GamCare has been the leading provider of information, advice, and support for anyone affected by gambling harms for over 25 years. We operate the National Gambling Helpline, provide structured support for anyone who is harmed by gambling, create awareness about safer gambling and treatment, and encourage an effective approach to safer gambling within the gambling industry. GamCare is also the System Coordinator of the National Gambling Support Network (NGSN), a network of service oriented charities working to support people affected by gambling-harms, which are the largest scale providers of specialist services whose staff and volunteers hold professional expertise. The majority of GamCare service users completing treatment showed improvements against GamCare's key success measures. Using CORE-10, the majority moved from 'moderate' to 'healthy' gambling behaviours (17.4 to 6.5), and using PGSI, they moved from 'problem gambling' levels to 'moderate levels (average scores of 17.1 to 3.5).	Thank you for your comment and for the information about GamCare services. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

				This depth of experience and delivery of treatment provides us with expert insight and understanding of the gambling landscape and the impact on third sector treatment provision. The guideline recommends that people with a PGSI score of 8 and above be directed to NHS commissioned specialist services. The guideline itself highlights that PGSI is not a robust clinical tool and the Gambling Commission states that "there are a number of caveats that need to be considered" and "the term 'at-risk' can imply that people who are classified as low or moderate risk gamblers on the PGSI are not experiencing harm now will do in the future when in fact they are showing signs of problematic behaviour now but remain below the threshold for 'problem' gambling".	

				PGSI is currently used by GamCare and the NGSN to assess someone's gambling harm at the start, at intervals throughout and at end of an intervention, which helps to determine progress and outcome but does not determine their treatment pathway. GamCare and the NGSN also employs questionnaires including the CORE-10, PHQ-9, and GAD-7, alongside service-user choice which offer more accurate clinical assessment and avoid over and under treating some, alongside wider risk assessments. While PGSI talks about the level of risk, it does not specify a type of treatment associated with different types of risk. There is no evidenced based correlation between a PGSI score and a specific mode of intervention or treatment. The guideline must clearly set out the rational of using PGSI as tool to decide a treatment pathway and the evidence for this approach.	

Gambling with Lives	Guideline	General	General	Emphasis on financial harm rather than harm to mental health We are concerned that there are several examples of harm from gambling being described more in terms of financial harm rather than harm to mental health. Considering these guidelines are health guidelines, this area must be improved and can be with ease. For specific examples and individual recommendations within the guidelines, see our comments 12, 14, 15 and 21.	Thank you for your comment. The mental health harms and financial harms are both mentioned numerous times in the guideline, and the committee has rearranged some sections of the guideline to ensure mental health issues feature above financial issues. Your other comments have been addressed individually.
His Majesty's Prison and Probation Service (HMPPS)	Evidence Review A	6	6	Maybe helpful to note that anyone at any time can be affected by gambling harms and there are not always prevalent risk factors associated with it.	Thank you for your comment and suggestion. We have added a sentence to the introduction to mention that anyone can experience harmful gambling without any pre-disposing risk factors.

GambleAware	Evidence review A	6	21	Risk Factors - The focus on studies whose sample involves individuals presenting at a setting means that studies based on population surveys or random samples have been excluded from the analysis. There is a broader literature on inequalities in gambling harms which is pertinent to the issue of risk factors. This systematic review provides useful evidence and should be incorporated: https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-021-10337-3	Thank you for your comment and thank you for providing the links to other articles. We have checked each link you provided for potential inclusion: Unfortunately, we were unable to access the following links as it seems these have been removed: https://www.begambleaware.org/sites/default/files/2022-03/Annual%20GB%20Treatment%20and%20Support%20Survey%20Report%202021%20%28FINAL%29.pdf (pp. 25-32) https://www.begambleaware.org/sites/default/files/2022-11/202216_GA_Annual%20stats_report_English_v4.pdf (pp. 11-30) The remaining reports that we were able to access do not meet the inclusion criteria for our review of the evidence. None of them are systematic reviews of diagnostic test accuracy studies nor individual studies of diagnostic test accuracy, RCTs, or studies with random selection of the target participants from which diagnostic data can be extracted. Furthermore, these reports do not report any relevant outcomes and can therefore not be included in the evidence review.

				Moreover, it appears that non-academic studies have been excluded. A number of reports commissioned by GambleAware contain important evidence on the risk factors for gambling harms or the inequalities in these harms: https://www.begambleaware.org/sites/default/files/2022-03/Annual%20GB%20Treatment%20and%20Support%20Survey%20Report%202021%20%28FINAL%29.pdf (pp. 25-32) https://www.begambleaware.org/sites/default/files/2022-11/202216_GA_Annual%20stats_report_English_v4.pdf (pp. 11-30) https://www.begambleaware.org/sites/default/files/2023-03/Minority%20Communities%20Final%20Report_0.pdf https://www.begambleaware.org/sites/default/files/2020-12/2020-12-09-gambling-among-adults-from-black-asian-and-minority-ethnic-commmunities-report.pdf https://www.begambleaware.org/sites/default/files/2020-12/gambleaware-women-in-focus-report.pdf	

				https://www.begambleaware.org/sites/default/files/2023-08/GambleAware%20Secondary%20Analysis-%20Final%20Report%20June%202023%20-%20Alma%20Economics.pdf	
His Majesty's Prison and Probation Service (HMPPS)	Evidence review A	29	011 & 012	I think that yes cocaine use it is a moderately sensitive factor predicting gambling, however, should be very cautious about using this in isolation. Family history of gambling might be stronger.	Thank you for your comment. The result that cocaine use is a moderately sensitive factor predicting gambling is not for cocaine use in isolation but rather it is cocaine use plus a family history of gambling. The studies did not focus on family history alone and therefore we do not have any data on the risk factor for family history of gambling compared to cocaine use. No changes have therefore been made to this evidence summary.

His Majesty's Prison and Probation Service (HMPPS)	Evidence review A	29	018 - 019 - 020	Drug use found to be not sensitive but on lines 11 and 12 it says cocaine use found to be moderately sensitive so this is a bit confusing and needs further clarification.	Thank you for your comment. The risk factors are described as reported in the studies, and one study reported 'other drug use' as a risk factor, whilst another was more specific and reported 'cocaine use', or 'cocaine use' combined with other risks. Lines 12-18 describe that cocaine use combined with a number of risk factors was found to be moderately sensitive (e.g. cocaine use in last 3 months plus family history of gambling). In contrast, lines 18-25 describe that cocaine use combined with various other risk factors *(not the same as those listed in lines 12-18)* was found not to be sensitive (e.g. cocaine use in last month plus diagnosis of panic disorder).

His Majesty's Prison and Probation Service (HMPPS)	Evidence review A	29	023 - 026	I would want practitioners asking all people on probation regardless of their risk factor as this would be a more thorough and effective way of capturing all who have needs.	Thank you for your comment. Your page and line referencing don't correspond with a recommendation but we have made an assumption that you are referring to the recommendation about asking people about gambling in certain situations (and which mentions probation services). The recommendation states that people should be asked about gambling at each key contact with the criminal justice system, which includes probation services so this is in line with what you have suggested. The committee therefore did not make any changes in light of this comment.
His Majesty's Prison and Probation Service (HMPPS)	Evidence Review B	8	6	Need to mention that some people may not even realise they have a gambling problem.	Thank you for your comment, we have added this to the list of examples.

His Majesty's Prison and Probation Service (HMPPS)	Evidence review B	8	6	"Many people affected by gambling-related harms do not seek treatment (which could be for a number of reasons including stigma, shame, or because they do not know that treatment is available) and therefore pro-actively identifying these people may increase the number of people entering into treatment"	Thank you for your comment. Committee members were acutely aware of the stigma attached to gambling that harms and the difficulty this creates in terms of access to services. This is reflected in many of the recommendations they made, such as the need recognise that there is stigma related to gambling that harms, to recognise that stigma can prevent people who are affected by gambling-related harms from seeking and accessing treatment, to lessen the impact of stigma and to support access to treatment by using a person-centred approach and discussing any fears or concerns that are preventing people from accessing treatment, and to consider to modify treatments or their delivery to reduce stigma.
				Gambling is seen as a 'hidden addiction' which also adds to the statistic that many people affected by gambling related harm do not seek treatment, it is also not widely recognised as a mental health condition which is another added barrier for access to treatment. Gambling needs to be widely recognised as a mental health issue to reduce stigma and reduce barriers to accessing treatment.	

His Majesty's Prison and Probation Service (HMPPS)	Evidence review B	8	14	"The aim of this review is to determine if there is a brief screening tool which can be used in non-specialist settings to identify people who may be experiencing gambling-related harms."	Thank you for your comment. The purpose of this review was to find a tool that could help in identifying gambling-related harms in all settings and not just specialist settings. Unfortunately there was a lack of evidence regarding brief screening tools (including the PGSI or the mini PGSI) so the committee decided by consensus to include 2 specific examples of direct questions to ask people about gambling which are 'Do you gamble?' and 'are you worried about your own or another person's gambling?'. The committee decided that the questions need to be simple enough to be used by non-specialists in healthcare and social care settings, and broad enough to identify both people experiencing gambling that harms themselves and those experiencing gambling-related harms due to another person's gambling. However, the committee did recommend (also based on consensus) that if people wanted to assess their own gambling-related harms they could be directed to the PGSI tool on the NHS website.

				The PGSI Screening tool would be beneficial to be used in all settings including GP settings, mental health services, Probation (in Court, Prison & Probation), Substance misuse services, third sector support services, other health and social care services. The PGSI 'mini' tool could be utilised by Court staff to improve the ability of the Probation Service to identify and address gambling and gambling related harm within the Criminal Justice System. This tool also supports with being able to identify gambling as a mitigating factor at court.	

His Majesty's Prison and Probation Service (HMPPS)	Evidence review B	11	17	It would be useful for the PGSI Screening tool to be considered for use in Court at Pre-Sentence report stage or for practitioners to use at initial induction stage, or equally in prison when identifying sentence plan objectives.	Thank you for your comment. The purpose of this review was to find a tool that could help in identifying gambling-related harms in all settings and not just specialist settings. Unfortunately there was a lack of evidence regarding brief screening tools (including the PGSI or the mini PGSI) so the committee decided by consensus to include 2 specific examples of direct questions to ask people about gambling which are 'Do you gamble?' and 'are you worried about your own or another person's gambling?'. The committee decided that the questions need to be simple enough to be used by non-specialists in healthcare and social care settings, and broad enough to identify both people experiencing gambling that harms themselves and those experiencing gambling-related harms due to another person's gambling. However, the committee did recommend (also based on consensus) that if people wanted to assess their own gambling-related harms they could be directed to the PGSI tool on the NHS website, and if the criminal justice system wished to use this tool in their settings this could be implemented by them.

GambleAware	Evidence Review B	11	019-021	We are concerned that screening for gambling related harm is being likened to more common and regular screening for smoking, alcohol and substance use. The committee mentions that people are “used to being asked by professionals about their smoking behaviour, about how many units of alcohol they drink, and if they use other substances”. The implicit assumption is that they therefore would not be concerned about being asked about gambling as well. However, this does not take account of the different stigma around gambling compared to drinking alcohol and smoking, meaning that asking the question may not lead to an honest answer. This cannot be relied upon as the only means of identifying more people struggling with gambling harms.	Thank you for your comment. The committee did not imply that there is an equivalence between experiencing alcohol dependence and experiencing harm from gambling. Instead they agreed that as clinicians are used to asking people about alcohol and drug use, they should become used to asking about gambling behaviour, and this in itself may help to reduce stigma. The committee are acutely aware of the stigma attached to gambling and the barrier to accessing help and support that this creates and they made other recommendations to highlight and address stigma.

GambleAware	Evidence Review B	19	043 - 045	Assessment - We would like to share additional evidence on the PGSI measure, including recommendations and discussion points for the future interpretation and use of PGSI by those wishing to understand and reduce the scale of gambling problems:	Thank you for your comment and providing the additional evidence. Unfortunately, the suggested report does not meet inclusion criteria set out in the protocol for this review, as it does not compare the PGSI to a reference standard (for example the DSM criteria or ICD criteria for diagnosing gambling disorder), does not have any of the outcomes set out in the protocol (sensitivity, specificity, PPV and NPV), and the population were adults in the UK not people presenting to specialist gambling services. However, despite the lack of evidence for the PGSI in evidence review B, the committee discussed the use of the tool extensively and agreed the PGSI tool should still be considered as a possible tool for assessing gambling-related harms, although a much broader assessment was required. The committee also noted the other factors that should also be considered during this holistic assessment. The committee is acutely aware of the lack of evidence regarding the PGSI and other tools for the use in assessing gambling-related harms and this is reflected in their recommendation for future research on this topic.

				Summary report: https://www.begambleaware.org/sites/default/files/2023-11/PGSI%20tech%20report.pdf Technical report: https://www.begambleaware.org/sites/default/files/2023-11/PGSI%20tech%20report.pdf The key findings of these have been informed by an extensive programme of advanced analytics, conducted on a sample of 21,172 responses to the 2020 and 2021 Annual GB Treatment and Support Surveys commissioned by GambleAware. Please note that these findings relate to the use of the PGSI within the general population, not within specialist gambling treatment services. Key findings include: Items in the PGSI scale should not be treated equally; individually they make a different contribution to assessments of risk. Despite its limitations, the PGSI scale should continue to be used as a general instrument to estimate potential risk of 'problem gambling' among larger groups.	

				There is a clear link between PGSI scores and psychological distress, it is therefore appropriate to continue to use PGSI as an indicator of likely harm. There is merit in revisiting the traditional PGSI classifications; however, this should be traded against pragmatic considerations to identify, target and track groups over time. Overall, there is a risk that that PGSI underreports the proportion of individuals who are at risk of harm from gambling; where possible, additional survey measures should therefore be explored that ask people to self-refer as experiencing harm. Careful consideration should be given to the use of PGSI 1+ as a threshold at which 'harm' begins. Avoid use of the short forms PGSI measure unless there is extremely limited opportunity to interact with individuals.	

NIHR, Policy Research Unit in Health and Social Care Workforce, The Policy Institute, King's College London	Evidence Review B	General	General	Regarding evidence of simple tools to identify gambling-related harms to individuals and affected others in non-specialist settings, please see our recent study: https://academic.oup.com/bjsw/advance-article/doi/10.1093/bjsw/bcad155/7205469. The following two questions were developed for use in adult social care settings and found to be valid and reliable against gold standard measures used for clinical diagnosis of gambling harms. See (https://www.kcl.ac.uk/research/identifying-gambling-harms) Is your own gambling or that of someone else causing you any worries? Do you feel you are affected by any gambling, either your own or someone else's?	Thank you for your comment. We have checked your paper for possible inclusion in review B and although the population and outcomes match our protocol the reference standard (being the PGSI) does not (DSM or ICD were stated in our protocol). The committee nevertheless discussed the questions suggested by your study and they agreed that the ones they used in the draft guideline seem simple and clear and therefore fit the intended purpose. They agreed not to make changes to that recommendation.

His Majesty's Prison and Probation Service (HMPPS)	Evidence Review C	14	1	No specific mention of the interventions for those in the criminal justice system.	Thank you for your comment. This paragraph describes the review findings relating to information and support, which did not include anything about interventions in the criminal justice system, which is why they are not mentioned here. On the basis of this review the committee did however recommend information about gambling be made widely available in settings where gambling harms are likely to be identified and this included criminal justice settings.
His Majesty's Prison and Probation Service (HMPPS)	Evidence review C	15	12	Consideration of the outcomes for those in criminal justice system and how to reduce re-offending	Thank you for your comment. This section provides a list of the themes that the committee expected to be located by the evidence review. The review was about the information and support needs of people experiencing harms from gambling so it was outside the scope of the protocol to identify evidence of interventions for reducing re-offending.

His Majesty's Prison and Probation Service (HMPPS)	Evidence Review D	9	33	Do we need a sub note in reference to the gambling levy funding and how this is/will be utilised.	Thank you for your comment. The committee discussed this and agreed to make a reference to the levy, in that the planned introduction of a statutory levy on the gambling industry would support this recommendation.
GambleAware	Evidence Review D	9	047 - 048	Model of care - We agree with the need for prompt assessment. Prompt treatment and support must also be provided alongside this. Current NHS provision assessments are relatively prompt, however there can be a significant wait before people receive treatment. In contrast, the NGSN assesses, supports and begins treatment within six working days on average (annual figures are published publicly with outcomes).	Thank you for your comment. As well as recommending prompt and ongoing assessment of the risk and severity of gambling harms, the committee recommended timely support so that treatment can start as soon as possible after assessment. The committee were aware that with the introduction of the statutory levy and the increased availability of funding for the NHS, that waiting times for NHS-commissioned services should remain short.

GambleAware	Evidence Review D	10	007-008	Model of Care - The PGSI is a survey tool for understanding the scale of problematic gambling behaviour and was not designed to provide a comprehensive assessment of individual clinical need for treatment purposes. Additionally, some PGSI questions are 'legacy questions' that would elicit an affirmative response irrespective of whether the individual is still gambling, which can lead to a score that may inaccurately suggest a high level of gambling activity.	Thank you for your comment. The committee acknowledge that the PGSI was originally designed as a population level tool and not as a clinical scale for measuring gambling severity. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated into gambling support services and gambling treatment services to clarify what different levels of services will provide.

				While someone presenting with PGSI 8+ should clearly be flagged as requiring further support, PGSI score alone should not lead to a direct referral to an NHS clinic, as not all people within a PGSI classification group are at the same risk of harm on wellbeing measures (IPSOS,UK 2023).Consideration should be made of local community support, other options, and discussion of service user choice. In many cases their needs can be met by third sector providers, which are also able to provide more complex treatment. To determine someone's full clinical presentation, and whether there is a need for stepped-up care, a full assessment of their needs is required, including to understand the patient's mental and emotional wellbeing. The guideline must set out how this can be accessed and undertaken.	

GambleAware	Evidence Review D	10	039 - 045	Model of Care - It is inaccurate to state that there is insufficient accountability or governance in third sector treatment provision. The NGSN is commissioned against a strategic framework and monitored against a rigorous quality assurance framework which is equivalent to NHS standards. This must be recognised and reflected in final decision-making on the guideline and its recommendations.	Thank you for your comment. The committee recognise that NGSN is commissioned against a strategic framework and monitored against a quality assurance framework and so this text has been removed. However this does not equate to the clinical governance standards and transparency seen in publicly commissioned or provided services. That said, it is likely that the reconfiguration of gambling treatment services will lead to more services being commissioned by the NHS, but delivered by a range of providers who meet these standards.

GambleAware	Evidence Review D	11	003 - 004	Model of Care - This statement is inaccurate of NGSN commissioned services. All services collect a wealth of information at baseline and end of treatment. The NGSN has an unrivalled national data set on service use and outcomes. This must be recognised and reflected in final decision-making on the guideline and its recommendations.	Thank you for your comment. The committee changed this sentence to clarify that 'not all' providers collect that information, and the data that are collected need to be transparent, as in all other publicly funded services - so that they can be used for the purposes of service design and addressing inequalities.

GambleAware	Evidence Review D	11	023-026	Model of Care - Comparative outcomes data is available on the high quality outcomes secured by the third sector in terms of waiting times, satisfaction rates, and drop out and completion rates.	Thank you for your comment and telling us about the data GambleAware collects. the committee agree these are the kind of data that would likely be included in the standardised dataset, and be routinely collected and published by all service providers.

GambleAware	Evidence Review D	11	039 - 042	Model of Care - We agree with the committee's rationale that effective gambling harms prevention and treatment will have offset cost benefits. However, the cost-effectiveness of third sector provision also needs to be taken into account. Including third sector provision as part of treatment pathways would be an efficient use of resources. According to independent economic modelling carried out by the NHS Health Economics Unit (available upon request), NGSN Tier 3 specialist treatment has a unit cost of £840. This is less than half the approximate unit cost of NHS specialist gambling clinics for equivalent provision (roughly £2,000). This is provided in an existing system which aligns with and refers to the NHS. There will not be a need to create an entirely new treatment system, as is suggested, instead the significant expertise and careful planning of the NGSN should be further enhanced and supported.	Thank you for your comment. No economic evidence was identified in this area but the committee considered resource implications and issues around cost-effectiveness when making recommendations. The guideline specifies that gambling treatment and gambling support services should be commissioned by the NHS, but they may be provided by a number of different providers, as long as they are fit for purpose and do not simply replicate current provision. The aim of NICE guidelines is not to recommend the least costly service, but services that are value for money, where additional benefits (and potential future cost-savings) outweigh additional provision costs, compared with current care. Currently, there is no evidence that NHS-commissioned services would be less cost-effective than existing NGSN services and cost-effectiveness cannot be established by solely comparing provision costs. The figure of £2,000 per referral has been an estimate calculated by dividing the current annual funding of £6 million allocated to the NHS specialist gambling clinics by the number of 3,000 patients a year that are planned by NHS to be treated across these clinics. However, the comparison between NHS clinics and the NGSN provider costs do not take into account what type of care is provided in each setting (including assessment, support, treatment and aftercare), by whom (specialist or not), and the outcomes expected to be achieved in each setting. Moreover, the cost estimate of £2000 per referral is based on current NHS provision of 15 specialist gambling clinics and does not take into account the fact that NHS is planned to commission gambling treatment and gambling support services, which may be provided by a range of providers, including the NHS or the voluntary and charity sector. The introduction of the statutory levy (which is expected to raise approximately £90-100 million annually by 2027 – see Government response to the consultation on the structure, distribution and governance of the statutory levy on gambling operators - GOV.UK) is likely to increase the funding available to spend on gambling support

					and treatment services commissioned by the NHS and a significant reconfiguration of services is expected to meet different levels of need. It is anticipated that the guideline will take a period of time to implement fully. As there is currently largely unmet need for these services (according to OHID figures on treatment needs: https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates/gambling-treatment-need-and-support-in-england-main-findings-and-methodology) and the financial and social costs associated with gambling-related harms are very high (according to OHID figures https://assets.publishing.service.gov.uk/media/63bc25b4d3bf7f262c5ad31f/The-economic-cost-of-gambling-related-harm-in-England_evidence-update-2023.pdf and NIESR figures https://www.niesr.ac.uk/wp-content/uploads/2023/04/The-Fiscal-Costs-and-Benefits-of-Problem-Gambling.pdf), it is anticipated that expanded, NHS commissioned, gambling treatment and gambling support services will gradually cover a larger part of the population needs, resulting in benefits and cost-savings that are likely to offset, at least partially, the high costs associated with gambling-related harms, so that these services represent value for money. It is agreed that there will not be a need to create an entirely new treatment system – the guideline does not suggest this. Instead, careful planning and reconfiguration of services will need to be implemented, which may involve setting up new services, reconfiguring existing services and transferring current staff or services from other providers into NHS-commissioned services.

GambleAware	Evidence Review D	11	044 - 045	We are concerned that available evidence has not been utilised by the committee. We urge the committee to consider costs per referral for NGSN services compared to the NHS and reconsider its conclusions.	Thank you for your comment. No economic evidence was identified in this area but the committee considered resource implications and issues around cost-effectiveness when making recommendations. The guideline specifies that gambling treatment and gambling support services should be commissioned by the NHS, but they may be provided by a number of different providers, as long as they are fit for purpose and do not simply replicate current provision. The aim of NICE guidelines is not to recommend the least costly service, but services that are value for money, where additional benefits (and potential future cost-savings) outweigh additional provision costs, compared with current care. Currently, there is no evidence that NHS-commissioned services would be less cost-effective than existing NGSN services and cost-effectiveness cannot be established by solely comparing provision costs. The comparison between NHS clinics and the NGSN provider costs do not take into account what type of care is provided in each setting (including assessment, support, treatment and aftercare), by whom (specialist or not), and the outcomes expected to be achieved in each setting. Moreover, your cost estimate of £2000 per referral, mentioned in another related comment that you made, is based on current NHS provision of 15 specialist gambling clinics and does not take into account the fact that NHS is planned to commission gambling treatment and gambling support services, which may be provided by a range of providers, including the NHS or the voluntary and charity sector. The introduction of the statutory levy (which is expected to raise approximately £90-100 million annually by 2027) is likely to increase the funding available to spend on gambling support and treatment services commissioned by the NHS and a significant reconfiguration of services is expected, as discussed above, to meet different levels of need. It is anticipated that the guideline will take a period of time to implement fully as services are reconfigured. As there is currently largely unmet need for these services (according to OHID figures on

					treatment needs) and the financial and social costs associated with gambling-related harms are very high (according to OHID and NIESR figures), it is anticipated that expanded, NHS commissioned, gambling treatment and gambling support services will gradually cover a larger part of the population needs, resulting in benefits and cost-savings that are likely to offset, at least partially, the high costs associated with gambling-related harms.

GambleAware	Evidence Review E	14	22	Pharmacological - We do not support this recommendation as there is no evidence to support the use of naltrexone for the treatment of gambling harms. The evidence review acknowledges this, yet this recommendation has been made regardless.	Thank you for your comment. Although there was no evidence evaluating the effects of naltrexone on gambling expenditure, gambling frequency, or time spent gambling. there was evidence that did show that naltrexone was more effective than placebo at reducing gambling symptom severity. The committee used this evidence and their own knowledge and clinical experience in using naltrexone for treatment of harmful gambling to make a weak 'consider' recommendation for its use in certain circumstances.
GambleAware	Evidence Review E	14	027 - 029	Pharmacological - We do not support this recommendation as there is no evidence to support the use of naltrexone for the treatment of gambling harms. The evidence review acknowledges this, yet this recommendation has been made regardless.	Thank you for your comment. Although there was no evidence evaluating the effects of naltrexone on gambling expenditure, gambling frequency, or time spent gambling. there was evidence that did show that naltrexone was more effective than placebo at reducing gambling symptom severity. The committee used this evidence and their own knowledge and clinical experience in using naltrexone for treatment of harmful gambling to make a weak 'consider' recommendation for its use in certain circumstances.

GambleAware	Evidence Review F	7	19	Psychological - We strongly agree that outcomes of gambling related harm should encompass a variety of factors in addition to financial loss, including frequency, time spent gambling, and psychological wellbeing. However, PGSI score as a scale of symptom severity does not gauge this. Importantly, we would recommend further research into how this is not an appropriate measurement tool for all groups/communities.	Thank you for your comment. The committee were aware of the limitations of the PGSI and they acknowledge that it was designed as a population level tool and not as a clinical scale aiming to measure gambling symptom severity. However it was given in the review protocol as one example of a validated scale, not least because of the committee's knowledge of the widespread use of the PGSI in research settings. The decision to include outcome data based on the PGSI was also linked with the economic model, conducted as part of this review because there are available data that link gambling symptom severity captured in PGSI scores with harmful gambling-related cost and utility data, which were essential in populating the economic model. As the committee were aware of the limitations of the PGSI they made a research recommendation to identify tools to assess gambling-related harms.

GambleAware	Evidence Review F	10	023 - 025	Psychological - We strongly suggest that qualitative studies and evidence be included to encompass the full scope of information available on the reduction of gambling harms.	Thank you for your comment. The committee fully accept the value of qualitative data and this is reflected in the decision to include 3 qualitative reviews in the development of this guideline. Qualitative studies were outside the scope of this specific review, which is a review of effectiveness and cost-effectiveness data for psychological and psychosocial treatment of harmful gambling. The qualitative data generated from the 3 qualitative reviews did provide evidence of what works well and what could be improved in gambling treatment services; the barriers and facilitators to accessing treatment for harmful gambling and the support and information needs of people experiencing harmful gambling and affected others - and this evidence was all based on the views and experiences of people experiencing harmful gambling, practitioners and affected others. Qualitative data informed many of the guideline recommendations and this is described in the evidence reports C, I and K.
				RCTs offer a high standard of study, but the inclusion of other types of evidence is important to ensure full understanding of the issue. The lack of non-experimental data means that the evidence review makes assumptions that may not be fully accurate, and means the committee must rely on their opinion rather than the full scope of available data.	

GambleAware	Evidence Review F	59	44	The document states that there is a lack of data on trauma-informed and residential interventions. This is not correct – there is evidence on the outcomes from these interventions in a real-world setting. As this does not align with the criteria set by the committee with regards to evidence type, this evidence has been discounted. We are concerned that this may have led to a deprioritising of impactful gambling harms interventions by the committee.	Thank you for your comment. The review of psychological and psychosocial interventions for people who participate in harmful gambling is an effectiveness and cost-effectiveness review and used NMA methodology, therefore only RCT evidence was considered as this provides the most robust evidence for estimating treatment effectiveness and making recommendations. The NMA of treatments for reducing the severity and frequency of gambling looked for evidence for residential treatment, but did not find any evidence that met the protocol criteria. As a result the committee were unable to recommend this as a specific intervention. The committee understand that a parallel but non-evidence-based piece of work on treatment need conducted by the Office for Health Improvement and Disparities may have included consideration of residential treatment, but at the present time, until more evidence is available, it is not possible to recommend this as a specific setting for care in this guideline.

GambleAware	Evidence Review F	64	26	The PGSI is a survey tool for understanding the scale of problematic gambling behaviour and was not designed to provide a comprehensive assessment of individual clinical need for treatment purposes.	Thank you for your comment. The committee acknowledge that the PGSI was originally designed as a population level tool and not as a clinical scale for measuring gambling severity. The recommendations have been amended to remove PGSI as the sole determinant of gambling severity and to include a new section in the guideline on referral and triage and directing people to the correct level of treatment and support. The services have also been differentiated

				Additionally, some PGSI questions are 'legacy questions' that would elicit an affirmative response irrespective of whether the individual is still gambling, which can lead to a score that may inaccurately suggest a high level of gambling activity. While someone presenting with PGSI 8+ should clearly be flagged as requiring further support, PGSI score alone should not lead to a direct referral to an NHS clinic. Consideration should be made of local community support, other options, and discussion of service user choice. In many cases their needs can be met by third sector providers, which are able to provide more complex treatment too. To determine someone's full clinical presentation, and whether there is a need for stepped-up care, a full assessment of their needs is required, including to understand the patient's mental and emotional wellbeing. The guideline must set out how this can be accessed and undertaken.	into gambling support services and gambling treatment services to clarify what different levels of services will provide.

GambleAware	Evidence Review F	65	General	We are concerned that group CBT has been presented as the most effective intervention. As only clinical studies were included, evidence around the potential effectiveness of other interventions such as self-help strategies have not been included.	Thank you for your comment. The systematic review of psychological and psychosocial interventions for people who participate in harmful gambling did include evidence on self-help. The network meta-analysis (NMA) considered RCT evidence only, as this has the highest quality for estimating treatment effectiveness. The NMA included RCTs of guided self-help and self-help with minimal or no support. In fact, self-help had the largest evidence base in the NMA (for example, 644 people were tested on guided self-help and 1,616 on self-help with minimal or no support in the NMA of change in symptom severity) as it can be seen in Table 3 of the evidence review. However, neither of these showed evidence of effect versus no treatment, as it can be seen in Figure 2 and Table 4. The pairwise analysis also included evidence from studies comparing self-help, and although some comparisons found important benefits for self-help, these included a very low participant number in all instances (less than 100 participants) and individual results were only derived from single studies. Therefore, the committee decided not to include self-help interventions for recommendations as the evidence for self-help was insufficient.

GambleAware	Evidence Review F	67	General	We agree that where CBT is offered, clinicians should have gambling-specific training and competence to help reduce barriers to support and stigmatising stereotypes. However, we question the limited evidence noted around counselling, motivational interviewing, and other therapeutic interventions for reducing gambling harms. Growing research suggests self-help strategies may be effective, particularly when it comes to overcoming the stigma of accessing help for gambling harms.	Thank you for your comment. According to our inclusion criteria as stated in our review protocol (Appendix A), both RCTs and non-randomised controlled trials were eligible for inclusion. The review included 48 studies (47 RCTs and 1 non-RCT) reported in 51 publications. There was only one study assessing counselling. Counselling had been tested on 76 trial participants in total (both for the outcome of gambling symptom severity and the outcome of gambling frequency – Table 3). In the NMA on gambling symptom severity, the effect (SMD) of counselling versus no treatment showed high uncertainty, with 95% CrI that crossed the line of no effect (Table 4). Similar results were found for counselling regarding gambling frequency (Table 5). Based on this limited and uncertain evidence, the committee decided not to make a recommendation for counselling. More evidence was available for motivational interviewing: it was tested on 303 people in 5 trial arms regarding gambling symptom severity (Table 4) and 290 people in 6 trial arms regarding gambling frequency (Table 5). Compared with no treatment, motivational interviewing showed a moderate and uncertain effect on gambling symptom severity, and a moderate effect on gambling frequency (Tables 5 and 6). As reported in the Committee's discussion of benefits and harms, the committee expressed the view that gambling frequency is only one aspect of gambling symptom severity, noted the more limited evidence base for every treatment in the NMA of gambling frequency compared with the NMA of gambling symptom severity, and decided to consider mainly the results on symptom severity when formulating recommendations. Combining clinical findings with the results of the economic analysis, which suggested that motivational interviewing is a very cost-effective option, and considering that an initial session of motivational interviewing was often part of the offered intervention in CBT trials, the committee made a 'consider' recommendation for motivational interviewing as an option in some circumstances. Self-help had the

				A research recommendation should be made to further explore the appropriateness/effectiveness of group/individual CBT versus other intervention types using other sources of evidence or primary research.	largest evidence base in the dataset (guided self-help was tested on 644 people in 11 trial arms for gambling symptom severity and 608 people in 9 trial arms for gambling frequency; self-help with no or minimal support was tested on 1616 people in 22 trial arms for gambling symptom severity and 1526 people in 18 trial arms for gambling frequency). Regarding gambling symptom severity, which was the main outcome considered by the committee when making recommendations, guided self-help showed a very small and uncertain effect versus no treatment, whereas self-help with minimal or no support showed no effect versus no treatment. Guided self-help was included in the economic analysis and was less cost-effective than no treatment. Therefore no recommendations on self-help for treating gambling that harms were made. However, the guideline includes recommendations on provision of online information and support through apps or social media. Unfortunately, we are unable to make a research recommendation to explore the effectiveness of group/individual CBT vs other intervention types as this review already found relevant evidence for this, which prioritised RCTs as this has the highest quality for estimating treatment effectiveness. The committee did however make research recommendations on (a) the long-term effectiveness and cost-effectiveness, including prevention of suicide and self-harm, of psychological treatments for gambling that harms and (b) the effectiveness and cost-effectiveness of psychological or psychosocial interventions to reduce gambling symptoms and increase recovery capital. Both research recommendations are relevant to group or individual CBT, and recommend comparisons between active psychological interventions.

GambleAware	Evidence Review F	81	General	We are concerned with the search protocol only including experimental studies. Of these studies many were low/very low quality or had limited participants.	Thank you for your comment. We agree that most of the evidence was rated as low/very low quality according to GRADE. GRADE assessments define the quality of a body of evidence across outcomes, rather than the individual studies. So 'quality' in this context refers to the extent to which one can be confident that an estimate of effect is close to the quantity of specific interest. GRADE takes into account the risk of bias of the studies contributing to each outcome and this was generally high (risk) due to lack of blinding of participants. This resulted in an overall low quality of evidence according to the GRADE approach. Most of these outcomes however were rated to be of low risk of bias in all other GRADE domains and should therefore not be disregarded. The committee took into account the quality of each body of evidence on which they based their recommendations but as per protocol, evidence rated low according to GRADE would not be excluded from a review.

Gambling with Lives	Evidence Review F	189	General	Age – "… cohorts considered in the economic model was set at 36 years, to reflect the mean age of treatment-seeking people experiencing gambling-related harms in 6 three UK studies." It is the overwhelming experience of GwL that people suffering serious gambling harms are considerably younger than 36. The 3 studies referred to are all "treatment seeking people", reflecting the flawed and inadequate provision and level of knowledge across the treatment sector. The NICE guidelines MUST reflect the future position when through better treatment provision, accessibility of complete information and the tackling of stigma that many more young people will access treatment 'early'. It is widely acknowledged that development of gambling disorder can be rapid: unless a person has started gambling later in life, then by age 36 they are likely to have developed a severe disorder.	Thank you for your comment. The guideline economic analysis assessed the cost-effectiveness of interventions provided to people presenting to services, therefore the study population had to be people seeking treatment. Currently, evidence suggested that the mean age of people seeking treatment was 36 years. It is agreed that in the future, following increased identification of people experiencing gambling that harms and improved access to treatment, the mean age of people seeking treatment is likely to become lower. For this reason, although the starting age of the cohort was set at 36 years, a sensitivity analysis explored the impact of different starting ages on the results. As stated in the report, the starting age only affected the estimation of the expected mortality in the study population, and results suggested that ranging the age from 20 to 48 years had no impact on the results. Please note that the model assumed that the standardised mortality ratio for overall mortality and for suicide associated with gambling-related harms is the same across the ages of 20-49 years of age, based on data availability. As alternative data on differential age-specific suicide effects of gambling were not available, such differential effects were not possible to model. Please note that the focus of the economic analysis was not to estimate the impact of gambling on suicide, but to assess the impact of interventions on gambling symptom severity (which was further translated into a change in suicide rates). In any case, the economic analysis showed that group and individual CBT, which were the only treatments with evidence of effectiveness (the latter only marginally) in the NMA of gambling symptom severity were also cost-effective versus no treatment under a public sector perspective, and were thus recommended as treatment options (evidence of effectiveness was determined by 95%CrI not crossing the line of no effect, as stated in

				While the text refers to sensitivity analysis varies the starting age of cohorts between 20 and 48, this is an inadequate approach. Noting bullets 2 and 3, it is not clear what would be the impact of this poor assumption. However, it is likely to lead to a substantial underestimation of the value of treatment and the cost of no-treatment. This will be particularly the case when considering the cost of suicide: the experience of GwL is that most deaths occur well before age 36, so that the calculation of QALYs will be a huge underestimate.	Evidence review F. Therefore even if differential age-specific data on the impact of gambling on suicide were available and could be used, they would only strengthen the finding of group and individual CBT being cost-effective under a public sector perspective and would thus make no difference in the recommendations made.

Gambling with Lives	Evidence Review F	189	General	Suicide – it appears that suicide has been considered only as a "scenario analysis". Given that OHID have calculated suicide to be the largest of the factors that they were able to quantify [ref}, this seems to be a wholly inadequate approach to calculating the 'economic' (or any other) impact of suicide. AS noted in bullets 2 and 3, it is not possible to understand what this 'scenario' showed or how it influenced any decisions. There is wide agreement and substantial research which has highlighted the link between gambling and suicide: it must be core to calculations, not explored through scenario analysis.	Thank you for your comment. Increase in mortality due to suicide associated with gambling-related harms, as reflected on (1) costs associated with suicide (such as NHS costs, local authority coroner costs, criminal justice system costs, as well as the NHS bereavement costs incurred by family and/or friends) and (2) life-years and QALYs lost have been considered in the base-case analysis, which had a time horizon of 2 years due to lack of longer term data on treatment effectiveness as well as the course of gambling that harms regarding events such as relapse and natural remission. In addition to these impacts of suicide, the scenario analysis estimated the full QALY loss of people who died of suicide during the 2-year time horizon of the model, beyond the model time horizon and over their anticipated life expectancy (as estimated according to general population statistics). Results of this scenario analysis are shown in Evidence Review F, Appendix I, in Tables 89 (OHID cost set – NHS/PSS perspective), 92 (OHID cost set – Public sector perspective), 95 (NIESR cost set – NHS/PSS perspective) and 98 (NIESR cost set – Public sector perspective). These results show that the net monetary benefit (NMB) of all treatment options has been reduced (as lifetime QALY loss has been considered). However, the relative cost-effectiveness of active treatments versus no treatment has been improved, as treatments prevent QALY loss due to suicide, as it can be seen by comparing each scenario with the respective base-case analysis (according to the cost dataset and perspective used). The comparison reveals that the only substantial changes in the conclusions under the scenario analysis are that (1) motivational interviewing became more cost-effective than no treatment using the OHID dataset under an NHS/PSS perspective and (2) individual CBT, individual BT and counselling became more cost-effective than no treatment using the

					OHID dataset under a public sector perspective. This scenario analysis further supported the cost-effectiveness of individual face-to-face treatments versus no treatment and strengthened the recommendations on individual CBT (which was already shown to be cost-effective under a public sector perspective using NIESR costs in the base-case analysis). The results of this analysis have now been added in the Committee's discussion in Evidence Review F, under 'Cost effectiveness and resource use'.

Gambling with Lives	Evidence Review F	204	General	Suicide/QALYs – We believe that the calculation of QALYs underestimates the cost (public sector perspective) substantially. Separately we have challenged OHID's calculation since it seems to assume that gambling related suicides occur at similar ages to 'other' suicides. GwL's experience is that gambling related suicides occur much earlier leading to far more 'lost' QALYs. We are also very concerned that the economic model uses much lower cost for QALYs than even OHID with any justification other than it is "not consistent with NICE principles and the reference case (NICE 2014)". This requires more explanation and justification since OHID uses government Green Book principles. Again, it is not clear what impact this changed assumption has or how recommendations might be influenced. But, once again, the impact of suicide is substantially underestimated.	Thank you for your comment. We are not clear how the calculation of QALYs can underestimate costs, as these are two different impacts of gambling-related harms. Reading your comment suggests that you may be possibly referring to a potential underestimation of mortality due to suicide, which may have subsequently led to underestimation of related costs and QALYs. The model does not assume that gambling related suicides occur at similar ages to 'other' suicides. However, the model does assume that the standardised mortality ratio for overall mortality and for suicide associated with gambling-related harms is the same across the ages of 20-49 years of age, based on data availability and due to lack of alternative age-specific data. The value of the QALY in the economic analysis was set at £20,000, which is consistent with the NICE lower cost-effectiveness threshold used routinely across guidance published by the Institute (with the exception of highly specialised technologies), reflected also in NICE's core principles. Please see: https://www.nice.org.uk/about/who-we-are/our-principles: "Principle 7. Base our recommendations on an assessment of population benefits and value for money", point 24 "Interventions with an ICER of less than £20,000 per QALY gained are generally considered to be cost effective" and also Developing NICE guidelines: the Manual, available here: https://www.nice.org.uk/process/pmg20/chapter/incorporating-economic-evaluation. This value of £20,000/QALY is not a 'changed assumption', it is a value used throughout NICE guidelines, including all other mental health guidelines published by NICE. In any case, using this value resulted in almost all assessed interventions (group CBT, individual CBT, motivational interviewing, counselling, individual BT) being cost-effective under a public sector perspective (which was the primary perspective considered by the committee), with the exception of guided self-help, which, in any case, showed a very small clinical effect compared with no treatment. Therefore, attaching

					a higher monetary value to a QALY would practically not have had any impact either on the conclusions of the economic analysis, or on the guideline recommendations (which were informed by the clinical analysis, the economic analysis and further clinical considerations).

Gambling with Lives	Evidence Review F	250	General	Costs – This section acknowledges the very substantial costs which are not estimated and do not feature in the model. International analyses to estimate the costs of gambling (and other product) harms often note that these 'non-estimated costs' usually outweigh the minority of costs which can be calculated. Beyond acknowledging that the costs do not feature, the section does not detail how they can be considered. It seems a major oversight not to attempt to estimate how their inclusion might have influenced findings and recommendations. Our concerns with the treatment of all these factors feature in the presentation of model findings from p212 onwards. Finally, we note that the modelling presents both NHS/PSS and Public Sector Perspective. As the report acknowledges, most of the costs associated with harms are incurred outside of the NHS, therefore it seems that prominence should be given to the "Public Sector Perspective" results. It is not always clear that this is the case.	Thank you for your comment. The economic analysis utilised costs estimated in two different reports prepared by OHID and NIESR. Like other international analyses, both sources acknowledged that a wide range of excess costs associated with gambling-related harms were not possible to estimate, due to lack of relevant data (e.g. costs in the education system) or because some costs are intangible and difficult to measure (e.g. emotional distress of family, friends and close others). For the same reason, it was not possible to estimate and incorporate such costs in the economic analysis. As stated in the Discussion section of Appendix I (evidence review F): "Costs relating to reduced performance at work or study, crime, cultural harms, healthcare costs associated with suicide attempts, anxiety and stress, non-suicidal self-harm, other mental and physical health conditions to the person experiencing problem gambling and/or their family, friends and close others were either not estimated or partly estimated in the two reports. Excess costs to the individual, their family and close others, such as financial harms and bankruptcy or debt, lower financial inclusion (inability to access affordable financial products and services), limited or no financial planning, as well as intangible costs such as physical, emotional or psychological distress, relationship breakdown or problems and wider impacts on the families of gamblers, were not estimated in either report [this refers to OHID and NIESR reports], due to lack of relevant data. A range of these costs fall outside a NHS/PSS or a public sector perspective, so they would not be included in the estimation of costs in the guideline economic analysis, but should nevertheless be qualitatively considered when making recommendations." So, the report does advise that these costs be considered when making recommendations. In the committee's discussion, under 'Cost effectiveness and resource use' it is stated that the committee commented that "the total costs associated with gambling-related harms were likely underestimated in the economic analysis, due to

					lack of relevant data or because some costs lie outside the perspective of the analysis. Regarding the perspective of the analysis, as stated in Appendix I, “the economic analysis adopted the perspective of the NHS and personal social services (PSS), as recommended by NICE (NICE, 2014). In addition, a public sector perspective was considered, as the majority of costs associated with problem gambling are borne to services beyond NHS and PSS, within the wider public sector”. Results using each perspective were separately presented. In the committee’s discussion, under ‘Cost effectiveness and resource use’ section, it is clearly reported that the committee “agreed that economic results from a public sector perspective should be given a higher weight when formulating recommendations”. Under this perspective, all interventions (with the exception of guided self-help which only showed very small effects compared with no treatment in the guideline NMA) were found to be cost-effective. Guideline recommendations were made based on these cost-effectiveness conclusions, conclusions on the evidence of effectiveness determined by 95% CrI not crossing the line of no effect, and other clinical considerations. The full rationale for how recommendations were formulated using the results of the economic analysis is discussed in the same section. Therefore, hypothetical inclusion of currently non-estimated costs (if it was possible to estimate them) would not have had any further influence either on the results and conclusions of the analysis or on the guideline recommendations, since all interventions were already cost-effective (albeit some did not show evidence of effectiveness) without inclusion of such costs – it would only further strengthen the findings on the interventions’ cost-effectiveness.

Gambling with Lives	Evidence Review F	General	General	We welcome inclusion of details of the Economic Model within the review as part of the commitment to transparency of decision making. However, for true transparency we believe that the model requires much fuller and clearer explanation. Despite our request, we were not able to speak to anyone to be able to clarify any of the following: Its structure – the complexity of the Excel model is difficult to follow, requiring a detailed examination of the formulae across several sheets with the overall spreadsheet Its assumptions – it is not always clear where assumptions about the value of different cost factors or how the relationship between factors in the various scenarios or sensitivity analyses have been derived: indeed it is unclear how many sensitivity analyses were carried out, interpreted or used. Its use – it is unclear how and where in the main review the model (and its various scenario/sensitivity analyses) are actually used: results from the model are rarely quoted or discussed in full.	Thank you for your comment. It is standard NICE policy that all economic models developed by NICE to inform guideline recommendations become available during consultation with stakeholders for transparency, and to inform stakeholders' understanding of the guideline. In line with this policy, the economic model developed to inform this guideline also became available during the consultation with stakeholders. This was the full, workable version of the model, which was used to run the guideline economic analysis and inform relevant treatment recommendations. As stated in the notes under 'Model terms and conditions' in the Excel file, using the model requires relevant technical expertise. Unfortunately, it is not a NICE policy to enable verbal communication between the technical team and stakeholders during consultation to clarify the details of the economic model (or any other technical analyses carried out to support guideline development). The Excel file includes a 'Model map' sheet, which provides an overview of the model spreadsheets and functions. Full description of the model structure and assumptions is provided in Evidence Review F, Appendix I. The Excel file needs to be checked in conjunction with the Appendix. The Excel model is necessarily complex to allow representation of the conceptual structure and appropriate calculations and links between model inputs and outputs. The conceptual model structure is described in Appendix I (under the respective subheading) and illustrated in Figure 7 of the report. All assumptions used in the model are described within the report. All input data and assumptions in the Excel file are provided in the sheets shown under 'Model Input Parameters' in the 'Model map' sheet, and the functions in the dependent cells. It is acknowledged that checking all data and functions is likely to be a complex process for a person without technical expertise, but, as noted above, this is highlighted in the 'Model terms and conditions' cover sheet. Developing a simpler version of the model in order to be more 'approachable' to non-

				Therefore, it is difficult to provide comments on the model or its use with any degree of certainty. With that caveat in mind, we have the following comments. The references relate to pages within "Harmful gambling: identification, assessment, and management [F]. Psychological and psychosocial treatment of harmful gambling."	technical experts would require simplification of (or even inappropriate) assumptions, loss of important aspects around the course and treatment of gambling that harms, and, ultimately, a compromise in the quality of the economic analysis. The assumptions about the value of different cost factors are described in Appendix I of Evidence Review I, under the 3 headings of 'Intervention resource use and costs', 'Costs associated with gambling-related harms' and 'Costs associated with completed suicide' (13 pages in total) and summarised in Tables 83, 84 and 85, respectively. Under the heading 'Handling uncertainty' and at the bottom of this section, there is a list with all scenarios tested in sensitivity analysis, including alternative cost assumptions. Under the heading 'Economic modelling results' full results of the base-case analyses are provided, for each cost dataset used (OHID or NIESR) and perspective (NHS/PSS or public sector), resulting in 4 sets of results. Due to the high number of sensitivity analyses tested, results are shown only for scenarios that changed the cost-effectiveness of active treatments relative to no treatment, and thus the conclusions of the analysis. These are shown in Tables 88, 91, 94 and 97. All results (both base-case and from sensitivity analysis) were considered by the committee when making recommendations, and discussion of how economic findings informed recommendations is included in committee's discussion, under heading 'Cost effectiveness and resource use' in the report. It is true that there is no explicit reference to the results of sensitivity analysis, although the term 'scenarios' refers both to (1) the 4 analyses undertaken after combining the 2 sets of OHID and NIESR costs and the 2 perspectives of NHS/PSS and public sector, and (2) scenarios tested in sensitivity analysis. For this reason, more detail has now been added in this section. In the Excel file, there are different sheets named 'Gambling OHID and suicide costs' and 'Interventions costs' that show the calculations and assumptions behind the cost input values. The sheet 'Input parameters' provides

					the values of all model inputs, including all cost elements. The sheet 'Deterministic SA' shows all scenarios tested in sensitivity analysis, including alternative scenarios and assumptions around costs. By clicking the buttons next to each scenario, the results of the deterministic analysis (shown in sheet 'Results determ') change, showing the results for each respective scenario tested.

GambleAware	Evidence Review F	General	General	Psychological - We agree that the data extracted is internally valid. We have no issues with how data has been treated in the guidelines. The evidence review acknowledges this, yet this recommendation has been made regardless.	Thank you for your comment. It is not clear what concerns are being described here. If the concern is that we used 'low quality rated evidence' to make a recommendation for CBT treatment, the overall evidence was judged to be adequate to make this recommendation. To further clarify, evidence was rated as low/very low quality according to GRADE. GRADE assessments define the quality of a body of evidence across outcomes, rather than the individual studies. So 'quality' in this context refers to the extent to which one can be confident that an estimate of effect is close to the quantity of specific interest. GRADE takes into account the risk of bias of the studies contributing to each outcome and this was generally high (risk) due to lack of blinding of participants. This resulted in an overall low quality of evidence according to the GRADE approach. Most of these outcomes however were rated to be of low risk of bias in all other GRADE domains and should therefore not be disregarded. The committee took into account the quality of each body of evidence on which they based their recommendations but as per protocol, evidence rated low according to GRADE would not be excluded from a review.

GambleAware	Evidence Review F	General	General	Psychological - While we understand the need for robust evidence, the inclusion of only RCTs in this review may have led to decisions by the committee which do not reflect real world learnings. Given their nature, the results from RCTs cannot always be easily transferred to real world practice. A combination of RCTs and real world evidence is important. While the search strategy did not specifically search for RCTs, the protocol inclusions must be adjusted so they do not necessarily require a strict 'comparison' intervention, instead allowing for observational or naturalistic research to be included in the review. RCTs are not always superior to other forms of evaluation (https://www.sciencedirect.com/science/article/pii/S0277953617307359)	Thank you for your comment. The review of psychological and psychosocial interventions for people who participate in harmful gambling is an effectiveness and cost-effectiveness review and used NMA methodology, therefore only RCT evidence was considered as this provides the most robust evidence for estimating treatment effectiveness and making recommendations. The protocol which was used for this review was agreed a priori and it governed the title and abstract and full text screening of the search results. The committee is aware of the value of qualitative data, which is reflected in the fact that 3 qualitative reviews were conducted for the development of this guideline. However qualitative evidence was outside the scope of this specific review, which is a review of effectiveness and cost-effectiveness data for psychological and psychosocial treatment of harmful gambling. The qualitative data generated from the 3 qualitative reviews did provide evidence of what works well and what could be improved in gambling treatment services; the barriers and facilitators to accessing treatment for harmful gambling and the support and information needs of people experiencing harmful gambling and affected others - and this evidence was all based on the views and experiences of people experiencing harmful gambling, practitioners and affected others. Qualitative data informed many of the guideline recommendations and this is described in the evidence reports C, I and K. This review does report the demographic data of participants, which can be found in the evidence table of supplement 3: psychological treatment evidence tables. The committee recognised that there was a lack of evidence for people from minority communities and so made two research recommendations relating to improving access and treatment for diverse groups.

				RCTs are generally not valid for the evaluation of socially complex service interventions (https://pubmed.ncbi.nlm.nih.gov/11967443/) RCTs can inadvertently lead to some types of intervention being prioritised over other types of intervention (https://www.sciencedirect.com/science/article/abs/pii/S095539592030181X) RCTs can lead to undue focus on those presenting for care in specialist settings, and lack relevance to the broader population experiencing harm (https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-015-0437-x) https://www.sciencedirect.com/science/article/pii/S0277953617307359 RCTs do not adequately convey the uncertainty and complexity surrounding the estimated treatment effect, including the wider factors and circumstances which an estimated treatment effect is likely to be a function of (https://www.sciencedirect.com/science/article/abs/pii/S0277953619304812)	

				It is important to note that the sole use of data from RCTs leads to a focus on the most medicalised and specialist forms of intervention, simply because these are the ones that have been evaluated with an RCT. This is problematic in the field of gambling harms as only a small proportion of those getting treatment for gambling harms receive the most intensive and medicalised forms of support. Additionally, the studies included do not mention the demographics of participants and it is therefore difficult to see whether the needs of communities who experience higher burdens of harm (such as ethnic or religious minority groups, women, traveller communities and other inclusion health groups) were considered. Our research has demonstrated that it is important to understand whether treatment is known about, trusted, accessible, and effective for all groups and communities (cultural, religious or otherwise), as demonstrated in the below: https://www.begambleaware.org/sites/default/files/2023-03/Minority%20Communities%20Final%20Report_0.pdf	

				https://www.begambleaware.org/sites/default/files/2023-05/Building%20Knowledge%20of%20Women%E2%80%99s%20Lived%20Experience%20of%20Gambling%20and%20Gambling%20Harms%20Across%20Great%20Britain.pdf RCTs have historically excluded minority communities so should not be included as the only evidence source. Such groups face additional barriers to accessing support, such as a lack of trust or stigma associated with seeking support, and therefore may not have been included in clinical intervention studies.	

GambleAware	Evidence Review F	General	General	Assessment of harm in this guideline seems to be based on a clinical model. Research such as the Gambling Harms Framework scoping study has demonstrated that conceptions of gambling based on clinical models which pathologise gambling harms can perpetuate and compound negative and stigmatising stereotypes of gambling harm, particularly in relation to minority groups.	Thank you for your comment. The protocol for this evidence review included a broad range of outcomes including measures of wellbeing and personal, social and life functioning. Therefore, the recommendations based on this review have taken account of data on these outcomes. The committee were aware of the importance of taking an all harms approach to this guideline, which is reflected in the recommendations about a holistic assessment and the provision of help and support with a broad spectrum of needs and not focussing only on the highest level of harms or severity. In addition the committee were aware of the impact of stigma and made several recommendations to improve awareness of and lessen the impact of stigma.

GambleAware	Evidence Review G	7	13	While we understand the need for robust evidence, the inclusion of only RCTs in this review may have led to decisions by the committee which do not reflect real world learnings. Given their nature, the results from RCTs cannot always be easily transferred to real world practice. A combination of RCTs and real world evidence is important. While the search strategy did not specifically search for RCTs, the protocol inclusions must be adjusted so they do not necessarily require a strict 'comparison' intervention, instead allowing for observational or naturalistic research to be included in the review. RCTs are not always superior to other forms of evaluation (https://www.sciencedirect.com/science/article/pii/S0277953617307359) RCTs are generally not valid for the evaluation of socially complex service interventions (https://pubmed.ncbi.nlm.nih.gov/11967443/)	Thank you for your comment. The review of psychological and psychosocial interventions for people who participate in harmful gambling is an effectiveness and cost-effectiveness review and used NMA methodology, therefore only RCT evidence was considered as this provides the most robust evidence for estimating treatment effectiveness and making recommendations. The protocol which was used for this review was agreed a priori and it governed the title and abstract and full text screening of the search results. The committee is aware of the value of qualitative data, which is reflected in the fact that 3 qualitative reviews were conducted for the development of this guideline. However qualitative evidence was outside the scope of this specific review, which is a review of effectiveness and cost-effectiveness data for psychological and psychosocial treatment of harmful gambling. The qualitative data generated from the 3 qualitative reviews did provide evidence of what works well and what could be improved in gambling treatment services; the barriers and facilitators to accessing treatment for harmful gambling and the support and information needs of people experiencing harmful gambling and affected others - and this evidence was all based on the views and experiences of people experiencing harmful gambling, practitioners and affected others. Qualitative data informed many of the guideline recommendations and this is described in the evidence reports C, I and K.

				RCTs can inadvertently lead to some types of intervention being prioritised over other types of intervention (https://www.sciencedirect.com/science/article/abs/pii/S095539592030181X) RCTs can lead to undue focus on those presenting for care in specialist settings, and lack relevance to the broader population experiencing harm (https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-015-0437-x) https://www.sciencedirect.com/science/article/pii/S0277953617307359 RCTs do not adequately convey the uncertainty and complexity surrounding the estimated treatment effect, including the wider factors and circumstances which an estimated treatment effect is likely to be a function of (https://www.sciencedirect.com/science/article/abs/pii/S0277953619304812) It is important to note that the sole use of data from RCTs leads to a focus on the most medicalised and specialist forms of intervention, simply because these are the ones that have been evaluated with an RCT. This is problematic in the field of gambling harms as only a small proportion of those getting treatment for gambling harms receive the most intensive and medicalised forms of support.	

GambleAware	Evidence Review G	11	023 - 024	It is unclear why this evidence was included when it was all judged to be of low or very low quality. GambleAware is happy to share its reviews of literature, focused on interventions for children and young people impacted by gambling harms, including those impacted as affected others, as a source of higher quality evidence for the committee to consider. This shows that there are interventions with promising evidence for being effective for this cohort.	Thank you for your comment. As per the review protocol, decisions about including or excluding evidence were not based on assessments of quality, they are based on whether studies fit the 'PICO' as well as other considerations such as study design and year of publication. You are right that the GRADE ratings in this review were either low or very low. GRADE assesses the quality of evidence for each outcome, rather than the quality of the included studies (which are assessed using the Cochrane Risk of Bias 2 tool). The GRADE assessment does however take account of the risk of bias of studies contributing to the evidence per outcome as risk of bias is one of the 4 GRADE domains (the others being inconsistency, indirectness and imprecision) If concerns about just one of those domains is 'very high' then the quality of the evidence for that outcome is downgraded to be of low quality. In the case of this evidence report, the evidence for most outcomes was low or very low because of serious or very serious concerns in the risk of bias domain, stemming from the studies being assessed with a high risk of bias due to lack of blinding of participants. Although blinding of participants is not completely impossible for these types of interventions it is difficult and quite rare. This is why almost all evidence for this review was at least 'low' quality. The committee do not ignore such evidence but they do take account of the GRADE assessment in making recommendations.

GambleAware	Evidence Review G	12	022 - 023	The review states that 'the committee discussed the importance of ensuring that affected others remain at the centre'. However, as no qualitative studies or evidence that included assessment of or the views of these individuals were used in the review, we are concerned this aim has not yet been met. The review must be revised to include a broader range of evidence sources that consider affected others – a particular example that may be of interest is this report exploring the experiences of women who are affected others: Building Knowledge of Women's Lived Experience of Gambling and Gambling Harms Across Great Britain.pdf (begambleaware.org).	Thank you for your comment and highlighting your concerns about a lack of qualitative data in this review. This review question was designed to locate evidence of the effectiveness of interventions and approaches for reducing gambling-related harms for families and affected others. The review focused on RCTs because they provide the most robust evidence for estimating treatment effectiveness. The protocol which was used for this review was agreed a priori and it governed the title and abstract and full text screening of the search results. The committee is aware of the value of qualitative data, which is reflected in the fact that 3 qualitative reviews were included in the development of this guideline. The qualitative data generated from those 3 reviews did provide evidence of what works well and what could be improved in gambling treatment services; the barriers and facilitators to accessing treatment for harmful gambling and the support and information needs of people experiencing harmful gambling and affected others - and this evidence was all based on the views and experiences of people experiencing harmful gambling, practitioners and affected others. Qualitative data informed many of the guideline recommendations and this is described in the evidence reports C, I and K. Finally, thank you for the suggested report, which we checked and found that it does not meet the inclusion criteria for this review.

				For example, on page 64, this document notes the importance of emotional, non-judgemental interventions through a direct quote from a woman who is an affected other: “Feeling judged and being given the wrong support or lack of communication can prevent anyone from engaging with any support offered or accessed”. The lack of qualitative research used in this review means that the voices and experiences of affected others have not been appropriately included.	
GambleAware	Evidence Review G	12	029 - 031	We agree that developing an understanding of long-term/legacy harms or impacts of gambling, for affected others and for people who gamble, is a key area of research that is currently underdeveloped.	Thank you for your comment and your support for the outcomes chosen in this review.
His Majesty’s Prison and Probation Service (HMPPS)	Evidence Review G.	12	017 – 018 - 019	“Economic model - No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.”	Thank you for your comment. Prioritisation of topics for de novo economic modelling follows considerations of factors such as the potential overall expected benefit and resource implications of an intervention for individuals and for the whole population, and the degree of uncertainty around cost-effectiveness and the likelihood that economic analysis will clarify matters (see Developing NICE guidelines: the Manual). For this specific review question, the committee acknowledged the large impact of gambling-related harms

				In each of the Appendix D Evidence Tables the "Sources of Funding" is reported as "Unclear funding source".	on family, friends and close others. However, existing clinical evidence, which was required to inform a de novo economic analysis, was limited and uncertain, reporting a variety of outcomes for the study population (such as unmet needs, satisfaction, anxiety) that could not be meta-analysed or translated into QALYs; therefore, the value of developing a formal model in this area was considered more limited compared with other areas, as interpretation of cost-effectiveness would be less straightforward. Nevertheless, in the lack of formal economic evidence, the committee made qualitative cost-effectiveness considerations when making recommendations. The source of funding in Appendix D evidence tables refers to the source of funding obtained by each individual study included in this review. When the funding source is reported to be 'unclear' it means that either the study did not disclose their funding source or it is unclear if it is industry funded or not.
His Majesty's Prison and Probation Service (HMPPS)	Evidence Review G.	12	017 – 018 - 019	"Economic model - No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation." The relevance of working with the Proceeds of Crime Act (POCA) is a critical feature of working with affected others. The long lasting and often devastating impact of debt and recovery of monies needs to be factored into a sustainable health recovery plan. This should raise the priority.	Thank you for your comment. Prioritisation of topics for de novo economic modelling follows considerations of factors such as the potential overall expected benefit and resource implications of an intervention for individuals and for the whole population, and the degree of uncertainty around cost-effectiveness and the likelihood that economic analysis will clarify matters (see Developing NICE guidelines: the Manual). For this specific review question, the committee acknowledged the large impact of gambling-related harms on family, friends and close others. However, existing clinical evidence, which was required to inform a de novo economic analysis, was limited and uncertain, reporting a variety of outcomes for the study population (such as unmet needs, satisfaction, anxiety) that could not be meta-analysed or translated into QALYs; therefore, the value of developing a formal model in this area was considered more limited compared with other areas, as interpretation of cost-effectiveness would be less straightforward. Nevertheless, in the lack of formal economic evidence, the committee made qualitative cost-

					effectiveness considerations when making recommendations. Consideration of the interface between the Proceeds of Crimes Act and the treatment of gambling-related harms was not included in the scope of the guideline.

GambleAware	Evidence Review G	13	044 - 046	We are concerned that decisions have been made based on the experiences and knowledge of committee members, rather than focused on the evidence presented. While a more holistic collection of evidence, which may include expert opinions from the committee, is important, this does not align with the strict criteria set for evidence that could be included in this review. This means important evidence has not been included, yet select expert opinions have.	Thank you for your comment. Committee members were recruited for their expertise and experience in this topic and include a multidisciplinary group of practitioners together with lay members championing the perspectives of people with experience of gambling-related harms and treatment as well as family members. Their role was to make recommendations based on their consideration of the evidence presented to them. In doing so they considered the quality of the evidence and the extent to which it agreed with their own expertise. In the case of the discussion of recommendations that you reference in your comment, the committee noted that the CRAFT programme only actually included one aspect of support for affected others, only assessed one outcome of interest and did not measure outcomes in the long term. Furthermore, they were concerned about the low participant numbers in the study in question and for these reasons they did not feel the evidence provided a sound basis on which to make a recommendation. In these circumstances the committee are able to make a recommendation, within the scope of the review, which is based on consensus decision making and which does not have the same weight (or strength) as a recommendation made on the basis of high quality evidence. This is in line with the NICE methodology for developing guidelines.

GambleAware	Evidence Review G	14	010 - 013	We strongly agree with the 'importance of non-judgemental communication in conversations surrounding addiction' from affected others. The following research highlights this and offers recommendations. This should be pointed to in the guideline as a resource to signpost affected others to: Building Knowledge of Women's Lived Experience of Gambling and Gambling Harms Across Great Britain.pdf (begambleaware.org)	Thank you for your comment. NICE guidelines do not usually refer to reports such as this written by other organisations.
GambleAware	Evidence Review G	14	015 - 016	We agree with the recommendation for further research in this area.	Thank you for your comment and support for this research recommendation.

GambleAware	Evidence Review G	14	004 - 005	We strongly agree that 'stigma, information and support and access to treatment apply to affected others as well as people experiencing harmful gambling' and that 'providers of gambling treatment services offer help and advice to affected others, both individually or with the person experiencing harmful gambling if appropriate'. These are all issues that GambleAware is currently funding projects to address. For example, the ongoing stigma research programme led by the University of Wolverhampton and the National Centre for Social Research includes a particular exploration of stigma among affected others. Additionally, many of the support services that are currently funded by GambleAware provide support for the affected other and family, along with or in isolation of the person who gambles. The expertise that has been established by these providers in providing this specific type of support must not be lost in the future treatment system. Examples of these services include:	Thank you for your comment and telling us about these services. The committee took an all-harms approach to the development of the guideline and so, as you have noted, agreed that many of the recommendations in the guideline would apply to affected others. However, as there was very little evidence for any specific interventions for affected others, the committee was unable to make recommendations on these.

				Aquarius standard offer: All staff offer affected other interventions to focal clients. This can be as part of a family session or as a one-to-one with a separate practitioner. Affected others are offered to join Crafty Cuppa sessions, and the option to join as volunteers.	

				Aquarius have an affected others virtual group running, facilitated by our volunteer lead. Aquarius have met with a Church group in an area of high deprivation and need and are developing a pathway with them to support their community and in particular, the affected others that use the service. The focus is on early intervention and financial management to reduce foodbank use and debt. They will provide interpreters to help raise awareness and also provide family/one-to-one support sessions. PCGS ask all patients suffering from gamble harm whether they would like the service to engage with any affected other in the family. These are generally referred to the third sector for those requiring more intensive psychological support. Beacon's core offer for affected others involves 121 therapy, and couples therapy. Within this quarter they have enrolled several therapists to attend couples counselling training to refresh their skills and ensure they are offering the most up to date and appropriate therapeutic approaches when working with service users through couples counselling.	

				The aftercare programme has adapted to the needs of affected others. Beacon's 121 aftercare offer for affected others regarding practical support to address the legacy harms of someone else's gambling continues to be successful and our families link worker has been working closely with the following organisations to establish collaborative relationships and referral pathways with; Lancashire Armed Forces Covenant Network (organisations across Lancashire working with individuals within the armed forces and their families) Smartworks (Northwest based organisation supporting women get back into employment) Safenet (domestic violence support service) Lancashire Women (women's support service) Preston Wellfest (network of support services across Preston)	

His Majesty's Prison and Probation Service (HMPPS)	Evidence review H	9	10	Important to note the reduction in anxiety for individuals receiving individual or group treatment as would play a role in the effectiveness in the longevity of the treatment outcomes.	Thank you for your comment. Yes, the study also reported an important benefit (compared with no treatment) for a subjective indicator of gambling severity - at 12 months and while it is conceivable the two are linked, data analysis to demonstrate this wasn't reported in the paper.
GambleAware	Evidence Review H	9	006 - 020	GambleAware agree that people who have experienced harms related to gambling need support and opportunities to build their recovery capital and help prevent relapse. GambleAware has therefore invested in aftercare provision through the NGSN. This includes additional support around finances, relationships, self-esteem, employability, mental health or other areas of life harmed by gambling.	Thank you for your comment and the information about your aftercare provision.

His Majesty's Prison and Probation Service (HMPPS)	Evidence review H	10	1	Low quality evidence for all outcomes therefore more localised evidence from outcome data of gambling charities work around relapse prevention and their intended outcomes could be utilised rather than published research papers.	Thank you for your comment. As per the review protocol, decisions about including or excluding evidence were not based on assessments of quality, they are based on whether studies fit the 'PICO' as well as other considerations such as study design and year of publication. You are right that the GRADE ratings in this review were either low or very low. GRADE assesses the quality of evidence for each outcome, rather than the quality of the included studies (which are assessed using the Cochrane Risk of Bias 2 tool). The GRADE assessment does however take account of the risk of bias of studies contributing to the evidence per outcome as risk of bias is one of the 4 GRADE domains (the others being inconsistency, indirectness and imprecision) If concerns about just one of those domains is 'very high' then the quality of the evidence for that outcome is downgraded to be of low quality. In the case of this evidence report, the evidence for most outcomes was low or very low because of serious or very serious concerns in the risk of bias domain, stemming from the studies being assessed with a high risk of bias due to lack of blinding of participants. Although blinding of participants is not completely impossible for these types of interventions it is difficult and quite rare. This is why almost all evidence for this review was at least 'low' quality. The committee do not ignore such evidence but they do take account of the GRADE assessment in making recommendations

His Majesty's Prison and Probation Service (HMPPS)	Evidence review H	10	7	No evidence identified for a list of interventions therefore again utilising local evidence around the effectiveness of interventions from those with lived experience and case studies or data recordings of relapses from charities that engage with people whom have participated in the interventions would be beneficial.	Thank you for your comment. This review question was designed to locate evidence of the effectiveness of interventions to prevent relapse in people who have previously participated in harmful gambling. The review focused on RCTs, which provide the most robust evidence for estimating treatment effectiveness. The protocol which was used for this review was agreed a priori and it governed the title and abstract and full text screening of the search results. The committee is aware of the value of qualitative data, which is reflected in the fact that 3 qualitative reviews were included in the development of this guideline. The qualitative data generated from those reviews did provide evidence of what works well and what could be improved in gambling treatment services; the barriers and facilitators to accessing treatment for harmful gambling and the support and information needs of people experiencing harmful gambling and affected others - and this evidence was all based on the views and experiences of people experiencing harmful gambling, practitioners and affected others. Qualitative data informed many of the guideline recommendations and this is described in the evidence reports C, I and K.

GambleAware	Evidence Review H	10	001-002	GambleAware has also identified that there is a need to grow the evidence base on aftercare. Our own emerging data from aftercare projects such as Peer Aid and the Epic Restart Foundation indicate that aftercare support can have a significant impact on long term recovery and mental wellbeing, however the link with reducing relapse rates has not yet been more broadly evidenced. In response to this we have commissioned gambling specific models of relapse prevention.	Thank you for your comment and highlighting these projects. As there was so little evidence on relapse prevention the committee made a research recommendation.

GambleAware	Evidence Review H	10	007-011	GambleAware commissions the following services which should be considered in the guideline: Person-centred coaching interventions for people who have experienced significant harms from their gambling; An online or in-person network for people to connect and share ideas about aftercare and long-term recovery; Relationship or whole family counselling delivered in partnership between a specialist counselling charity and a gambling harm charity;	Thank you for your comment and the information about your aftercare provision. No evidence for any of these interventions that met the protocol criteria was identified.
				A community navigator role within a gambling harm service, helping people find networks and avenues within the community; and Specialist services for specific target groups (e.g., younger people, women, or people from minoritised communities).	

GambleAware	Evidence Review H	10	028 - 032	Whilst GambleAware agree that relapse prevention is important, some people experiencing gambling harms may not go through any treatment or support and instead only access relapse prevention. Others may only access online support/community support in the shape of peer support/peer aid and thereafter access relapse prevention. This must be reflected when assessing service outcomes and effectiveness.	Thank you for your comment. The outcomes used in the evidence review may not be the same as the outcomes that would be used when assessing service outcomes and effectiveness, but the aim of all treatment for gambling (however accessed) is to prevent gambling that harms and so this is likely to be included as an outcome for initial treatment and relapse prevention.

GambleAware	Evidence Review H	10	033 - 039	We agree that definitions of relapse vary depending on the outcome a person wanted to achieve from treatment. This must be reflected in the guideline.	Thank you for your comment. The recommendations for initial treatment state that the aim of treatment should be agreed and there are recommendations which state that relapse prevention should be considered when 'agreed outcomes have not been reached'. This reflects that the desired outcomes may be different for different people.

GambleAware	Evidence Review H	10	040 - 042	We agree that this is a critical outcome. The NGSN's programme outlines that service users can always access support/treatment again if they feel they need it. Our core long-term outcome is improved recovery capital. 'Recovery capital' is defined as the internal and external assets needed to initiate and sustain recovery – to essentially recover a life that has meaning for the individual. Recovery capital looks different for everyone, but may include a combination of some core intermediate outcomes: Improved mental health and wellbeing Increased interaction with a community of understanding (those with similar experiences, whether they are individuals who have experienced gambling harm or as affected others) / decreased isolation Increased positive personal networks of support Improved self-image (including, but not limited to, reducing stigma) Increased practical skills, including but not limited to financial and employability skills	Thank you for your comment. As you point out, there are potentially a range of outcomes which could be used to measure the effectiveness of relapse prevention services and the committee decided that recovery capital was a critical outcome for their review and included it, but found no evidence that reported this as an outcome. The committee agreed that a flexible approach to relapse prevention was required, as you state, and included this in their recommendations.

				Increased confidence and self-belief in ability to accomplish goals (self-efficacy) Increased knowledge about relevant support available for those who experienced gambling harms (directly or as affected others) and among their support networks. This includes gambling recovery tools, as well as housing or other support that may be required. As specialist provision of treating people experiencing gambling disorder and its related harms, the system understands the complexities of life in recovery. With this in mind, across the NGSN there is a consistent emphasis on ensuring that people experiencing gambling harms do not feel stress and shame if they are finding recovery difficult and experience relapse. Pathways facilitate people who have been in treatment so they do not have to go through the whole treatment pathway again. Instead they are able to work with practitioners that are able to meet them where they are. This may include top-up support or just being able to touch base and talk through/problem solve when they are experiencing challenges.	

His Majesty's Prison and Probation Service (HMPPS)	Evidence review H	11	47	Agree with the statement around follow up support to be offered and rapid access to re-access treatment but would also add that opportunities to mentor others and support others as part of their recovery could be an important way increase relapse prevention.	Thank you for your comment. The committee agree with you about the important contribution of peer support and they made a number of recommendations which reflect this, including in the section of the guideline on relapse and ongoing support, but found no evidence that doing the mentoring or peer support was in itself beneficial.
GambleAware	Evidence Review H	12	001 - 002	The NGSN has been developed to provide for the different needs of individuals and communities, which the committee rightly recognise is a need. With this in mind, GambleAware has invested in a variety of different models for the aftercare programme.	Thank you for your comment and telling us that the NGSN provides aftercare.

GambleAware	Evidence Review I	6	15	GambleAware is undertaking work to improve early access to care and support (further details available here: https://www.begambleaware.org/sites/default/files/2023-04/GambleAware%20Impact%20Report%202023.pdf) 1.Public Awareness Campaigns: to reduce stigma and increase knowledge about available treatment and support options, encouraging individuals to seek help without fear of judgment.	Thank you for your comment and telling us about the work to improve early access to care and support.

				2. Community Outreach: GambleAware commissions the NGSN to deliver outreach programmes that bring treatment and support services to communities, making them more accessible to individuals who may have limited mobility or transportation. With research indicating that people in more deprived areas are three times more likely to experience gambling harms compared to those in the least deprived communities, GambleAware sought to provide funding that specifically targeted minoritised and marginalised groups to enhance the support they receive and ensure they have access to the right help and guidance to address gambling harm. 3. Remote support services: The NGSN has expanded its remote service options for counselling and therapy across East Midlands, Yorkshire and Humber, Scotland, Wales, South West, East of England and London making it easier for individuals to access treatment remotely, especially in areas with limited local services.	

				4. 24/7 helplines: We maintain 24/7 helplines staffed by trained professionals who can provide immediate assistance and referrals to treatment services. GambleAware commissions the National Gambling Helpline which received over 42,000 calls in 2022/23. 5. Integration with Primary Care: We encourage primary care providers to screen for gambling problems during routine health check-ups and refer individuals to specialised treatment when necessary. The Primary Care Gambling Service (PCGS) is a primary care-based national programme for adults aged 18 or over experiencing harm from gambling. The Hurley Group – an NHS Partnership led by practicing GPs – developed and delivers the PCGS. The service integrates primary care and third sector support to provide accessible, consistent and whole patient focused support to people who experience gambling harm. The service works in partnership with the NGSN partners and has been funded by GambleAware since April 2022.	

				6. Culturally Sensitive Services: We develop treatment programmes that are culturally sensitive and tailored to the specific needs of diverse populations. The Helpline currently offers the Language Line and many of our providers across the system are delivering specific tailored programmes of work to reach many diverse communities. 7. Peer Support and Support Groups: We promote peer support programmes and support groups where individuals in recovery can help each other navigate the treatment journey. 9. Research and Evidence-Based Practices: We continuously assess the effectiveness of different treatment methods and adjust strategies based on research findings to ensure the best outcomes. 10. Reduced Waiting Times: We minimise waiting times for treatment services, as immediate access to help can be crucial for individuals in crisis. The NGSN waiting times achieved across the system met with all targets in Quarter 1 (April-July 2023) (5-9 days), showing that people are being treated in a timely manner. Most providers have waiting times of 1-2 days.	

GambleAware	Evidence Review I	6	18	Most of the detail within this table is already collected by GambleAware and the NGSN network. There is already a wealth of data on population, phenomenon of interest, views of lived experience after accessing treatment and support as well as lived experience communities who work with GambleAware and NGSN organisations to inform improvements and service re-design. This encompasses types of treatment or support, personalised care, opening times etc. GambleAware research focusing on the impact of gambling harm among women and among minority communities demonstrates the individual experiences, structural inequalities and stigma for these communities in relation to gambling and gambling harms. GambleAware has also completed some modelling on the costs of services, including indirect and direct costs, and has a robust understanding of how our providers are funded through external donations/funds.	Thank you for your comment. The list shows the themes that the committee anticipated would be located in the evidence review and data were found for almost all of them, which are then described in further detail in the rest of the evidence review. It may be that much of the GambleAware work was not identified because it did not use qualitative methods and analysis, as was specified in the review protocol.

				There is work taking place to use the data collated for resource allocation. Scoping studies on LGBTQ+ and neurodiversity are currently being investigated by GambleAware to better understand the causes and consequences of inequality. We are already aware that pre-existing inequalities, stigma and discrimination can play a part in driving or exacerbating gambling harm.	

GambleAware	Evidence Review I	6	003 – 004 - 005	Barriers GambleAware has identified the following key barriers that hinder access to support, and we have undertaken activity to address these. 1. Limited Training: Primary care practitioners may lack specific training in gambling harms, making it challenging to refer for onward support. GambleAware is working in partnership with the Royal College of GPs to create e-learning tools to improve the responsiveness of GPs and their teams in identifying patients with gambling problems and signposting them to the National Gambling Helpline and services across the NGSN to provide treatment or support.	Thank you for your comment, which focusses on the review question for evidence review I. The data located to answer that question are explained in detail in the body of the report and in the appendices. Thank you for providing your interpretation of the barriers and facilitators for accessing treatment, which seem to chime with much of the committee's own experience, particularly around stigma, integration of services and the important of education and information. It may be that much of the GambleAware work was not identified because it did not use qualitative methods and analysis, as was specified in the review protocol.

				Practitioners working across the NGSN are clinically trained, with backgrounds in psychology, counselling, social work and knowledge of treatment modalities, equipping them with skills to assess and treat individuals with gambling related harms. 2. A lack of integration of services: The NGSN is a network of providers working in collaboration, including a focus on integrating gambling treatment and support into existing addiction or mental health services to provide a holistic approach to facilitating access. 3. Stigma: Stigma surrounding gambling addiction may discourage HCPs from addressing it or patients from seeking help. GambleAware is delivering on a programme of work tackling stigma to encourage help-seeking behaviour, promote early intervention, and support families and affected others, as well as raise awareness among the public.	

				While we agree that there are barriers for practitioners and other professionals, these are largely experienced by those that are not currently working in the gambling harms landscape. All practitioners within the NGSN come with high quality skills, experience and qualifications across all treatment modalities, supporting people experiencing gambling harms at the right time and at the right place. There is clear evidence on their excellent outcomes for service users and affected others. Facilitators 1. Support Groups: Access to support groups and counselling services for affected others can be a significant facilitator. Support groups/online communities (including women-only groups) are made available via the NGSN.	

				2. Education: Information and education about gambling related harms and its effects can empower affected individuals to seek help. GambleAware currently commissions the following education programmes: English, Scottish and Welsh Education Gambling Hubs, Citizens Advice Scotland, GAP programme, Royal College of GPs, and Bet you can help. These are all catered to raise awareness of gambling related harms and provide early intervention and prevention for specific audiences. 3. Intervention: Well-planned interventions, when conducted with care, can encourage people to seek treatment and support.	

GambleAware	Evidence Review I	6	007 - 009	Low levels of treatment access reflect the severe under-resourcing of gambling harms treatment services, rather than any issues with commissioning or provision. GambleAware has undertaken significant work to address this, including by increasing treatment capacity – backed up by a 60% increase in funding for treatment services this year. Our 2022 annual statistics demonstrated that of the 7,072 people who received structured treatment in the NGTS (now known as National Gambling Support Network) between April 2021 and March 2022, 92% demonstrated problematic gambling behaviour as defined by the PGSI. 92% of people who completed treatment had reductions in PGSI score. 50% were seen within five days of contacting the NGTS. https://www.begambleaware.org/sites/default/files/2023-07/GambleAware%202022%20Treatment%20and%20Support%20Report.pdf	Thank you for your comment. There are many reasons why people don't access treatment services and the purpose of this review was to identify these reasons and make recommendations to overcome them. With the introduction of the statutory levy and the planned reconfiguration of gambling treatment services it is likely that capacity will increase.

GambleAware	Evidence Review I	8	001 - 009	We are concerned that many of the studies used for the systematic review of literature are over 10 years old. GambleAware proposes using up-to-date evidence and insight from service users/people with lived experience who have accessed NGSN treatment and support, or to gather insight from our professionals who currently deliver treatment services within the NGSN. A group like this is already in place: Alerts, an independent group made up of people with lived experience who have accessed the NGSN system. The committee should contact this group to gather their experiences to consider in the final guideline. GambleAware routinely audits all commissioned services through quarterly contractual Quality reviews against a quality assurance framework that aligns to the six domains of quality standards set out by the CQC. This could also assist the work on the guideline.	Thank you for your comment. NICE ensures the most up to date evidence is used for the reviews. Of the 14 included studies, only 2 of the papers included in this review are over 10 years old, while 7 of the included papers were published within the last 5 years. While it would be interesting to include the current insights from professionals and/or current service users, these can only be included if they are reported within a published qualitative research paper that meets our protocol inclusion criteria. It may be that much of the GambleAware work was not identified because it did not use qualitative methods and analysis, as was specified in the review protocol.

GambleAware	Evidence Review I	22	1	All services (treatment and support) across the NGSN are free.	Thank you for your comment. The aim of this section in the evidence report is to summarise the evidence found. However, the committee did make a recommendation that it should be explained to people that gambling treatment and support services are usually free, although some charges may be payable (for example, for prescriptions) and this is explained in the committee's discussion of the evidence.
GambleAware	Evidence Review I	22	001 - 016	The NGSN is effective in ensuring confidentiality and consent is maintained at all times. Service users are informed on their rights and their consent is accessed right from the outset. Treatment options are based on individual choice. All of our services use destigmatising language. All our providers have been trained and will continue to be trained on Stigma and Discrimination.	Thank you for your comment. The aim of this section in the evidence report is to summarise the evidence found. However, the committee did make recommendations on maintaining confidentiality and on minimising stigma and this is explained in the committee's discussion of the evidence.

GambleAware	Evidence Review I	22	005-018	All our providers deliver treatment and support with a holistic lens. We understand that a person experiencing gambling harms may have a whole host of complex health and social care challenges, mental health, co-morbidities, other addictions, domestic violence etc. We will ensure that a MDT is conducted, and all relevant stakeholders are either signposted to, or brought into, support with the consent of the individual to ensure they are supported holistically. To do this, our providers are very confident that they have good relationships with other stakeholders and robust referral pathways in place.	Thank you for your comment. The aim of this section in the evidence report is to summarise the evidence found. However, the committee did make recommendations on ensuring coordination across services to provide holistic care and this is explained in the committee's discussion of the evidence.

GambleAware	Evidence Review I	22	019 - 044	While more work needs to be done, scoping studies and research are underway to provide evidence-based needs analysis on the gaps in provision and how GambleAware can commission areas of work that will tackle some of these. There is a host of work underway to ensure that there are culturally appropriate treatment options available such as specific programmes of work targeting diverse communities and relationships with faith groups and organisations to facilitate awareness and signposting to services. Our commissioned Primary Care Gambling Service delivers sessions designed to meet the needs of those with co-morbidities, trauma or ADHD.	Thank you for your comment. The aim of this section in the evidence report is to summarise the evidence found. However, the committee did make recommendations on ensuring culturally appropriate services and reasonable adjustments to services for people with other needs and this is explained in the committee's discussion of the evidence.

GambleAware	Evidence Review I	23	028 - 031	We agree that GPs do not offer screening which can lead to people going undetected. We are working with providers on the ground to ensure that they are aware of the signs and symptoms of gambling harms, understand what questions to ask and how to signpost to the NGSN. We are also working with the Police/Criminal justice system in this respect.	Thank you for your comment. The aim of this section in the evidence report is to summarise the evidence found. However, the committee did make recommendations on increasing the identification of people with gambling-related harms and signposting and this is explained in the committee's discussion of the evidence.
GambleAware	Evidence Review I	23	033 - 040	Whilst external motivators are very important, and push people to seek help, it is the practitioners and therapists who ensure service users complete their treatment. Our system has seen that the majority of services users build a strong relationship with their therapists, in some cases they have no one else to turn to. However, a key role for the NGSN is to support the person experiencing gambling harms to work through all areas of their lives that they need assistance with to tackle their gambling.	Thank you for your comment. The aim of this section in the evidence report is to summarise the evidence found. However, the committee did make recommendations on building therapeutic relationships and this is explained in the committee's discussion of the evidence.

GambleAware	Evidence Review I	24	001 - 034	The gambling industry has absolutely no input, influence or authority over any of our activity. To state otherwise is not only incorrect and slanderous but also has negative consequences for service users keen to access other effective services outside of the NHS.	Thank you for your comment. The section you are referring to only summarises the findings of studies that were supported by industry funding. The results were stratified according to the protocol to show results of studies with unclear industry funding, no industry funding, and industry funding.
GambleAware	Evidence Review I	25	001 - 006	We would agree with this, the NGSN is working to expand the engagement and training that is being delivered within the criminal justice system.	Thank you for your comment and your support for the findings reported in that section.
GambleAware	Evidence Review I	25	009 - 014	The NGSN offers flexibility in treatment options and we ensure that we cater services to patient needs. Treatment times can be made flexible to reflect service users' needs/caring/working responsibilities etc.	Thank you for your comment. The aim of this section in the evidence report is to summarise the evidence found, which relates to the criminal justice system. The committee chose not to make very specific recommendations for the criminal justice system, as implementation within this system will need to take into account localised issues such as prison routines and escort procedures.

GambleAware	Evidence Review I	25	016-022	GambleAware research focusing on the impact of gambling harm among women and minority communities demonstrates the individual experiences, structural inequalities and stigma for these communities in relation to gambling and gambling harms. Whilst drivers behind gambling participation and associated risk factors vary, both of these communities experience gaps in service provision. For women, there is an evident lack of gender-sensitive approaches to treatment and support, and women who were affected others often were not aware of the support available. Other reasons surrounding low take up of support among women include practical barriers, such as waiting times, distance to and the location of support, financial constraints, and lack of internet access, and experiencing domestic abuse which makes accessing support even harder. All of this points to a need for a warm, women-centred approach to treatment.	Thank you for your comment. The aim of this section in the evidence report is to summarise the evidence found. However, the committee did make recommendations on women-only groups and this is explained in the committee's discussion of the evidence. It may be that much of the GambleAware research was not identified because it did not use qualitative methods and analysis, as was specified in the review protocol.

				The NGSN providers are currently delivering key pieces of work targeted to support women such as peer support groups that are for women only.	
GambleAware	Evidence Review I	30	11	We have evidence to suggest that the waiting times for accessing NHS gambling treatment clinics are from 6 weeks to 3 months – NGSN waiting time target is 5-9 days across the system.	Thank you for your comment. The evidence reported on this line related to the negative effect that any kind of waiting time had on people seeking help and support; it was less about the exact length of the wait and more to do with there being any gap between initial contact and accessing services. Although you provide useful information here, it is not within the scope of the review to report on the specific performances of NHS or NGSN services. In addition, following the introduction of the statutory levy and the increase in funding for NHS-commissioned gambling treatment services it is hoped the waiting times will be acceptable in all settings.

GambleAware	Evidence Review I	30	006 - 030	Cost effectiveness and resource use: there is clear evidence that the current system is being delivered to meet the needs of people experiencing gambling harms.	Thank you for your comment. We are not aware of this evidence. According to OHID, there are almost 1.6 million adults who gamble who may benefit from some type of treatment or support for harmful gambling in England. (https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates/gambling-treatment-need-and-support-in-england-main-findings-and-methodology). Currently, the vast majority of people experiencing gambling-related harms are not in contact with gambling treatment services and thus do not receive appropriate (or indeed any) care. Consequently, the current system does not appear to meet the needs of the total population of people who experience gambling-related harms. Therefore, according to the above, what is stated in this section is accurate: “there is currently reduced access to gambling treatment services”.

His Majesty's Prison and Probation Service (HMPPS)	Evidence Review J	6	8	Particularly like that diverse groups are included – adapted treatment really needs to be considered for different groups.	Thank you for your comment.
His Majesty's Prison and Probation Service (HMPPS)	Evidence Review J	8	23	Consideration should be given to a community sentence treatment requirement to address problem gambling for those in the criminal justice system.	Thank you for your comment. The section you refer to provides a description of the outcomes that the committee decided would matter the most for the purposes of making recommendations. As these outcomes were agreed by the committee a priori, this change cannot now be made.

His Majesty's Prison and Probation Service (HMPPS)	Evidence Review K	7	18	Good opportunity to mention peer mentoring and the positive impact of working alongside those with lived experience.	Thank you for your comment. The section you refer to is a summary of the review protocol, which sets out the population of interest and the themes that the committee thought would be likely to be located in the evidence. These were general themes, applicable across gambling treatment and support and the committee did not mention any specific services in this context. However, on the basis of evidence presented to them, the committee made several recommendations about peer support. For example a recommendation about providing unbiased information on how to access treatment support services including information on peer support services, a recommendation about treatments being delivered by competent practitioners including those who provide peer support, and a recommendation to offer peer support as an integral part of the support for gambling that harms.

GambleAware	Evidence Review K	30	023 - 025	Imposing desired outcomes onto potential service users goes against a person-centred model of working. It does not take into account the individuals' personal treatment goals and may act as a barrier to people coming forward for support if they are in disagreement with the imposed desired outcome.	Thank you for your comment. The committee discussed the evidence and recommendation and agreed to re-word this recommendation so that desired outcomes are not imposed onto service users and ensure a person-centred approach is still obtained. They therefore only used 'abstinence' as an example for a potential treatment goal rather than stating it was the preferred goal.

GambleAware	Evidence Review K	30	031 - 037	We agree that choice is key to successful engagement and improving access. A strict NHS-first approach does not align with this patient choice ambition, as individuals should have the choice on receiving their treatment through whichever setting works best for them and their needs, whether that is NHS or third sector/community based.	Thank you for your comment. With the planned reconfiguration of services, treatment services will be commissioned by the NHS but are likely to be provided by a range of providers. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition. Self-referral will remain an option.

GambleAware	Evidence Review K	30	038 - 045	We agree that measures should be taken to reduce stigma associated with gambling, which can be exacerbated by association with other addictions. A strict NHS-first approach risks playing into this stigma, by associating the harm as a solely clinical/medical issue requiring health system treatment only, and not recognising that it is a societal issue as well. The committee has discussed the need to separate gambling harm NHS service location from other addictions. NGSN service providers are located outside of these settings, meaning this ask is already in place through the third sector.	Thank you for your comment and your support for the guideline recommendations designed to recognise and address stigma. The committee also added additional wording to the rationale, in light of stakeholder consultation, about the normalisation of gambling in society leading to stigma. With the planned reconfiguration of services, treatment services will be commissioned by the NHS but are likely to be provided by a range of providers. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition. Self-referral also remains an option. Finally, thank you for informing us about how NGSN already overcomes stigma; this will be taken into consideration in the planned reconfiguration of services.

GambleAware	Evidence Review K	30	046 - 051	The document fails to recognise that there is an entire established workforce providing effective support in purely gambling specialised services. We strongly call on the committee to recognise the value of the third sector and outline how it can work closely with the NHS to provide services.	Thank you for your comment. The section you refer to describes findings from the qualitative review that people (in the research) preferred to be treated by gambling specific services, rather than services adapted from the treatment of other addictions, and the committee made recommendations based on this evidence, that treatment should be made available in locations which are separate from other addiction services. With the planned reconfiguration of services, treatment services will be commissioned by the NHS but are likely to be provided by a range of providers. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition. Self-referral will continue to be an option.

GambleAware	Evidence Review K	31	003-012	We fully agree that the therapeutic relationship with the practitioner is key to successful outcomes. As such we are concerned that the recommendation to offer CBT via online groups as the first approach will not support this. A personal relationship is harder to establish online compared to in person.	Thank you for your comment. The committee recommended that group CBT should be offered and should start as soon as possible after diagnosis. The recommendation does not say that this should be online, and the committee has made recommendations that a choice of delivery methods should be offered.

GambleAware	Evidence Review K	31	022-031	We agree with the evidence here and wish to point out that this very much speaks to the strengths of the NGSN who, due to working as an integrated system, are able to effectively coordinate the treatment of comorbidities and social issues. We wish to reiterate that this system is being overlooked in the guidelines despite it already working very effectively against some of the evidence being presented as optimum for this client group.	Thank you for your comment. There is a planned reconfiguration of gambling treatment services and although services will be commissioned by the NHS it is hoped that the strengths of existing services will be retained, which is why these aspects have been recommended in the guideline.

GambleAware	Evidence Review K	32	001 - 003	Continuity of care is important. As the third sector/NGSN provides the vast majority of treatment at present, the third sector must continue to be involved in the gambling harms ecosystem and involved in the ongoing care of people experiencing harm.	Thank you for your comment. There is a planned reconfiguration of gambling treatment services and although services will be commissioned by the NHS it is hoped that the strengths of existing services will be retained, which is why these aspects have been recommended in the guideline.
GambleAware	Evidence Review K	32	005 – 006 & 009 - 011	Peer support exists and is widely offered across the NGSN. These established services must be recognised in the guideline, with referral pathways outlined to them for healthcare professionals.	Thank you for your comment. There is a planned reconfiguration of gambling treatment services and although services will be commissioned by the NHS it is hoped that the strengths of existing services will be retained, which is why these aspects have been recommended in the guideline.

GambleAware	Evidence Review K	32	018 - 029	The committee makes recommendations about reasonable adjustments being necessary which ignores the evidence of the need for proper gender specific delivery.	Thank you for your comment. 'Reasonable adjustments' refer to any alterations that need to be made to treatments to make them accessible and appropriate for differing groups. The recommendation suggests that different treatment options should be offered and examples such as gender-specific services such as women-only groups, vocation-specific services such as veterans' groups, and culturally sensitive services are listed in this recommendation, ensuring that this evidence is not being overlooked.

GambleAware	Evidence Review K	32	042 - 045	We agree on the importance of people understanding what led to them developing a gambling disorder. Group online CBT is not necessarily the way to achieve this and other options may be more appropriate. https://onlinelibrary.wiley.com/doi/10.1111/add.16221	Thank you for your comment. The committee recommended that group CBT should be offered and should start as soon as possible after diagnosis. The recommendation does not say that this should be online, and the committee has made recommendations that a choice of delivery methods should be offered. Thank you for providing the link for a new NMA about CBT treatments. We have checked this NMA and all the studies included in their NMA were also included in our review, with the exception of 2 studies which did not meet our inclusion criteria (Sylvian et al. 1997 was published prior to 2000 and Harris et al. 2016 was non-randomised and there is no control for confounding).
GambleAware	Evidence Review K	32	047 - 048	Crisis intervention is critical but high waiting times mean the NHS is not able to meet this need. In contrast, the NGSN commissioned specialised gambling services are able to offer this in a more timely fashion. The helpline responds to people within 60 seconds, all regional services will respond to applications for treatment/support within 24 hours.	Thank you for your comment. Following the planned reconfiguration of gambling treatment services after the introduction of the statutory levy, it is anticipated that funding for gambling treatment services will increase and that the NHS will commission a wide range of treatment services so it is not anticipated that wait times will exceed those of current services.

GambleAware	Evidence Review K	33	001 - 005	We agree that integration is fundamental to responding to the needs of this population group. The NGSN is a fully integrated network operating across England, Scotland and Wales and looks to work with the NHS across all regions. We call on the committee to recognise that this integration is already being offered by the NGSN and the expertise built in the development of this should be sustained at all costs.	Thank you for your comment. The section you refer to describes evidence from the qualitative review that respondents generally felt that providing integrated services may lead to earlier referral and earlier interventions. On that basis and informed by their own expertise, the committee recommended that integrated delivery becomes standard practice, as you suggest.
GambleAware	Evidence Review K	33	009 - 010	We agree that high waiting times are a significant barrier to access. People experiencing harms, or affected others, are able to be assessed and access treatment quicker in the NGSN than the NHS. As such, an NHS-first approach may cause people to wait longer.	Thank you for your comment. Following the planned reconfiguration of gambling treatment services after the introduction of the statutory levy, it is anticipated that funding for gambling treatment services will increase and that the NHS will commission a wide range of treatment services so it is not anticipated that wait times will exceed those of current services.

GambleAware	Evidence Review K	33	044 - 051	We are concerned that the committee has chosen not to include existing evidence on best practice against these recommendations, including what is already being delivered across the NGSN. In relation to the costs required to deliver, the existing model already has the buildings, facilities and staff, making it far more cost effective to ensure the system's continuation and expansion.	Thank you for your comment. No economic evidence was identified in this area but the committee did consider resource implications and issues around cost-effectiveness when making recommendations. The guideline specifies that gambling treatment and gambling support services should be commissioned by the NHS, but they may be provided by a number of different providers, as long as they are fit for purpose. Currently, there is largely unmet need for these services (according to OHID figures on treatment needs: https://www.gov.uk/government/publications/gambling-treatment-need-and-support-prevalence-estimates/gambling-treatment-need-and-support-in-england-main-findings-and-methodology). As the funding available to spend on NHS commissioned gambling support and treatment services is likely to increase following the introduction of the statutory levy, reconfiguration and expansion of services, with additional requirements for buildings, facilities and staff, is expected, including potential transferring of current staff or services from other providers into NHS-commissioned services. It is anticipated that expanded, NHS commissioned, services will gradually cover a larger part of the population needs, resulting in benefits and cost-savings that are likely to offset, at least partially, the high financial and social costs associated with gambling-related harms, so that the NHS commissioned gambling treatment and gambling support services represent value for money.

GambleAware	Evidence Review K	34	012 - 015	We are concerned that these recommendations do not take account of available evidence and therefore will not meet the aims of the guideline to improve treatment access and outcomes.	Thank you for your comment. The aim for this review was to learn what works well and what could be improved in gambling treatment services, from the perspective of practitioners, people who participate in harmful gambling, and their family, friends, and others. The committee used this evidence to make a wide range of recommendations to improve treatment services, and evidence from the qualitative review on access (see evidence review I) was used to make recommendations to overcome barriers and improve access.
GambleAware	Evidence Review K	34	004 - 005	No evidence has been presented that an NHS-first approach will improve access. Not only are waiting times longer, but there are some groups in society (many of whom are disproportionality affected by gambling harms) that have a mistrust of the NHS, making an NHS-first approach challenging to meet their needs.	Thank you for your comment. Based on stakeholder feedback the guideline has been amended to explain the role of gambling treatment services, and although following the planned reconfiguration of gambling services these will be commissioned by the NHS it is likely that they will be delivered by a range of providers. People will also still have the option to self-refer.

His Majesty's Prison and Probation Service (HMPPS)	Evidence Review K	154	n/a	"What worked well: Central location Harmful gambling treatment services located in a city centre increase accessibility due to established public transport and plenty of parking. Co-location with multipurpose government facility was a benefit as it can help to decrease stigma attached with accessing mental health services, raise awareness of gambling related harms with other government departments and organisations, and be a symbol of partnership in treatment harmful gambling." The rurality of Wales and some parts of England would present a challenge to the adoption of this model. Families would potentially be excluded. Distance, transport, and resources all become factors to consider within a different model.	Thank you for your comment. In this section of the evidence report (evidence tables) we are showing the findings of each study. In this instance results of this study showed that central locations for harmful gambling treatment services worked well, however no recommendations have been made which specifically mention this as the committee decided that this could cause a problem for people from rural areas. This reflects that the committee do not make recommendations on the basis of detailed findings from individual studies but instead from the themes and sub-themes generated by the evidence synthesis.

Gambling Harm UK	Economic model	General	General	We are concerned that gambling harm may be misframed and minimised by omission of quality of life impacts.	Thank you for your comment. Quality of life impacts of gambling harm have been considered in the analysis and expressed in the form of QALYs (this was the measure of outcome of the economic analysis). Over the 2-year time horizon of the analysis, the model considered quality of life ('utility') data associated with gambling that harms, a utility loss prior to suicide, as well as utility loss due to suicide, and translated them into QALYs (or QALY losses, as relevant). In addition, in a scenario analysis, the model estimated the full QALY loss of people who died of suicide during the 2-year time horizon of the model, beyond the model time horizon and over their anticipated life expectancy (as estimated according to general population statistics). Please see Evidence Review F, Appendix I, under heading 'Utility data and estimation of quality adjusted life years (QALYs)' for a detailed description of quality of life considerations and utility data used in the analysis.

Betknowmore UK	Equality Impact Assessment 3	3	004 - 005	This states that "The preliminary recommendations do not make it more difficult in practice for a specific group to access services compared with other groups". The equality impact assessment fails to take into account the unequal health outcomes that exist within the NHS for some ethnic groups (e.g. https://www.bma.org.uk/news-and-opinion/rebuilding-trust-in-medicine-among-ethnic-minority-communities), women and those with disabilities, including those that are neurodevelopmental. The Guideline recognises that these groups feel especially high levels or shame and stigma and some may be fearful of disclosing gambling harms, yet the Guideline fails to recognise that these same groups have low levels of trust in the NHS and therefore may avoid disclosing gambling harms to GPs, social care workers and other NHS professionals. NGSN services, embedded in their local communities, have worked hard over recent years to break down shame and stigma and form trusting relationships with communities who traditionally have been reluctant to seek support. One service user commented: "speaking to experts in the field who have a reputation of delivering effective support gave me confidence". The Guideline risks worsening health inequalities by failing to recognise that minoritised groups that have low levels of trust in NHS services and could avoid seeking treatment and support if the choice of NGNS services is taken away from them.	Thank you for your comment. The guideline already recognises in the sections on overcoming stigma and improving access to services that certain groups may feel additional stigma or need support to access services, as you state. In addition, the guideline has now been amended based on stakeholder feedback to clarify that following the planned reconfiguration of services after the introduction of the statutory levy, treatment services will be commissioned by the NHS but are likely to be delivered by a range of providers. As for any other condition where treatment is provided by the NHS, people will have choice about where and how to access services (for example, geographical location, provider, online or in-person) but will be offered evidence-based treatments. People who do not wish to access NHS-commissioned services will still have the opportunity to seek support from other providers such as the voluntary sector, as they would with any other health condition. Self-referral will still be an option.

GamFederation CIC	Guideline	16	27	Practioners meet multilingual skills, psychology/ psychiatrist, and Lived experience for complex case..	Thank you for your comment. This recommendation advises that interventions should be delivered by trained, competent practitioners and this would include psychologists and psychiatrists and, where appropriate people with lived experience. Practitioners would not always be multi-lingual but should have access to interpreters where necessary. This level of detail is contained in the NICE guideline on patient experience in adult NHS services which is cross-referenced from this guideline.
GamFederation CIC	Guideline	18	16	EPIC, Cold Water therapy, walk in dark forest, Rehabilitation and volunteering works need to be chosen before pharmacological treatment.	Thank you for your comment. No evidence was identified for any of these interventions for reducing the severity of gambling so these have not been recommended.
GamFederation CIC	Guideline	20	23	Please add immigration problem, NRPF	Thank you for your comment. Immigration problems and no recourse to public funds would be covered by this list of types of ongoing harms and so these have not been added separately.
GamFederation CIC	Guideline	21	20	Study opportunities various gambling harm related course for Lived Experience of gambling harm and third family members.	Thank you for your comment. This section advises that affected others receive support and help, but no evidence for specific interventions was found so these have not been listed.

GamFederation CIC	Guideline	28	2	PGSI has 9 index, please add " Do you gambled having Low income , NRPF(No recourse to public fund)? This could be save many minority groups Trap by gambling.	Thank you for your comment. The PGSI has a defined number of questions and so the committee were not able to add additional questions to the PGSI.
GamFederation CIC	Guideline	30	29	need to advertising in TV, social media, Borough Newsletter About gambling harm and its treatment.	Thank you for your comment. The guideline already contains advice about advertising services in health and social care, the wider community and the criminal justice system so no further additions have been made.
GamFederation CIC	Guideline	33	7	Illegal gambling person fear to take treatment as police may catch them and deported. Moreover they have fake believe to recover loses amount of all money.	Thank you for your comment. The recommendations already advise that migrants may face particular stigma and may need additional support to access services.

GamFederation CIC	Evidence review H	6	19	Shame and guilty about gambling causes relapse even after long term recovery. Workshop, research participants in gambling harm as lived experience, convey them you have purpose of your gambling to help others who are still spending Time energy money by gambling Trap.	Thank you for your comment. The section you refer to is a summary of the review protocol for this question and it can no longer be altered. We understand that you are highlighting the importance of peer support in the treatment of relapse prevention. The guideline committee did make recommendations about peer support including one about offering peer support as an integral part of a service or intervention for gambling related harms for people who wish to engage with it.
GamFederation CIC	Evidence review H	11	4	Relapse to recovery is very short journey. No need to start treatment as beginner. Educate about gambling harm, job opportunity in gambling treatment service unit encourage them to build up prosperous life.	Thank you for your comment. This guideline includes a recommendation to discuss the risk of relapse with people experiencing gambling harms, and to continue to provide support, follow-up and rapid re-access after a course of psychological intervention or pharmacological treatment according to the person's need and preferences.

GamFederation CIC	Evidence review K	7	18	Reward yourself for not to gamble. Own gambling free Story telling in media, Anonymously. Coordination among lived experience of gambling, drug , alcohol, substance misuse, cancer, adoption, angryness to find out different pathways of their different odd (addictive)behaviour	Thank you for your comment. The aim for this review was to learn what works well and what could be improved in gambling treatment services, from the perspective of practitioners, people who participate in harmful gambling, and their family and friends. This was therefore a qualitative review including studies using qualitative methods as these types of studies would provide the highest quality of evidence to answer this review question. The section you refer to is a summary of the review protocol, which describes the guideline population as well as a number of themes that the committee expected would be located in the evidence. These cannot be amended at this stage but any data that was found in located studies, which answered the review question, would have been reported, regardless of whether it was listed as an anticipated theme in the protocol.