NICE Guideline: Gambling causing harm: identification, assessment & management

Stakeholder scoping collated workshop notes, 20 October 2021

Welcome and presentations

The group were welcomed to the meeting and informed about the purpose of the day. The Stakeholder Scoping Workshop is an opportunity for stakeholders to review the draft scope and give their input into whether it is clinically appropriate.

The group received presentations about NICE's work and the work of the National Guideline Alliance. The Topic Advisor also presented the key elements of the draft scope.

Following questions, the stakeholder representatives were then divided into three groups which included a facilitator and a scribe. Each group had a structured discussion around the key issues.

SCOPE: Overall impression

- Overall, have we struck an appropriate balance between the need to keep the scope manageable and the relative importance of areas that could be included?

Stakeholders made the following comments:

- Good balance in the scope so far. The quality of the evidence has improved significantly since 2010.
- The language used in the scope is very important. It would be too narrow to purely look at medically diagnostic criteria, much better to look more broadly across gambling causing harm. Important that this is clear in scope.
- Prevention is not part of the title of the guideline. This is not something that can be easily divided from identification, diagnosis and management, and tackling gambling is more of a continual process through all areas (although not a public health guideline so prevention is unlikely to be covered)

Scope: Title – Gambling

- Should this be amended to 'Gambling disorder' or 'Problem gambling' (or something else?)

Stakeholders made the following comments:

- Definitely not problem gambling. Puts the issue on the person, rather than a spectrum of harms.
- 'Problem Gambling Severity Index' is used currently, however using 'problem' is very stigmatizing.
- 'Harmful gambling' could be an option, however concerns that this is also stigmatizing.
- Current title of just 'gambling' doesn't cover the issue sufficiently.
- There was agreement that 'harms' should be in the title somewhere.

Section 1 The definition of those with gambling disorders

- Are you happy with our approach to the population?

Stakeholders made the following comments:

- Given that we are working in unknown territory and the context is unprecedented, this might need to be reflected on and defined a bit more. This is still an emerging field and the environment for gambling is constantly changing (for example, internet and in-app purchasing).
- Needs clarification that 'significant problems or distress' is to an individual or affected others. 'Repeated' problem gambling isn't necessary (by definition if it's a problem it's because it's repeated).

Section 2 – Who the guideline is for

- Are there any other groups who will need to be aware of this guideline?

Stakeholders made the following comments:

- All providers of gambling services, but difficult to do this as NICE's remit is health & social care providers, not private or charity providers.
- Integrated care systems could replace commissioners.
- People with gambling disorders should be top of the list.
- Social care and work is a vital part of screening and identification. Co-morbidities are relevant for treatment and management. Social care is an important part of supporting families and carers.
- Community services could be added.
- Need for employer assistance for those with gambling problems at work, but could only be via occupational health services.
- People are often identified while in treatment for other addictions, so general addiction specialists or mental health professionals should be included.
- Prison populations and the criminal justice system are important to include

Section 3.1 Who is the focus?

- Do you agree with the groups that will be covered?

Stakeholders made the following comments:

- Those in areas of higher deprivation may need special consideration.
- Should remember that there could well be a difference in the people seeking treatment and people with gambling disorder.
- Wording needs to be changed to 'some ethnic groups'.
- Different cultures all have different entry points to treatment. More research needs to be done into minority groups to encompass our multicultural society.
- LGBTQ population, particularly transgender. Starting to see more of coming through treatment; although there are still low number they are a high risk group
- Homeless is a high risk population
- Military is a growing concern (serving and veterans)
- People working in the gambling industry are at an increased risk

- Do you agree with the age cut-off of 16 years? If not, what do you think it should be?

Stakeholders made the following comments:

- Laws have recently changed to allow scratch cards only to over 18s.

- Gambling is illegal under 18 so seems strange to have guideline for under 18s.
- Should include 16 and over as national clinic has a younger person's service.
- The 2019 NHS long term plan showed very clear evidence that 16 years is too high as there is evidence of younger people with gambling disorder.
- Do not see many people under 16 years but that does not mean that preventative and identification interventions would not be beneficial for this population. Based on experience and expertise, suggest cover 13 years and above.
- Need to distinguish between 'gaming' and 'gambling'. Many young people involved in gaming, with a gambling aspect, not traditional gambling.
- Interventions may need to be very different for under 18s, safeguarding issues important
- No overall consensus reached

› Do you agree with the groups we are specifically not covering?

No comments.

Section 3.3 Activities, services or aspects of care

› Do the topics listed in the scope (Section 3.3) cover the most important priorities for developing guidance on gambling disorders?

Stakeholders made the following comments:

- All groups thought the main issues were covered.
- Important to have an integrated approach to avoid revolving door syndrome i.e. address co-morbidities all at once.
- Need to include formal referral pathways
- There are 2 aspects of risk – 1st is risk factors which are biopsychosocial issues and the 2nd is managing risks, which is very different and need to be clear which we mean

› Are there any important omissions, or any topics on the list that should be deleted?

No comments.

Section 3.5 Key issues and draft review questions

› Do the proposed review questions map effectively to the issues that should be covered in the guideline?

Stakeholders made the following comments:

- Should consider locations that people first present with gambling. Not necessarily health care services, could be Citizen's Advice Bureau, via social care services.
- Should include people with and without gambling disorder – would still need to ensure people without diagnosed gambling disorder were supported/treated
- Need to consider longer-term timeframes too – for treatment, possibly ongoing information

› Does each issue to be covered in the guideline have an important review question identified?

Stakeholders made the following comments:

- Need to explore the underlying causes of gambling (i.e. trauma-informed), not just symptom management.
- People who are relapsing will often reach out to current community which would involve people going through/have gone through treatment (i.e. friends rather than professionals). These people are being asked to 'treat' people who are thinking of committing suicide, without any training and should be considered as a possible group.

› Do the proposed review questions represent the priorities for developing the guideline, or would some refocussing within the topic areas to be included be appropriate?

Stakeholders made the following comments:

- Should include consideration of gambling blocking software (may be covered in stimulus control)
- Historically, the UK's model is an acute model with a time limit. However, evidence shows this treating a chronic issue with an acute model does not work.
- Currently see people looking for support in debt services, homeless services, interpersonal violence services etc.
- No formal referral pathways but there are informal ones.
- Pharmacological options may not be available to some services, so separating out treatment from psychological treatments may be important.

Section 3.6 Main Outcomes

› What are the most important outcomes?

Stakeholders made the following comments:

- Duration should be considered, as an intervention effective after 3 months might not be still be effective after 3 years.
- Recovery is difficult to clarify

Section 3.2 Settings

› Have we included and excluded the right settings here?

Stakeholders made the following comments:

- Needs to be much broader. 'NHS-commissioned healthcare' doesn't cover gambling sufficiently. Identification isn't always within healthcare, can be through various other providers outside health.

Equalities

› How do inequalities impact on those with gambling disorders?

Stakeholders made the following comments:

- Hard to reach communities: LGBT, ethnic minorities, young women.

Guideline Committee Composition

› Are all the suggestions for guideline committee members appropriate and important? Are there any professional roles or other types of members that are missing?

Stakeholders made the following comments:

- CAMHS expertise is important if covering young people.
- Not sure about young person perspective - should then be matched by an older person perspective
- Charity treatment provider should be specified, rather than just 'charity/voluntary sector'.
- Charity and academic need to be independent
- Occupational health services/community services.
- Recruit both a male and female with lived experience. In gambling specifically, the pathways into and approach to treatment and support very different between these two. Need to be careful where these people are in their recovery pathway.
- Police representative – problematic gambling lead. And someone similar from criminal justice, such as prisons, probation, etc.

› Might any of the suggested members be more appropriate as co-opted members (invited to selected meetings that address specific aspects of the scope) rather than as full members of the guideline committee (who attend all meetings and formulate recommendations for the entire scope)?

No comments.

› Are there any other co-opted members that should be added?

No comments.