National Institute for Health and Care Excellence

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Gambling-related harms: identification, assessment and management

[I] Access

NICE guideline NG248

Evidence reviews underpinning recommendations 1.1.1, and 1.4.1 to 1.4.8 in the NICE guideline

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Accessing gambling treatment

Review question

What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

Introduction

Only a small proportion of people who experience gambling that harms access treatment, with some estimates suggesting this proportion may be less than 10% depending on the definitions of gambling that harms used.

The reasons for the low levels of treatment uptake may relate to the lack of availability or knowledge about services but there may be other factors that discourage people from seeking help.

The aim of this review was to identify the reasons that prevent access to gambling treatment services in order to make recommendations to overcome these barriers, and to identify if there are any facilitators which can be recommended to improve access to treatment.

Summary of the protocol

See Table 1 for a summary of the population and phenomenon of interest for this review.

Table 1: Summary of the protocol (population and phenomenon of interest)

Population	• People (aged 18 and over) who participate in gambling that is causing any level of harm to themselves or to their family, carers, and friends. • Family, friends, and others close to people who participate in harmful gambling. • People involved in identification, referral and treatment of harmful gambling (for example, health and social care staff, people working or volunteering in debt advice services, 'vulnerable customer teams' in banks, or front-line staff in the gambling industry, employers, colleagues and occupational health practitioners).
Phenomenon of interest	The committee wish to locate qualitative evidence about accessing treatment services for harmful gambling. They anticipate that data from included studies will cover a number of key themes although these are not exhaustive, and they are aware that other relevant themes may also be identified and reported: • Availability of treatment options. Views may be expressed about the availability of services including inpatient treatment, community outpatient, residential options and personalised care such as named contacts or key workers. Also, about opening times, appointment systems, eligibility criteria and online treatment options. • Acceptability. Experiences relating to provider expectations and user expectations might suggest ways of improving access to treatment for harmful gambling.

	• Affordability. There may be data about the costs (perceived or real), including direct and indirect costs, public funding and charitable donations or industry funding. • Knowledge and awareness of routes into treatment services for example, referral from primary care, self-referral, intermediary individuals and organisations, pathways from other addiction services. Data may also be identified regarding accessing gambling-related crisis services in periods of high-stress. • Equalities considerations. The extent to which treatment services are felt to demonstrate due regard to the equality duty may support or undermine access. For example, whether the needs of people from protected groups are met, such as having facilities for people whose first language is not English. Perceptions about the cultural competence of services may also affect accessibility. • Fear of treatment services. Experiences of stigma and discrimination associated with awareness raising, assessment, diagnosis and treatment lack of trust in services delivering treatment, and fears over confidentiality (for example, employment concerns where diagnosis/treatment can lead to loss of jobs or religious concerns where diagnosis/ treatment could lead to community disapproval) or lack of standardised oversight may act as a barrier. • Physical barriers. Data may be located about physical barriers preventing access to treatment, such as location of services or a lack of ramps or other built environment adjustments for disabled access. Barriers may also take the form of physical distance, detention or other confinement. • Information and awareness. The role of information and awareness surrounding harmful gambling is expected to influence access to treatment services. In particular, awareness and understanding among individuals, families and practitioners about gambling harms and risks, gambling products and the development of addiction. • Organisation of services. Data may be located which suggests that the planning and provision of suitable services is limited by the nature of service planning, organisation or funding.

For further details see the review protocol in appendix A.

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A and the methods document (supplement 1: methods).

Declarations of interest were recorded according to NICE's conflicts of interest policy.

Qualitative evidence

Included studies

A systematic review of the literature was conducted using a combined search for this and the other 2 qualitative review questions included in this guideline (see evidence review C 'Information and support needs' and evidence review K 'Improving gambling treatment services).

Eleven studies reported in 14 papers were included for this review: 8 studies were general qualitative inquiries (Bjelde 2008, Bramley 2020, Dabrowska 2017, Hing 2014, Itapuisto 2010, Jindani 2021, Pickering 2019, Scull 2005,); 2 studies were phenomenological (Beckett 2020, Kaufman 2017); 1 was a general qualitative inquiry within a mixed-methods study (Campos 2016). Four studies were conducted in Australia (Beckett 2020, Hing 2014, Pickering 2019, Scull 2005); 2 were conducted in UK (Bramley 2020, Kaufman 2017); 2 were conducted in the US (Bjelde 2008, Campos 2016); 1 study was conducted in Canada (Jindani 2021); 1 study was conducted in Finland (Itapuisto 2010); and 1 study was conducted in Poland (Dabrowska 2017).

The included studies are summarised in Table 2.

Three studies recruited participants based on their involvement in treatment services for harmful gambling. One study recruited people accessing harmful gambling services (Hing 2014); 1 study recruited people currently receiving treatment for harmful gambling (Itapuisto 2010); and 1 study recruited people who have self-excluded from gambling venues (Pickering 2019b). One study recruited participants based on a combination of receiving treatment for harmful gambling and gender (women only) (Kaufman 2017). Three studies recruited professionals working within or with harmful gambling services. One study recruited employees from a gambling venue (Beckett 2020); 1 study recruited counsellors involved in treating harmful gamblers (Bjelde 2008); and 1 study recruited professionals working within the criminal justice system (Jindani 2021). The remaining 4 studies recruited a combination of participants. One study recruited 1st and 2nd generation immigrants and professionals involved in supporting them (Bramley 2020); 1 study recruited people attending a local healthcare centre, service providers and stakeholders (Campos 2016)); 1 study recruited people experiencing harmful gambling, healthcare professionals involved in treatment of harmful gambling and social service professionals involved in the treatment of harmful gambling (Dabrowska 2017); and 1 study recruited people experiencing harmful gambling and affected others from non-English speaking backgrounds (Scull 2005).

The data provided evidence about the following themes: availability of treatment options; acceptability; affordability; knowledge and awareness of routes into treatment services; equalities considerations; fear of treatment services; information and awareness; and organisation of services.

See the literature search strategy in appendix B and study selection flow chart in appendix C.

Excluded studies

Studies not included in this review are listed, and reasons for their exclusion are provided in appendix J.

Summary of included studies

Summaries of the studies that were included in this review are presented in Table 2.

Table 2: Summary of included studies

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Beckett 2020 Phenomenological	N=20 employees from 1 gambling venue	**Data collection** Focus groups. **Data analysis**	• Availability of treatment options: Practical limitations

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Australia Any industry funding **Study aim** To explore the views and experiences of gambling venue employees regarding staff-customer interactions, and their suggestions to improve this aspect of customer service.	Age in years [Mean (SD)]: Not reported. Sex (n): Not reported. Gambling symptom severity scale and score [Mean (SD)]: Not applicable.	Inductive thematic analysis.	• Availability of treatment options: Training for venue staff • Information and awareness: Clear messaging about available help
Bjelde 2008 General qualitative inquiry US Unclear funding source **Study aim** To explore the views and experiences of gambling counsellors regarding the gambling behaviour of older adults in North Dakota.	N=6 gambling counsellors practicing in North Dakota • Licensed addiction counsellors: n=4 • Licensed professional counsellor: n=1 • Licensed social workers: n=1 Age in years [Mean (SD)]: Not reported. Sex (n): Not reported. Gambling symptom severity scale and score [Mean (SD)]: Not applicable.	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Equalities considerations: Socio-economic factors • Information and awareness: Understanding gambling harms and risks
Bramley 2020 General qualitative inquiry UK No industry funding **Study aim** To explore the views and experiences of recent immigrants and professionals offering support to this population. To explore	N=32 recent immigrants and practitioners • 1st or 2nd generation immigrants: n=20 • Staff of frontline agencies providing support for migrants: n=12 Age in years [Mean (SD)]: Not reported. Sex (n): M=18, F=14	**Data collection** Focus groups. **Data analysis** Thematic analysis.	• Affordability: Price of treatment • Knowledge and awareness of routes into treatment services: Knowledge and awareness of routes into treatment services • Knowledge and awareness of routes into treatment services: Initial access • Equalities considerations: Language barriers

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
immigrants' vulnerabilities to gambling-related harms and suggestions to improve support in this area.	Gambling symptom severity scale and score [Mean (SD)]: • Migrant participants: Not reported. • Frontline staff participants: Not applicable.		• Equalities considerations: Migrants • Equalities considerations: People with co-morbidities • Information and awareness: Understanding gambling harms and risks • Organisation of services: Harmful gambling screening
Campos 2016 General qualitative inquiry (within mixed-methods study) US No industry funding **Study aim** To explore the views and experiences of gambling and gambling-related harms in local Hispanic community.	N=63 people attending a health centre and practitioners • People attending health centre: n=49 • Service providers and stakeholders: n=14 Age in years [Mean (SD)]: • People attending health centre: 42.7 (13.5) • Service providers and stakeholders: 42.6 (12.8) Sex (n): • People attending health centre: M=12, F=37 • Service providers and stakeholders: M=3, F=11 Gambling symptom severity scale and score [Mean (SD)]: • People attending health centre: Not reported. • Service providers and stakeholders: Not applicable.	**Data collection** Semi-structured interviews and focus groups. **Data analysis** Grounded theory approach.	• Affordability: Price of treatment • Equalities considerations: Age • Equalities considerations: Language barriers • Equalities considerations: People with co-morbidities • Equalities considerations: Socio-economic factors

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis

Dabrowska 2017
 	
General qualitative inquiry
 	
Poland
 	
No industry funding
 	
Study aim
To explore the views and experiences regarding barriers to treatment for harmful gambling and how these differ from people accessing treatment for substance use disorders.
	N=90 people experiencing harmful gambling and practitioners
	• People experiencing harmful gambling: n=30
	• Professionals working with people experiencing harmful gambling: n=60
	  ○ Social workers employed in addiction treatment services: n=15
	  ○ Therapists employed in addiction treatment services: n=15
	  ○ General practitioners: n=15
	  ○ Psychiatrists: n=15
	
	Age in years [Mean (SD)]:
	• People experiencing harmful gambling: 38.3 (10.8)
	• Professionals working with people experiencing harmful gambling: 42.9 (12.0)
	
	Sex (n):
	• People experiencing harmful gambling: M=12, F=3
	• Professionals working with people experiencing harmful gambling: M=18, F=42
	
	Gambling symptom severity scale and score [Mean (SD)]:
	• People experiencing harmful gambling: Not reported.
		Data collection
		Semi-structured interviews.
		
		Data analysis
		Thematic analysis.
			• Affordability: Price of treatment
			• Knowledge and awareness of routes into treatment services: Initial access
			• Knowledge and awareness of routes into treatment services: Self-referral
			• Equalities considerations: Socio-economic factors
			• Fear of treatment services: Confidentiality and privacy
			• Fear of treatment services: Lack of trust in services
			• Fear of treatment services: Shame and stigma
			• Information and awareness: Understanding gambling harms and risks
			• Organisation of services: Harmful gambling screening
			• Individual barriers: Lack of self-motivation

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	• Professionals working with people experiencing harmful gambling: Not applicable.		
Dabrowska 2021 General qualitative inquiry Poland See Dabrowska 2017 **Study aim** To explore the views and experiences of social stigma related to harmful gambling, and how this can affect people accessing treatment services.	See Dabrowska 2017	**Data collection** See Dabrowska 2017 **Data analysis** See Dabrowksa 2017	• Fear of treatment services: Discrimination • Fear of treatment services: Shame and stigma • Information and awareness: Lack of understanding of gambling as an addiction • Individual barriers: Psychological barriers
Hing 2014 General qualitative inquiry Australia No industry funding **Study aim** To explore the views and experiences of people who participate in gambling regarding the Queensland self-exclusion programme for gambling venues, and suggestions for improving the service.	N=103 people accessing harmful gambling services • People who are self-excluded: n=53 • People who are not self-excluded: n=50 Age in years [Mean (SD)]: • People who are self-excluded: 42.3 (14.49) • People who are not self-excluded: 49.53 (13.82) Sex (n): • People who are self-excluded: M=34, F=19 • People who are not self-excluded: M=24, F=26 Gambling symptom severity scale and score [Mean (SD)]: Not reported.	**Data collection** Semi-structured interviews. **Data analysis** Grounded theory thematic analysis.	• Availability of treatment options: Knowledge of treatment options • Acceptability: Time required to access treatment • Knowledge and awareness of routes into treatment services: Knowledge among venue staff • Fear of treatment services: Confidentiality and privacy • Fear of treatment services: Lack of trust in services • Information and awareness: Understanding gambling harms and risks • Individual facilitators: External motivators

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Hing 2015 General qualitative inquiry Australia See Hing 2014 **Study aim** To explore what factors are important in choosing a treatment format for people seeking help for their harmful gambling.	See Hing 2014	**Data collection** See Hing 2014 **Data analysis** See Hing 2014	• Availability of treatment options: Knowledge of treatment options • Acceptability: Treatment limitations • Fear of treatment services: Confidentiality and privacy • Fear of treatment services: Experiences of past services • Information and awareness: Lack of understanding about gambling as an addiction • Individual facilitators: External motivators • Individual facilitators: Families and significant others • Individual facilitators: Therapists and practitioners • Individual barriers: Psychological barriers
Itapuisto 2019 General qualitative inquiry Finland No industry funding **Study aim** To explore the views and experiences of people experiencing harmful gambling in relation to barriers to accessing treatment.	N=12 people attending treatment for harmful gambling Age in years [Mean (SD)]: Not reported, paper notes 'most were between 20-40'. Sex (n): M=10, F=2 Gambling symptom severity scale and score [Mean (SD)]: Not reported.	**Data collection** Semi-structured interviews. **Data analysis** Thematic content analysis.	• Equalities considerations: Culturally appropriate treatment options • Fear of treatment services: Experiences of past services • Information and awareness: Understanding gambling harms and risks • Individual facilitators: External motivators • Individual barriers: Families and significant others

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
			• Individual barriers: Psychological barriers • Individual barriers: Lack of self-motivation
Jindani 2021 General qualitative inquiry Canada Unclear funding source **Study aim** To explore the views and experiences of professionals working in the criminal justice system on the barriers to accessing treatment services for harmful gambling, and how these differ between men and women prisoners.	N=16 professionals with criminal justice system involvement Age in years [Mean (SD)]: Not reported. Sex (n): M=5, F=11 Gambling symptom severity scale and score [Mean (SD)]: Not applicable.	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Availability of services: Criminal justice system • Fear of treatment services: Confidentiality and privacy • Fear of treatment services: Shame and stigma • Individual barriers: Reluctance to address gambling behaviour
Kaufman 2017 Phenomenological UK Unclear funding source **Study aim** To explore the views and experiences of women who have received treatment for harmful gambling regarding barriers to access and receiving treatment.	N=8 women with experience (current or historical) of treatment for harmful gambling • Individual CBT: n=7 • Group CBT: n=1 Age in years [Mean (SD)]: Not reported, age range 30-55. Sex (n): M=0, F=8 Gambling symptom severity scale and score [Mean (SD)]: Not reported.	**Data collection** Semi-structured interviews. **Data analysis** Interpretative phenomenological analysis.	• Availability of treatment options: Waiting times • Acceptability: Flexibility of treatment options • Acceptability: Time required to access treatment • Equalities considerations: Sex • Fear of treatment services: Fear of treatment services • Information and awareness: Lack of understanding about gambling as an addiction • Information and awareness: Understanding

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
			gambling harms and risks • Individual barriers: Reluctance to address gambling behaviour
Pickering 2019 General qualitative inquiry Australia Any industry funding **Study aim** To explore the views and experiences of people experiencing harmful gambling with a self-exclusion programme from land-based venues.	N=20 gamblers with a history of self-exclusion: • Currently self-excluded: n=13 • Previously self-excluded: n=7 Age in years [Mean (SD)]: 46.2(11.23) Sex (n): M=11, F=9 Gambling symptom severity scale and score [Mean (SD)]: Not reported, 90% participants classified as experiencing harmful gambling in previous 12 months.	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Knowledge and awareness of routes into treatment services: Knowledge of venue staff • Organisation of services: Access to support in gambling venues • Organisation of services: Clarity of roles for venue staff • Organisation of services: Re-accessing treatment options • Individual facilitators: External motivators
Scull 2005 General qualitative inquiry Australia No industry funding **Study aim** To explore the development of harmful gambling and the impact it has on immigrant communities, as well as the views and experiences of barriers to access treatment for harmful gambling services that these communities may experience.	N=8 people from a non-English speaking background • People with experience (either current or historical) of harmful gambling: n=5 • Affected others of people experiencing harmful gambling: n=3 Age in years [Mean (SD)]: Not reported, age range: • People with experience of harmful gambling: 30-72 • Affected others: 33-in their 50s Sex (n):	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Knowledge and awareness of routes into treatment services: Awareness among professionals • Equalities considerations: Culturally appropriate treatment options • Equalities considerations: Language barriers • Equalities considerations: Migrants • Fear of treatment services: Confidentiality and privacy • Information and awareness: Understanding

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	• People with experience of harmful gambling: M=3, F=2 • Affected others: M=0, F=3 Gambling symptom severity scale and score [Mean (SD)]: • People with experience of harmful gambling: Not reported. • Affected others: Not applicable.		gambling harms and risks • Individual barriers: Psychological barriers
Wieczorek 2018 General qualitative inquiry Poland See Dabrowska 2017 **Study aim** To explore the support and treatment needs of people experiencing both harmful gambling and alcohol/drug misuse, from the perspective of people undergoing treatment and healthcare professionals providing treatment.	See Dabrowska 2017	**Data collection** See Dabrowska 2017 **Data analysis** See Dabrowska 2017	• Affordability: Price of treatment • Individual facilitators: External motivators

CBT: Cognitive behavioural therapy; N/n: Number

See the full evidence tables in appendix D. As this was a qualitative review, no meta-analysis was conducted (and so there are no forest plots in appendix E).

Summary of the evidence

Across the 3 funding stratifications, the synthesis of the evidence generated 21 themes and 48 further sub-themes about facilitators and barriers to accessing treatment for harmful gambling:

- I1 Accessing gambling treatment services - from studies receiving no industry funding
  - I1.1 Availability of treatment options
    - I1.1.1 Knowledge of treatment options

  - I1.2 Acceptability
    - I1.2.1 Time required to access treatment
    - I1.2.2 Treatment limitations
  - I1.3 Affordability
    - I1.3.1 Price of treatment
  - I1.4 Knowledge and awareness of routes into treatment services
    - I1.4.1 Knowledge and awareness of routes into treatment services
    - I1.4.2 Awareness among professionals
    - I1.4.3 Initial access
    - I1.4.4 Knowledge among venue staff
    - I1.4.5 Self-referral
  - I1.5 Equalities considerations
    - I1.5.1 Age
    - I1.5.2 Culturally appropriate treatment options
    - I1.5.3 Language barriers
    - I1.5.4 Migrants
    - I1.5.5 People with co-morbidities
    - I1.5.6 Socio-economic factors
  - I1.6 Fear of treatment services
    - I1.6.1 Confidentiality and privacy
    - I1.6.2 Discrimination
    - I1.6.3 Experiences of past services
    - I1.6.4 Lack of trust in services
    - I1.6.5 Shame and stigma
  - I1.7 Information and awareness
    - I1.7.1 Lack of understanding about gambling as an addiction
    - I1.7.2 Understanding gambling harms and risks
  - I1.8 Organisation of services
    - I1.8.1 Harmful gambling screening
  - I1.9 Individual facilitators
    - I1.9.1 External motivators
    - I1.9.2 Families and significant others
    - I1.9.3 Therapists and practitioners
  - I1.10 Individual barriers
    - I1.10.1 Psychological barriers
    - I1.10.2 Lack of self-motivation

- I2 Accessing gambling treatment services - from studies receiving any industry funding
  - I2.1 Availability of treatment options
    - I2.1.1 Practical limitations
    - I2.1.2 Training for venue staff
  - I2.2 Knowledge and awareness of routes into treatment services

    - I2.2.1 Knowledge of venue staff
  - I2.3 Information and awareness
    - I2.3.1 Clear messaging about available help
  - I2.4 Organisation of services
    - I2.4.1 Access to support in gambling venues
    - I2.4.2 Clarity of roles for venue staff
    - I2.4.3 Re-accessing treatment options
  - I2.5 Individual facilitators
    - I2.5.1 External motivators

- I3 Accessing gambling treatment services - from studies receiving funding from an unclear funding source
  - I3.1 Availability of treatment options
    - I3.1.1 Criminal justice system
    - I3.1.2 Waiting times
  - I3.2 Acceptability
    - I3.2.1 Flexibility of treatment options
    - I3.2.2 Time required to access treatment
  - I3.3 Equalities considerations
    - I3.3.1 Sex
    - I3.3.2 Socio-economic factors
  - I3.4 Fear of treatment services
    - I3.4.1 Fear of treatment services
    - I3.4.2 Confidentiality and privacy
    - I3.4.3 Shame and stigma
  - I3.5 Information and awareness
    - I3.5.1 Lack of understanding about gambling as an addiction
    - I3.5.2 Understanding gambling harms and risk
  - I3.6 Individual barriers
    - I3.6.1 Reluctance to address gambling behaviour

Theme maps (Figures 1-3) illustrate these themes and their related sub-themes. Themes are shown in dark green and sub themes in light green.

Figure 1: Theme map for themes identified from studies receiving no industry funding

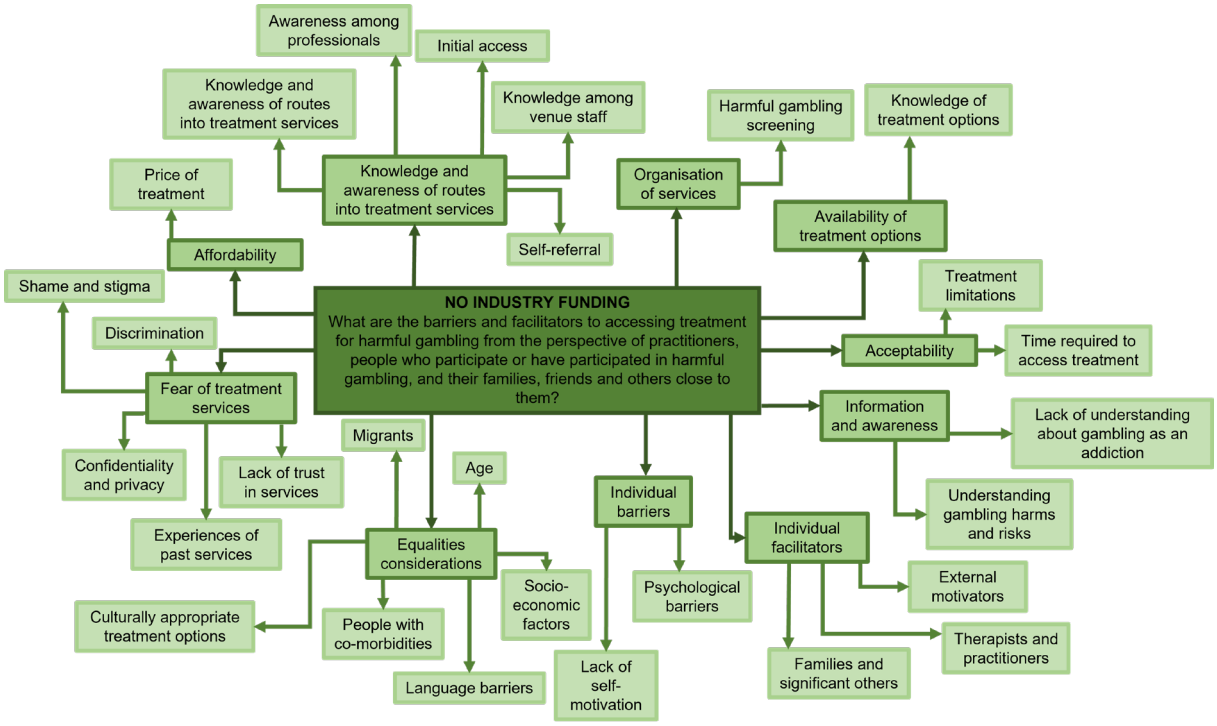


Figure 2: Theme map for themes identified from studies receiving any industry funding

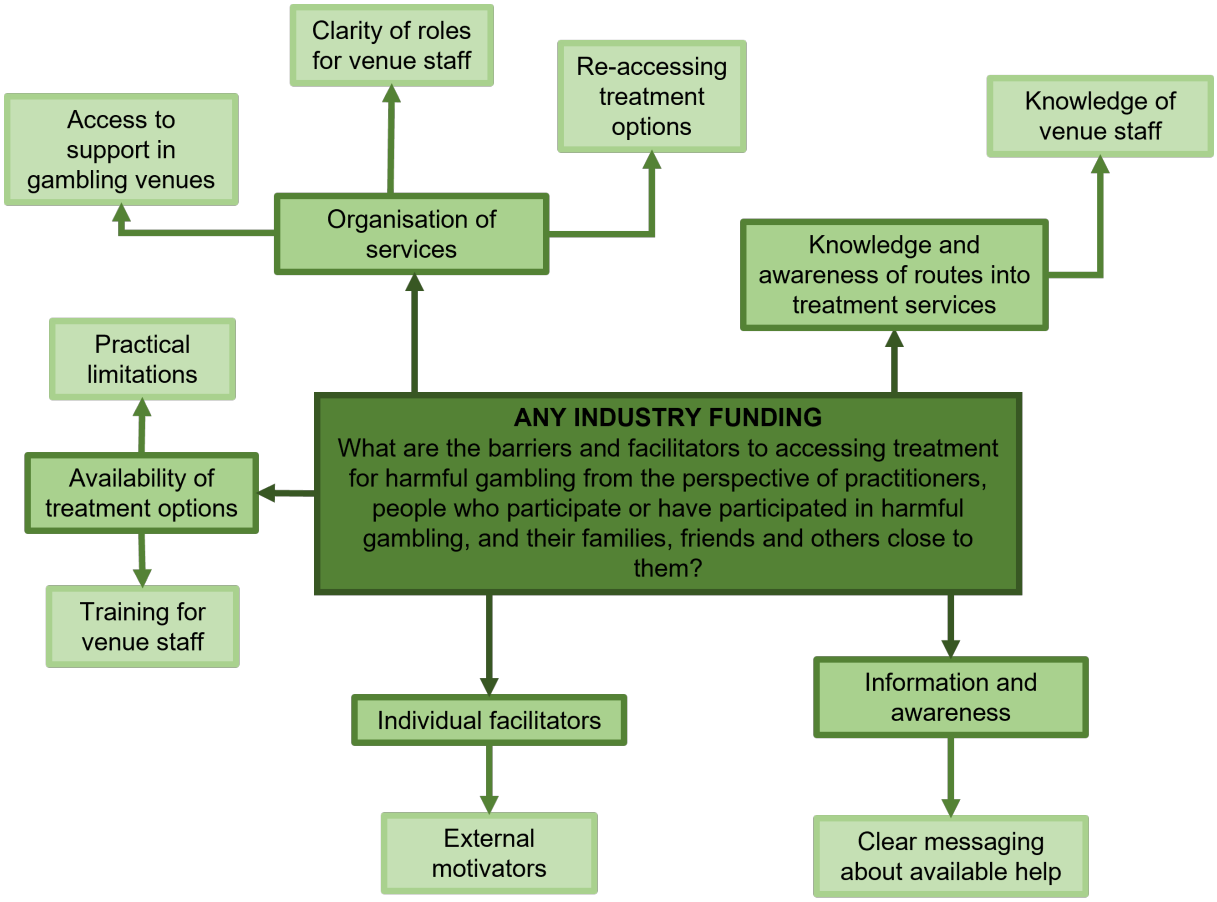
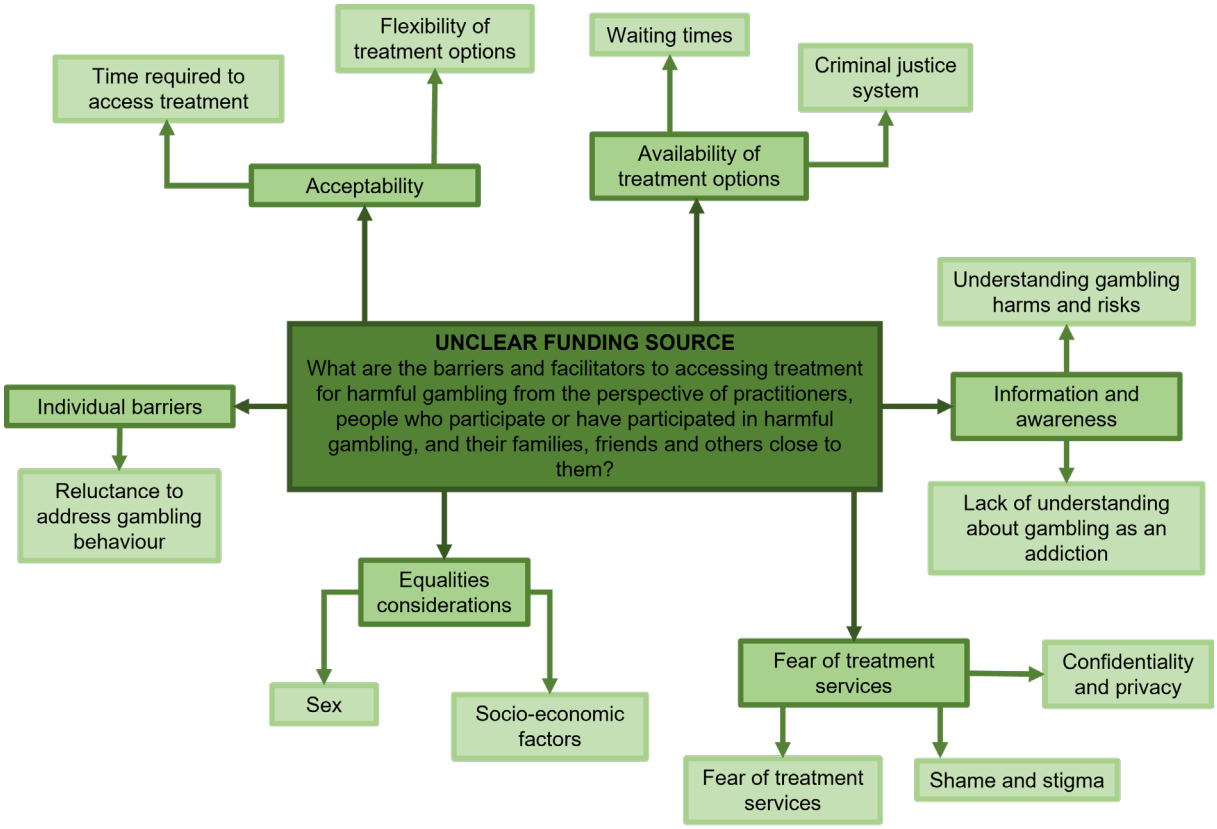


Figure 3: Theme map for themes identified from studies receiving funding from an unclear funding source



Accessing gambling treatment services - from studies receiving no industry funding

Ten main themes were identified for this stratification: availability of treatment options; acceptability; affordability; knowledge and awareness of routes into treatment services; equalities considerations; fear of treatment services; information and awareness; organisation of services; individual facilitators; and individual barriers.

Availability of treatment options:

One sub-theme regarding knowledge of treatment options was identified. Evidence (low confidence) from 1 study showed that people should be made aware of all the treatments for harmful gambling available to them through active promotion.

Acceptability:

Two sub-themes were identified. In the 'time required to access treatment' sub-theme, evidence (low confidence) from 1 study showed that people experiencing harmful gambling found long and complicated registration processes to be tiresome and discouraging when accessing treatment services. In the 'treatment limitations' sub-theme, evidence (low confidence) from 1 study suggested that people were less likely to access harmful gambling services if they doubted the effectiveness of the treatments offered.

Affordability:

One sub-theme regarding the price of treatment was identified. Evidence (moderate confidence) from 3 studies showed that the cost of harmful gambling treatment (either real or perceived) was an important consideration when deciding whether to seek treatment.

Knowledge and awareness of routes into treatment services:

Five sub-themes were identified. In the 'knowledge and awareness of routes into treatment services' sub-theme, evidence (low confidence) from 1 study suggested that case studies of how other people accessed treatment services may help people currently experiencing harmful gambling. In the 'awareness among professionals' sub-theme, evidence (very low confidence) from 1 study showed that all professionals working within treatment services for harmful gambling should be aware of what services are locally available, so they can correctly direct people. In the 'initial access' sub-theme, evidence (low confidence) from 2 studies showed that people may be unaware of how to initially access harmful gambling services which prevents them from seeking treatment completely. In the 'knowledge among venue staff' sub-theme, evidence (low confidence) from 1 study showed that people felt less confidence in self-exclusion programmes when venue staff appeared to by uninformed about how the registration process worked. In the 'self-referral' sub-theme, evidence (low confidence) from 1 study showed that people were prevented from accessing treatment via self-referral because they did not know this was an option.

Equalities considerations:

Six sub-themes were identified, relating to different aspects of the Equalities Impact Assessment for this guideline. In the sub-theme regarding 'age', evidence (low confidence) from 1 study suggested that older people may have decreased access to harmful gambling treatment services because they are less likely to see harmful gambling as a mental health diagnosis.

In the 'culturally appropriate treatment options' sub-theme, evidence (low confidence) from 2 studies showed that access to treatment is enabled when culturally appropriate options are made available. Efforts should be made to make sure non-stigmatised treatment and terminology are used for communities with different cultural backgrounds.

In the 'language barriers' sub-theme, evidence (moderate confidence) from 3 studies suggested that people without a good understanding of English were discouraged from accessing services which did not offer information or treatment options in their preferred language.

In the 'migrants' sub-theme, evidence (moderate confidence) from 2 studies showed that migrants may face several additional barriers when accessing treatment services for harmful gambling. Examples include being unaware of what services are available locally, a preference for accessing informal support, and stigma around receiving in psychological treatments.

In the 'people with co-morbidities' sub-theme, evidence (low confidence) from 2 studies suggests that mental health co-morbidities (for example, post-traumatic stress disorder or anxiety) may act as a barrier to accessing harmful gambling treatment.

In the 'socio-economic factors' sub-theme, evidence (low confidence) from 2 studies showed that people receiving government assistance may face an additional barrier to accessing treatment services because disclosure of their harmful gambling may affect their continued eligibility for financial aid.

Fear of treatment services:

Five sub-themes were identified. In the ‘confidentiality and privacy’ sub-theme, evidence (moderate confidence) from 3 studies showed that people may be not access treatment services for harmful gambling due to concerns over privacy and confidentiality. A way of addressing this barrier is to stress the confidentiality of treatment services, as well as offering individual, remote treatment options. In the ‘discrimination’ sub-theme, evidence (low confidence) from 1 study suggested that women may face greater stigma and social judgement when seeking treatment for addiction. In the ‘experiences of past services’ sub-theme, evidence (low confidence) from 2 studies showed that previous good experiences of treatment services for harmful gambling increased the probability of people re-engaging if needed. In the ‘lack of trust in services’ sub-theme, evidence (low confidence) from 2 studies showed that certain factors (for example, poor staff attitudes) increased people’s distrust in services for harmful gambling and therefore discouraged them from accessing treatment. In the ‘shame and stigma’ sub-theme, evidence (moderate confidence) from 1 study showed that shame and stigma of being labelled as ‘an addict’, or as ‘mentally ill’ as a consequence of receiving psychological treatment, can prevent people from seeking treatment for their harmful gambling.

Information and awareness:

Two sub-themes were identified. In the ‘lack of understanding about gambling as an addiction’ sub-theme, evidence (moderate confidence) from 2 studies showed that people experiencing harmful gambling feel that other people do not view their addiction as a disease. This can act as a barrier to accessing treatment services as it places a burden of responsibility on the person experiencing harmful gambling and it may promote the belief that their addiction will not respond to treatment. In the ‘understanding gambling harms and risks’ sub-theme, evidence (high confidence) from 5 studies suggested that people do not access treatment because they are unaware of the harms and risks associated with gambling, and the potential for addiction. Rather, they view it as a recreational activity.

Organisation of services:

One sub-theme of ‘harmful gambling screening’ was identified. Evidence (low confidence) from 2 studies suggested that a lack of routine screening for harmful gambling in non-specialist settings means that people often go undetected and therefore do not get offered treatment.

Individual facilitators:

Three sub-themes were identified. In the ‘external motivators’ sub-theme, evidence (moderate confidence) from 3 studies showed that people can experience a variety of external motivators that facilitate help seeking. Examples included co-morbidities, financial reasons, and legal concerns. In the ‘families and significant others’ sub-theme, evidence (low confidence) from 2 studies showed that families and significant others often prompt the decision to access treatment services. In the ‘therapists and practitioners’ sub-theme, evidence (low confidence) from 1 study suggested that therapists and practitioners can play a key role in promoting other treatment options for harmful gambling.

Individual barriers:

Two sub-themes were identified. In the ‘psychological barriers’ sub-theme, evidence (moderate confidence) from 5 studies showed that people can experience a variety of psychological barriers (for example, anger, loss of control, embarrassment, or shame) that may deter them from accessing treatment for harmful gambling behaviour. In the ‘lack of self-motivation’ sub-theme, evidence (very low confidence) from 2 studies suggests that a lack of self-motivation may prevent people from accessing treatment services.

Accessing gambling treatment services - from studies receiving any industry funding

Five main themes were identified for this stratification: availability of treatment options; knowledge and awareness of routes into treatment services; information and awareness; organisation of services; and individual facilitators.

Availability of treatment options:

Two sub-themes were identified. In the 'practical limitations' sub-theme, evidence (low confidence) from 1 study showed that the ability of gambling venue staff to identify and assist customers exhibiting signs of harmful gambling was limited by practical considerations (for example, lack of time). In the 'training for venue staff' sub-theme, evidence (low confidence) from 1 study showed that gambling venue staff had different views on the levels of training they receive in approaching people who may be experiencing harmful gambling. Some felt training was sufficient whereas others felt that their training was too focused on the legal aspects of their role.

Knowledge and awareness of routes into treatment services:

One sub-theme of 'knowledge of venue staff' was identified. Evidence (low confidence) from 1 study showed that people felt that information of self-exclusion programmes was not widely available and should be better promoted.

Information and awareness:

One sub-theme of 'clear messaging about available help' was identified. Evidence (low confidence) from 1 study suggested that gambling venues should include sufficient signage of responsible gambling initiatives.

Organisation of services:

Three sub-themes were identified. In the 'access to support in gambling venues' sub-theme, evidence (very low confidence) from 1 study suggested that gambling venues should include in-house counselling services for harmful gambling. In the' clarity of roles for venue staff' sub-theme, evidence (moderate confidence) from 1 study showed that gambling venue staff were unsure of their roles when asked to actively approach customers who may be exhibiting signs of harmful gambling. In the 're-accessing treatment options' sub-theme, evidence (low confidence) from 1 study suggested that self-exclusion programmes should have a simplified renewal process.

Individual facilitators:

One sub-theme was identified about 'external motivators'. Evidence (low confidence) from 1 study showed that some people find family members and friends to be good sources of support when accessing harmful gambling services.

Accessing gambling treatment services - from studies receiving funding from an unclear funding source

Six main themes were identified for this stratification: availability of treatment options; acceptability; equalities considerations; fear of treatment services; information and awareness; and individual barriers.

Availability of treatment options:

Two sub-themes were identified. In the 'criminal justice system' sub-theme, evidence (low confidence) from 1 study showed that the availability of harmful gambling treatment services within the criminal justice system was severely limited. Reasons for this included the inflexibility of institutional routines and additional staff needed to escort people to off-site treatment sessions. In the 'waiting times' sub-theme, evidence (low confidence) from 1 study suggested that long waiting lists for services prevented people accessing treatment services for harmful gambling when they needed them.

Acceptability:

Two sub-themes were identified. In the 'flexibility of treatment options' sub-theme, evidence (low confidence) from 1 study showed that people are more likely to access treatment services that can be flexible around people's needs and responsibilities. In the 'time required to access treatment' sub-theme, evidence (low confidence) from 1 study showed that a barrier to accessing harmful gambling treatment services was a large time investment during the registration process.

Equalities considerations:

Two sub-themes were identified relating to different aspects of the Equalities Impact Assessment for this guideline. In the 'sex' sub-theme, evidence (low confidence) from 1 study showed that women felt under-represented in treatment for harmful gambling, and therefore less likely to access group services. In the 'socio-economic factors' sub-theme, evidence (very low confidence) from 1 study suggested that people receiving government assistance may be deterred from accessing treatment services for harmful gambling as it may affect their eligibility for financial aid.

Fear of treatment services:

Three sub-themes were identified. In the 'fear of treatment services' sub-theme, evidence (low confidence) from 1 study showed that some people did not access treatment services as they were not confident that services would be able to help them with their gambling behaviour. In the 'confidentiality and privacy' sub-theme, evidence (low confidence) from 1 study showed that some people in the criminal justice system may not access treatment services for harmful gambling due to the possibility of being exploited by fellow prisoners. In the 'shame and stigma' sub-theme, evidence (low confidence) from 1 study showed that people may be discouraged from accessing harmful gambling treatment services due to worries about being negatively judged.

Information and awareness:

Two sub-themes were identified. In the 'lack of understanding about gambling as an addiction' sub-theme, evidence (low confidence) from 1 study showed that people may become un-motivated to seek help for their harmful gambling if they do not feel as though their addiction was understood by other people. In the 'understanding gambling harms and risk' sub-theme, evidence (low confidence) from 2 studies showed that some people did not access treatment services as they did not believe that harmful gambling is an addiction that can be treated by healthcare professionals.

Individual barriers:

One sub-theme about 'reluctance to address gambling behaviour' was identified. Evidence (moderate confidence) from 2 studies suggested that people may choose to not access treatment for their harmful gambling if they consider it a central part of their identity.

See appendix F for full GRADE-CERQual tables.

Economic evidence

Included studies

A single economic search was undertaken for all topics included in the scope of this guideline, but no economic studies were identified which were applicable to this review question. See the literature search strategy in appendix B and economic study selection flow chart in appendix G.

Excluded studies

No economic studies were reviewed at full text and excluded from this review.

Economic model

No economic modelling was undertaken for this review because the committee agreed that other topics were higher priorities for economic evaluation.

The committee's discussion and interpretation of the evidence

The outcomes that matter most

To address the issue of barriers and facilitators to accessing treatment services for gambling that harms, the review was designed to include qualitative data and as a result the committee could not specify in advance the data that would be located. Instead, they agreed, by informal consensus, on the following main themes to guide the review, although the list was not exhaustive, and the committee were aware that additional themes could be identified:

- Availability of treatment options – for example, views about the availability of services including inpatient treatment, community outpatient, residential options and personalised care such as named contacts or key workers. Additionally, opinions on opening times, appointment systems, eligibility criteria and online treatment options.
- Acceptability – for example, both provider and user expectations on gambling treatment services.
- Affordability – for example, people's concerns about the costs (perceived or real) involved in treatment for gambling that harms. These can include direct and indirect costs, public funding, charitable donations, or industry funding.
- Knowledge and awareness of routes into treatment services – for example, awareness of referral methods (from primary care, intermediary individuals and organisations, or self-referral), pathways from other addiction services, or how to access gambling-related crisis services.
- Equalities considerations – for example, views on whether the needs of people from protected groups are met, such as having facilities for people whose first language is not English, or whether treatment services are culturally appropriate.
- Fear of treatment services – for example, people's experiences with stigma and discrimination associated with awareness raising, assessment, diagnosis and treatment, trust in treatment services, fears over confidentiality and opinions on a lack of standardised oversight in non-Government services.
- Physical barriers – for example, people's preferences on location of services, availability of environment adjustments for disabled access (such as ramps).

- Information and awareness – for example, the awareness and understanding among individuals, families and practitioners about gambling harms and risks, gambling products and the development of addiction.
- Organisation of services – for example, how service planning, organisation and funding can affect the planning and provision of suitable gambling that harms treatment services.

These themes were chosen as they were expected to be the key aspects that influence internal and external facilitators to accessing treatment services for gambling that harms. Evidence was found for all these themes except physical barriers and in addition evidence was found for the themes of individual facilitators and individual barriers.

The quality of the evidence

The evidence was assessed using GRADE-CERQual methodology and the overall confidence in the findings ranged from very low to high.

The review findings were generally downgraded due to concerns over methodological limitations of included studies and for adequacy of data. Examples of methodological limitations included poorly described recruitment and data analysis methods, or a lack of justification on data collection techniques. Examples of adequacy concerns were when only 1 study contributed to a theme, or when multiple studies contributed to a finding but did not contribute rich data. Studies were also downgraded due to concerns over relevance (for example, when findings were derived from evidence with partial relevance to the context of the review protocol, in terms of population, phenomenon of interest or treatment options) and coherence of themes (for example, when themes included both positive and negative findings).

Benefits and harms

The committee reviewed the broad range of themes and sub-themes generated by this evidence review. They discussed whether to consider all the evidence or whether to prioritise themes from non-industry and unclear funding sources over evidence from research funded by the gambling industry. However, the committee noted that the themes and sub-themes identified in the industry funded research (availability of treatment options, knowledge and awareness of routes into treatment, organisation of services and individual facilitators) were very similar and in-line with themes and sub-themes identified by the other research, with no notable differences. They therefore agreed that they could use the evidence base as a whole to make recommendations. Similarly, the committee discussed whether to focus on just the high and moderate confidence evidence. However, they noted that some of the downgrading of evidence may in part be due to the stratification by funding source, and that similar themes across the 3 stratified groups may have been graded as higher confidence if combined (for example, with increased adequacy of data informing sub-themes). The committee also noted that many of the themes identified, even if low confidence, resonated with their knowledge of accessing gambling treatment services and so they agreed to consider all the evidence.

The committee discussed that the themes and sub-themes provided useful information on best practice to improve access to gambling that harms treatment services so agreed to make several recommendations.

A number of themes identified that fear, stigma and shame can act as barriers preventing people accessing treatment for gambling that harms. This evidence was from sub-theme 1.6.2 Discrimination (low confidence), sub-theme 1.6.5 Shame and stigma (moderate confidence), sub-theme 1.10.1 Psychological barriers (moderate confidence), sub-theme

3.4.1 Fear of treatment services, and sub-theme 3.4.3 Shame and stigma (low confidence), which showed that shame, stigma, psychological barriers, and fear of being labelled 'as an addict' all act as barriers. This evidence aligned with the committee's own knowledge and experience that there is a general fear of gambling treatment services due to perceived stigma, shame, and reactions from people close to them. The committee discussed that this stigma is not just experienced in wider society but can be exhibited by healthcare practitioners and other professionals involved in the treatment of gambling-related harms, which can discourage people from accessing treatment services. The committee discussed that the normalisation of gambling in society as an acceptable leisure pursuit can contribute to the societal stigma faced by people experiencing gambling-related harms. The evidence from these themes also showed that certain groups (for example those from marginalised or under-represented groups) may be even more susceptible to stigma and a sense of shame.

In order for people to feel more comfortable in accessing gambling treatment services, the committee advised, based on evidence from the same themes, that professionals should use a person-centred approach, and provide empathetic and non-judgemental support. The committee agreed the benefit of these recommendations would be to help overcome stigma and so remove barriers to accessing treatment.

Evidence showed that some groups of people who experience gambling-related harms (for example, migrants and women) faced additional barriers when accessing treatment services. These included feeling uncomfortable in mixed groups and not being aware of appropriate treatments. This evidence was from the themes about equalities considerations, specifically, sub-theme 1.6.2 Discrimination (low confidence), 3.3.1 Sex (low confidence), and 1.5.4 Migrants (moderate confidence). The committee agreed with this evidence and recommended that reasonable adjustments to treatment services be considered, for example modifying treatment options or delivery methods. They agreed this would ensure people feel comfortable and more likely to engage when accessing their services. The committee suggested that gender-specific services such as groups for women only and culturally sensitive services could be considered based on the evidence, but were aware that these will be dependent on the needs of local populations. In the committee's experience providing separate treatment sessions for particular groups, including for affected others, could increase access to gambling treatment as people may feel less stigmatised and more comfortable. The committee also discussed their own experience and knowledge that former service personnel are also less likely to access gambling treatment services, so they added vocation-specific services to the listed groups, with veterans given as a named example. The committee also used evidence presented in evidence review K to inform this recommendation – from sub-themes 1.4.1 Issues around fear, apprehensions, and trust (low confidence) and 1.3.1 Service needs for different sexes/genders (low confidence).

There was also evidence from evidence review K sub-theme 3.4.4 (low confidence) that people did not want to attend gambling treatment services in the same location as other addiction services as they felt this increased their sense of shame and so the committee agreed that recommending separate locations from other addiction services may reduce stigma and increase access.

There was evidence from sub-theme1.5.5 People with co-morbidities (low confidence) that mental health co-morbidities such as post-traumatic stress disorder, depression or anxiety could act as a barrier to accessing gambling treatment services. From their knowledge and experience, the committee agreed with the evidence presented and recommended that gambling that harms treatment services are aware of this and the reasons why this group face additional barriers to accessing treatment. The committee highlighted a potential reason was the lack of coordination between treatment for gambling-related harms and treatment for other co-existing mental health conditions and/or alcohol and substance dependencies. The

committee noted that they had already made recommendations in the section of the guideline on general principles of treatment about comprehensive coordinated services, so they added a cross-reference to this recommendation.

A number of themes identified that people who experience gambling that harms, professionals, and staff at gambling venues were often unaware of treatment services available locally and how to refer to and access these services. This evidence was captured by sub-themes 1.4.1 Knowledge and awareness of routes into treatment services (low confidence), 1.4.2 Awareness among professionals (very low confidence), 1.4.3 Initial access (low confidence), 1.4.4 Knowledge among venue staff (low confidence), and by themes 2.1 Availability of treatment options (low confidence), 2.2 Knowledge and awareness of routes into treatment services (low confidence), 2.3 Information and awareness (low confidence), 2.4.1 Access to support in gambling venues (very low confidence), and 2.4.2 Clarity of role for venue staff (moderate confidence). The committee agreed with the evidence and recommended that information about accessing gambling treatment services should be available from a local and national health and social care services and in relevant community services (for example, the criminal justice system), but agreed that provision of information had already been included in the recommendations in section 1.2 of the guideline on information and support so did not repeat the recommendations. In the committee's experience this would increase the knowledge of available treatment services and how to access these. This recommendation was also informed by evidence identified in evidence report K sub-themes 1.7.3 Referrals from gambling services (low confidence), 3.4.3 Improving integration (very low confidence), 3.3.2 Training and values of practitioners (moderate confidence), and 2.3.2 Partnership between services (very low confidence).

There was evidence from sub-themes 1.2.1 Time required to access treatment (low confidence), 1.4.5 Self-referral (low confidence), 1.6.4 Lack of trust in services (low confidence), 1.9.2 Families and significant others (low confidence), 1.9.3 Therapists and practitioners (low confidence), and 2.5.1 External motivators (low confidence) that a number of factors could increase access and engagement with gambling treatment services. The evidence showed that people preferred services that were simple and quick to access, and that they didn't like feeling that they were being made to 'jump through hoops' to access care. Similarly, people didn't know that they could self-refer and didn't need to go through other healthcare professionals to access treatment, so making them aware of this would increase access to services. There was also evidence from sub-theme 3.1.1 Criminal justice system (low confidence) that access to gambling treatment services for people in the criminal justice system was very difficult (for example they may need escort staff to attend with them) and so groups such as this may need special considerations to make services available for them. Families were also important in encouraging access and could prompt a decision to access help or make referrals themselves. The evidence also showed that therapists and practitioners were key to encouraging people to access treatment. Based on their knowledge and experience the committee agreed with the evidence and therefore recommended that treatment systems and referrals need to be simple and easy to access. The committee agreed this recommendation would greatly reduce the amount of people that commonly lose contact during an overly complicated referral process. They agreed that because people tend to reach out to services during a crisis, when their needs are acute, then enabling this initial easy access is crucial.

The committee discussed evidence from 3 studies in sub-theme 1.3.1 Affordability (moderate confidence) that the cost of treatment deterred people from seeking treatment. They therefore recommended that people be made aware that gambling treatment services are usually free at the point of access. Evidence from 2 sub-themes about confidentiality and privacy 1.6.1 (moderate confidence) and 3.4.2 (low confidence) showed that people avoided

accessing treatment services because they were worried other people would find out about it. The committee agreed and added from their own experience that people are more likely to access gambling treatment and open up if they know they can trust the service or person involved. They therefore recommended that people should be informed that all conversations are private and confidential, although it was important to note that some information may need to be shared without their consent (for example if they or others may be in danger).

Sub-theme 3.1.2 Waiting times (low confidence) showed that people may be discouraged from accessing treatment if there were long waiting times, and this was reinforced by evidence from evidence review K sub-theme 1.7.4 Wait times (high confidence) and sub-theme 3.2.2 Flexibility and convenience (low confidence) which also showed that complicated sign-up procedures would also discourage people from accessing treatment.

Sub-themes 1.5.2 Culturally appropriate treatment options (low confidence), 1.5.3 Language barriers (moderate confidence), and 3.2.1 Flexibility of treatment options (low confidence) highlighted that access to treatment services could be improved if treatment options were flexible and convenient, and could fit around people's preferences and other commitments, and be adapted to meet their needs. They agreed this would enable access to and engagement with gambling treatment services. These recommendations were also informed by sub-themes from evidence review K - 1.2.1 Flexibility and convenience (moderate confidence), 2.1.2 Flexibility and convenience (very low confidence), and 3.2.2 Flexibility and convenience (low confidence).

Some themes and sub-themes that emerged from this evidence were used to reinforce recommendations from other reviews. Sub-themes 1.1.1 Knowledge of treatment options (low confidence), 1.5.1 Age (low confidence), 1.7.1 Lack of understanding about gambling as an addiction (moderate confidence), 1.7.2 Understanding gambling harms and risks (high confidence), 3.5.1 Lack of understanding about gambling as an addiction (low confidence), and 3.5.2 Understanding gambling harms and risk (low confidence) were used to reinforce the recommendation about providing unbiased information to people experiencing gambling that harms and affected others (see evidence report C, Information and support for an account of the committees' discussion). Sub-theme 1.2.2 Treatment limitations (low confidence) was used to form the recommendation about discussing the choice of treatments with the person experiencing gambling related harms (see evidence report K, Treatment for harmful gambling, for an account of the committees' discussion). Sub-theme 1.8.1 Harmful gambling screening (low confidence) was used to form the recommendation about carrying out screening for gambling-relatedharms in all settings (see evidence report B, Identification and assessment of harmful gambling for an account of the committees' discussion).

In making recommendations, the committee agreed not to use some of the evidence from this review. For example, theme 1.5.6 Socio-economic factors (low confidence) and 3.3.2 Socio-economic factors (very low confidence) about disclosure of harmful gambling affecting eligibility for financial help, were not used as these themes were from research conducted outside the UK and the committee agreed that those findings were not transferable to the UK practice context. Themes 1.6.3 Experience of past services (low confidence), 1.9.1 External motivators (moderate confidence), 1.10.2 Lack of self-motivation (very low confidence), and 3.6.1 Reluctance to address gambling behaviour (moderate confidence) were not used because the committee agreed that although lack of self-motivation and people feeling that gambling forms part of their identity affects access to gambling treatment services, they are not factors that can be directly addressed through practice recommendations. Theme 3.2.2 Time required to access treatment (low confidence) was not used to inform a recommendation as the committee agreed that the time involved in registering for treatment cannot be avoided. Theme 2.4.3 Re-accessing treatment options (low confidence) about self-

exclusion programmes was not used to form a recommendation as the design of self-exclusion schemes is beyond the remit of this NICE guideline.

Stakeholders at consultation suggested a number of groups who may find it difficult to access gambling treatment and support services. These included people who may distrust NHS services, such as people from some ethnic minorities and people from deprived backgrounds. The committee noted that the recommendations on models of care had clarified the role of the voluntary and third sector as providers of gambling support and treatment services, and so although services may be commissioned by the NHS they may be provided outside the NHS which will give people a choice and so encourage access. The committee also agreed that self-referral to non-NHS services would also remain an option for people.

Stakeholders also suggested that women may need interventions delivered separately to encourage access but the committee noted that they had already recommended this and so made no further changes to the recommendations.

Stakeholders commented that people experiencing homelessness would need services to be designed to reach them, and so the committee added this to their recommendations on the requirements for gambling treatment and support services.

Cost effectiveness and resource use

No economic evidence was identified for this review. The committee acknowledged that there is currently reduced access to gambling treatment services, in particular for specific groups and expressed the view that promoting access within the framework set by these recommendations will reinforce good practice. Implementation of recommendations aiming at improving access may have an impact on resource use in the NHS, due to increased need for staff's time and venues. More health professionals' time will be needed across services to provide information about accessing assessment, treatment and support for gambling-related harms and to offer a referral and treatment system that is simple and easy to access and ensures timely initiation of treatment and support after diagnosis. Additional resources will also be needed to provide gambling interventions in accessible locations, including for people in the criminal justice system, as well as separately for distinct groups of people (for example, taking into account gender, vocation and cultural issues), and to coordinate treatment for co-existing conditions, which may inhibit access to gambling treatment and support services. However, the committee expressed the view that related recommendations are likely to improve access to services for people who experience gambling-related harms, which currently is very low, and improve outcomes relating both to gambling-related harms and comorbidities. Finally, the committee were aware that recommending a variety of methods for the delivery of interventions, including online and in-person delivery, entails resource implications, but they considered the guideline evidence on the cost-effectiveness of the recommended interventions, which took into account the interventions' mode of delivery. Overall, the recommendations made are expected to improve access, and subsequently treatment and support outcomes and quality of life of people who are affected by gambling that harms, their families, friends and others close to them, and these benefits, according to the committee's opinion, are likely to outweigh the anticipated resource implications.

Other factors the committee took into account

The funding sources for the studies included in this evidence review were:

- Any industry funding: Beckett 2020, Pickering 2019

- No industry funding: Bramley 2020, Campos 2016, Dabrowska 2017, Dabrowska 2021, Hing 2014, Hing 2015, Itapuisto 2019, Scull 2005, Wieczorek 2018
- Unclear funding source: Bjelde 2008, Jindani 2021, Kaufman 2017

The committee discussed that the themes identified by the 'any industry funding' evidence was coherent with the evidence from the other funding categories and so they considered all the evidence when making their recommendations but noted that most of the industry-funded research related to the provision of information and treatment in gambling venues only.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.1.1, and 1.4.1 to 1.4.8. Other evidence supporting these recommendations can be found in the evidence review K on improving gambling treatment services.

References – included studies

Qualitative

Beckett 2020

Beckett, Michelle, Keen, Brittany, Swanton, Thomas B et al. (2020) Staff Perceptions of Responsible Gambling Training Programs: Qualitative Findings. Journal of gambling studies 36(1): 405-419

Bjelde 2008

Bjelde, Kristine; Chromy, Barbara; Pankow, Debra (2008) Casino gambling among older adults in North Dakota: a policy analysis. Journal of gambling studies 24(4): 423-40

Bramley 2020

Bramley, S; Norrie, C; Manthorpe, J (2020) Exploring the support for UK migrants experiencing gambling-related harm: insights from two focus groups. Public health 184: 22-27

Campos 2016

Campos, Michael D, Camacho, Alvaro, Pereda, Karina et al. (2016) Attitudes Towards Gambling, Gambling Problems, and Treatment Among Hispanics in Imperial County, CA. Journal of gambling studies 32(3): 985-99

Dabrowska 2017

Dabrowska, Katarzyna; Moskalewicz, Jacek; Wieczorek, Lukasz (2017) Barriers in Access to the Treatment for People with Gambling Disorders. Are They Different from Those Experienced by People with Alcohol and/or Drug Dependence?. Journal of gambling studies 33(2): 487-503

Dabrowska 2021

Dabrowska, Katarzyna and Wieczorek, Lukasz (2021) Patients' and professionals' beliefs about the impact of social stigmatization on treatment of gambling-related disorders. Psychiatria polska 55(1): 181-196

Hing 2014

Hing, Nerilee, Tolchard, Barry, Nuske, Elaine et al. (2014) A process evaluation of a self-exclusion program: A qualitative investigation from the perspective of excluders and non-excluders. International Journal of Mental Health and Addiction 12(4): 509-523

Hing 2015

Hing, Nerilee, Nuske, Elaine, Tolchard, Barry et al. (2015) What influences the types of help that problem gamblers choose? A preliminary grounded theory model. International Journal of Mental Health and Addiction 13(2): 241-256

Itapuisto 2019

Itapuisto, Maritta (2019) Problem Gambler Help-Seeker Types: Barriers to Treatment and Help-Seeking Processes. Journal of gambling studies 35(3): 1035-1045

Jindani 2021

Jindani, Farah, Cook, Steve, Shi, Jing et al. (2021) Exploring the Gaps in Programming for Men and Women with a Gambling Disorder in the Correctional System in Canada. International journal of offender therapy and comparative criminology: 306624x211013743

Kaufman 2017

Kaufman, Anna; Jones Nielsen, Jessica D; Bowden-Jones, Henrietta (2017) Barriers to Treatment for Female Problem Gamblers: A UK Perspective. Journal of gambling studies 33(3): 975-991

Pickering 2019

Pickering, Dylan, Nong, Zhenzhen, Gainsbury, Sally M et al. (2019) Consumer perspectives of a multi-venue gambling self-exclusion program: A qualitative process analysis. Journal of Gambling Issues 41: 20-39

Scull 2005

Scull, Sue and Woolcock, Geoffrey (2005) Problem Gambling in Non-English Speaking Background Communities in Queensland, Australia: A Qualitative Exploration. International Gambling Studies 5(1): 29-44

Wieczorek 2018

Wieczorek, Lukasz and Dabrowska, Katarzyna (2018) What makes people with gambling disorder undergo treatment? Patient and professional perspectives. Nordisk 34lcohol- & narkotikatidskrift : NAT 35(3): 196-214

Appendices

Appendix A Review protocols

Review protocol for review question: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

Table 3: Review protocol

ID	Field	Content
0.	PROSPERO registration number	N/A
1.	Review title	Barriers and facilitators to accessing gambling treatment services
2.	Review question	What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?
3.	Objective	• To establish people's views about what helps people to access treatment for harmful gambling (including services for affected others). • To establish people's views about what makes it difficult to access treatment for harmful gambling (including services for affected others).
4.	Searches	The following databases will be searched: • Applied Social Science Index and Abstracts (ASSIA) • Cumulative Index to Nursing and Allied Health Literature (CINAHL) • Cochrane Central Register of Controlled Trials (CENTRAL) • Cochrane Database of Systematic Reviews (CDSR) • Embase • Emcare • Epistemonikos • Health Management Information Consortium (HMIC)

ID	Field	Content
		• Medline and Medline In-Process • PsycInfo • Social Care Online • Social Policy and Practice • Social Sciences Citation Index Searches will be restricted by: • Date: 2000 onwards (see rationale under Section 10) • English language • Human studies • Qualitative filter Other searches: • Inclusion lists of systematic reviews • Kings Fund reports • Campbell Collaboration • Gov.uk • National Grey Literature Collection • Be Gamble Aware • GamCare • Gambling Research Exchange Ontario • Gambling Commission • Advisory Board for Safer Gambling • Gambling Watch UK • Australian Gambling Research Centre • Gambling Compliance • Gambling and Addictions Research Centre • Responsible Gambling Council

ID	Field	Content
		• Victorian Responsible Gambling Foundation One search will be conducted to cover all qualitative questions. With the agreement of the guideline committee the searches will be re-run 6 weeks before final submission of the review and further studies retrieved for inclusion. The full search strategies will be published in the final review.
5.	Condition or domain being studied	Views, perceptions and/or lived experiences of access to treatment services for harmful gambling.
6.	Population	**Inclusion:** • People (aged 18 and over) who participate in gambling that is causing any level of harm to themselves or to their family, carers, and friends. • Family, friends, and others close to people who participate in harmful gambling. • People involved in identification, referral and treatment of harmful gambling (for example, health and social care staff, people working or volunteering in debt advice services, 'vulnerable customer teams' in banks, or front-line staff in the gambling industry, employers, colleagues and occupational health practitioners). **Exclusion:** Views, perceptions and or lived/experiences relating to accessing treatment services for harmful gambling in people under 18 years.
7.	Phenomenon of interest	The committee wish to locate qualitative evidence about accessing treatment services for harmful gambling. They anticipate that data from included studies will cover a number of key themes although these are not exhaustive, and they are aware that other relevant themes may also be identified and reported: • Availability of treatment options. Views may be expressed about the availability of services including inpatient treatment, community outpatient, residential options and

ID	Field	Content
		personalised care such as named contacts or key workers. Also, about opening times, appointment systems, eligibility criteria and online treatment options. • Acceptability. Experiences relating to provider expectations and user expectations might suggest ways of improving access to treatment for harmful gambling. • Affordability. There may be data about the costs (perceived or real), including direct and indirect costs, public funding and charitable donations or industry funding. • Knowledge and awareness of routes into treatment services for example, referral from primary care, self-referral, intermediary individuals and organisations, pathways from other addiction services. Data may also be identified regarding accessing gambling-related crisis services in periods of high-stress. • Equalities considerations. The extent to which treatment services are felt to demonstrate due regard to the equality duty may support or undermine access. For example, whether the needs of people from protected groups are met, such as having facilities for people whose first language is not English. Perceptions about the cultural competence of services may also affect accessibility. • Fear of treatment services. Experiences of stigma and discrimination associated with awareness raising, assessment, diagnosis and treatment lack of trust in services delivering treatment, and fears over confidentiality (for example, employment concerns where diagnosis/treatment can lead to loss of jobs or religious concerns where diagnosis/ treatment could lead to community disapproval) or lack of standardised oversight may act as a barrier. • Physical barriers. Data may be located about physical barriers preventing access to treatment, such as location of services or a lack of ramps or other built environment adjustments for disabled access. Barriers may also take the form of physical distance, detention or other confinement. • Information and awareness. The role of information and awareness surrounding harmful gambling is expected to influence access to treatment services. In particular, awareness and understanding among individuals, families and practitioners about gambling harms and risks, gambling products and the development of addiction. • Organisation of services. Data may be located which suggests that the planning and provision of suitable services is limited by the nature of service planning, organisation or funding.

ID	Field	Content
8.	Comparator/Reference standard/Confounding factors	N/A
9.	Types of study to be included	Studies employing qualitative methods, including: • Systematic reviews and meta-syntheses of qualitative studies • Studies using qualitative methods: focus groups, semi-structured and structured interviews, observations • Surveys conducted using open ended questions and a qualitative analysis of responses Note: Mixed methods studies will be included but only qualitative data will be extracted and risk of bias assessed.
10.	Other exclusion criteria	Inclusion: • Full text papers • Studies conducted in high income (according to the World Bank) countries in Europe as well as Australia, Canada and the US. Exclusion: • Articles published before 2000. • Papers that do not include methodological details will not be included as they do not provide sufficient information to evaluate risk of bias/ study quality. • Studies using quantitative methods only (including surveys that report only quantitative data) • Surveys using mainly closed questions or which quantify open ended answers for analysis. • Non-English language articles • Conference proceedings • Abstract only • Books and book chapters • Theses and dissertations

ID	Field	Content
		Thematic saturation: 1. Data or theme(s) from included studies will not be extracted for particular theme(s) if thematic saturation is reached. 2. Papers included on full text will subsequently be excluded when the whole anticipated framework of phenomena (9 themes listed in row 7) has reached thematic saturation. That is, when evidence synthesis and the application of GRADE-CERQual show that data about all 9 aspects of the phenomenon of interest are 'adequate' and 'coherent'. See row 7 above for details of the anticipated framework of phenomenon and associated rationale.
11.	Context	All settings where harmful gambling may be identified and assessed and where NHS-commissioned healthcare is provided for people who participate in harmful gambling or affected others.
12.	Primary outcomes (critical outcomes)	Not applicable as this is a qualitative review. For anticipated themes, see row 7 above, 'Phenomenon of interest'.
13.	Secondary outcomes (important outcomes)	N/A
14.	Data extraction (selection and coding)	• All references identified by the searches and from other sources will be uploaded into EPPI-Reviewer 5 and de-duplicated. • Titles and abstracts of the retrieved citations will be screened to identify studies that potentially meet the inclusion criteria outlined in the review protocol. • Dual or duplicate screening will be undertaken for 10% of items (90% agreement is required and disagreements will be resolved via discussion with the senior systematic reviewer). • Full versions of the selected studies will be obtained for assessment. Studies that fail to meet the inclusion criteria once the full version has been checked will be excluded at this stage. Each study excluded after checking the full version will be listed along with the reason for its exclusion. • The included and excluded studies lists will be circulated to the Topic Group for their comments. Resolution of disputes will be by discussion between the senior reviewer, Topic Advisor and Chair. • A standardised form will be used to extract data from included studies, providing study reference, research question, data collection and analysis methods used, participant

ID	Field	Content
		characteristics, second-order themes, and relevant first-order themes (i.e., supporting quotes). One reviewer will extract relevant data into a standardised form. This will be quality assessed by the senior reviewer.
15.	Risk of bias (quality) assessment	Quality assessment of individual studies will be performed according to Developing NICE guidelines: the manual, using the following checklists: • CASP checklist for systematic reviews • CASP checklist for qualitative studies The quality assessment will be performed by one reviewer and this will be quality assessed by the senior reviewer.
16.	Strategy for data synthesis	Extracted second-order study themes and related first-order quotes will be synthesised by the reviewer into third-order themes and related sub-themes as 'review findings'. The GRADE-CERQual approach will be used to summarise the confidence in the review findings synthesized from the qualitative evidence ('Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series'; Lewin 2018). The overall confidence in evidence about each review finding will be rated on four dimensions: methodological limitations, coherence, adequacy, and relevance.
17.	Analysis of sub-groups	Themes identified from industry-funded evidence will be reported separately: • Any industry funding • No industry funding • Unclear funding source As this is a qualitative review sub-group analysis is not possible. However, if data allow, the review will include information regarding differences in views held between certain groups, for example people participating in gambling causing different levels of harm, people in different age groups or people with different comorbidities. In these circumstances the committee will consider whether there is a case to make separate recommendations for different groups of for people in different circumstances.

ID	Field	Content			
18.	Type and method of review	☐	Intervention		
		☐	Diagnostic		
		☐	Prognostic		
		☒	Qualitative		
		☐	Epidemiologic		
		☐	Service Delivery		
		☐	Other (please specify)		
19.	Language	English			
20.	Country	England			
21.	Anticipated or actual start date	June 2022			
22.	Anticipated completion date	February 2024			
23.	Stage of review at time of this submission	Review stage		Started	Completed
		Preliminary searches		☑	☑
		Piloting of the study selection process		☑	☑
		Formal screening of search results against eligibility criteria		☑	☑
		Data extraction		☑	☑
		Risk of bias (quality) assessment		☑	☑
		Data analysis		☑	☑
24.	Named contact	**5a Named contact** National Institute for Health and Care Excellence (NICE) **5b Named contact e-mail**			

ID	Field	Content
		Gambling@nice.org.uk **5c Organisational affiliation of the review** National Institute for Health and Care Excellence (NICE)
25.	Review team members	NICE review team
26.	Funding sources/sponsor	This systematic review is being completed by NICE which receives funding from the Department of Health and Social Care.
27.	Conflicts of interest	All guideline committee members and anyone who has direct input into NICE guidelines (including the evidence review team and expert witnesses) must declare any potential conflicts of interest in line with NICE's code of practice for declaring and dealing with conflicts of interest. Any relevant interests, or changes to interests, will also be declared publicly at the start of each guideline committee meeting. Before each meeting, any potential conflicts of interest will be considered by the guideline committee Chair and a senior member of the development team. Any decisions to exclude a person from all or part of a meeting will be documented. Any changes to a member's declaration of interests will be recorded in the minutes of the meeting. Declarations of interests will be published with the final guideline.
28.	Collaborators	Development of this systematic review will be overseen by an advisory committee who will use the review to inform the development of evidence-based recommendations in line with section 3 of Developing NICE guidelines: the manual. Members of the guideline committee are available on the NICE website: https://www.nice.org.uk/guidance/indevelopment/gid-ng10210.
29.	Other registration details	N/A
30.	Reference/URL for published protocol	N/A
31.	Dissemination plans	NICE may use a range of different methods to raise awareness of the guideline. These include standard approaches such as: • notifying registered stakeholders of publication • publicising the guideline through NICE's newsletter and alerts • issuing a press release or briefing as appropriate, posting news articles on the NICE website, using social media channels, and publicising the guideline within NICE.

ID	Field	Content	
32.	Keywords	Qualitative; gambling disorder; treatment; service access; barriers;	
33.	Details of existing review of same topic by same authors	N/A	
34.	Current review status	☒	Ongoing
		☐	Completed but not published
		☐	Completed and published
		☐	Completed, published and being updated
		☐	Discontinued
35..	Additional information	N/A	
36.	Details of final publication	www.nice.org.uk	

CASP: Critical Skills Appraisal Programme; GRADE-CERQual: Grading of Recommendations Assessment, Development and Evaluation - Confidence in the Evidence from Reviews of Qualitative research; NHS: National health service; NICE: National Institute for Health and Care Excellence; N/A: Not applicable

Appendix B Literature search strategies

Literature search strategies for review question: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

Qualitative searches

Please note that a combined literature search was undertaken to cover the three qualitative questions in reviews C, I and K.

Database: Medline and Medline In-Process

Date of last search: 21/03/2022

#	Searches
1	GAMBLING/
2	gambl*.ti,ab.
3	betting.ti,ab.
4	(bet or bets).ti,ab.
5	wager*.ti,ab.
6	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
7	(pokies or pokey or puggy or fruities).ti,ab.
8	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
9	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
10	or/1-9
11	limit 10 to english language
12	limit 11 to yr="2000 -Current"
13	ANIMALS/ not HUMANS/
14	exp ANIMALS, LABORATORY/
15	exp ANIMAL EXPERIMENTATION/
16	exp MODELS, ANIMAL/
17	exp RODENTIA/
18	(rat or rats or mouse or mice).ti.
19	or/13-18
20	12 not 19
21	interview:.mp.
22	experience:.mp.
23	qualitative.tw.
24	or/21-23
25	20 and 24

Database: Embase

Date of last search: 21/03/2022

#	Searches
1	GAMBLING/
2	PATHOLOGICAL GAMBLING/
3	gambl*.ti,ab.
4	betting.ti,ab.
5	(bet or bets).ti,ab.
6	wager*.ti,ab.
7	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
8	(pokies or pokey or puggy or fruities).ti,ab.
9	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.

#	Searches
10	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
11	or/1-10
12	limit 11 to english language
13	limit 12 to yr="2000 -Current"
14	ANIMAL/ not HUMAN/
15	NONHUMAN/
16	exp ANIMAL EXPERIMENT/
17	exp EXPERIMENTAL ANIMAL/
18	ANIMAL MODEL/
19	exp RODENT/
20	(rat or rats or mouse or mice).ti.
21	or/14-20
22	13 not 21
23	interview:.tw.
24	exp HEALTH CARE ORGANIZATION/
25	experiences.tw.
26	or/23-25
27	22 and 26

Database: Emcare

Date of last search: 21/03/2022

#	Searches
1	GAMBLING/
2	PATHOLOGICAL GAMBLING/
3	gambl*.ti,ab.
4	betting.ti,ab.
5	(bet or bets).ti,ab.
6	wager*.ti,ab.
7	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
8	(pokies or pokey or puggy or fruities).ti,ab.
9	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
10	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
11	or/1-10
12	limit 11 to english language
13	limit 12 to yr="2000 -Current"
14	ANIMAL/ not HUMAN/
15	NONHUMAN/
16	exp ANIMAL EXPERIMENT/
17	exp EXPERIMENTAL ANIMAL/
18	ANIMAL MODEL/
19	exp RODENT/
20	(rat or rats or mouse or mice).ti.
21	or/14-20
22	13 not 21
23	interview:.tw.
24	exp HEALTH CARE ORGANIZATION/
25	experiences.tw.
26	or/23-25
27	22 and 26

Database: PsycInfo

Date of last search: 21/03/2022

#	Searches
1	GAMBLING/
2	GAMBLING DISORDER/
3	gambl*.ti,ab.
4	betting.ti,ab.
5	(bet or bets).ti,ab.
6	wager*.ti,ab.

#	Searches
7	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
8	(pokies or pokey or puggy or fruities).ti,ab.
9	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
10	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
11	or/1-10
12	limit 11 to english language
13	limit 12 to yr="2000 -Current"
14	animal.po.
15	(rat or rats or mouse or mice).ti.
16	or/14-15
17	13 not 16
18	experiences.tw.
19	interview:.tw.
20	qualitative.tw.
21	or/18-20
22	17 and 21
23	limit 22 to ("0100 journal" or "0110 peer-reviewed journal")

Database: Health Management Information Consortium (HMIC)

Date of last search: 21/03/2022

#	Searches
1	GAMBLING/
2	GAMBLERS/
3	GAMBLING MACHINES/
4	AMUSEMENT ARCADES/
5	CASINOS/
6	BOOKMAKERS/
7	LOTTERIES/
8	NATIONAL LOTTERY/
9	gambl*.ti,ab.
10	betting.ti,ab.
11	(bet or bets).ti,ab.
12	wager*.ti,ab.
13	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
14	(pokies or pokey or puggy or fruities).ti,ab.
15	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
16	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
17	or/1-16
18	limit 17 to yr="2000 -Current"
19	interview*.ti,ab.
20	experience*.ti,ab.
21	qualitative*.ti,ab.
22	view?.ti,ab.
23	survey*.ti,ab.
24	focus group?.ti,ab.
25	or/19-24
26	18 and 25

Database: Social Policy and Practice

Date of last search: 21/03/2022

#	Searches
1	gambl*.ti,ab.
2	betting.ti,ab.
3	(bet or bets).ti,ab.
4	wager*.ti,ab.
5	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.

#	Searches
6	(pokies or pokey or puggy or fruities).ti,ab.
7	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
8	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
9	or/1-8
10	limit 9 to yr="2000 -Current"
11	interview*.ti,ab.
12	experience*.ti,ab.
13	qualitative*.ti,ab.
14	view?.ti,ab.
15	survey*.ti,ab.
16	focus group?.ti,ab.
17	or/11-16
18	10 and 17

Database: Cochrane Central Register of Controlled Trials (CENTRAL); and Cochrane Database of Systematic Reviews (CDSR)

Date of last search: 21/03/2022

#	Searches
#1	MeSH descriptor: [Gambling] this term only
#2	gambl*:ti,ab
#3	betting:ti,ab
#4	(bet or bets):ti,ab
#5	wager*:ti,ab
#6	((gaming or gambling or slot or fruit or poker or lottery or lotteries) near/5 (machine* or terminal*)):ti,ab
#7	(pokies or pokey or puggy or fruities):ti,ab
#8	((dice or card or cards or roulette or blackjack or poker or baccarat or crap or craps or keno or casino* or bingo or bookmaker* or "book maker" or bookie* or lottery or lotteries or lotto or "scratch card*" or scratchcard* or raffle or raffles or sweepstak* or "amusement arcade*" or slot or slots) near/5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)):ti,ab
#9	((game or games or gaming or gamer*) near/5 (money or monetization or monetisation or monetary)):ti,ab
#10	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9
#11	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 with Cochrane Library publication date Between Jan 2000 and Mar 2022
#12	interview*:ti,ab
#13	experience*:ti,ab
#14	qualitative*:ti,ab
#15	(view or views):ti,ab
#16	survey*:ti,ab
#17	"focus group*":ti,ab
#18	#12 or #13 or #14 or #15 or #16 or #17
#19	#11 and #18

Database: Epistemonikos

Date of last search: 21/03/2022

#	Searches
	(title:((gambl* OR betting OR bet OR bets OR wager* OR "gaming machine*" OR "slot machine*" OR "fruit machine*" OR "poker machine*" OR "lottery machine*" OR "lotteries machine*" OR "gaming terminal*" OR "slot terminal*" OR "fruit terminal*" OR "poker terminal*" OR "lottery terminal*" OR "lotteries terminal*" OR pokies OR pokey OR puggy OR fruities) AND (interview* OR experience* OR qualitative* OR view OR views OR survey* OR "focus group*")) OR abstract:((gambl* OR betting OR bet OR bets OR wager* OR "gaming machine*" OR "slot machine*" OR "fruit machine*" OR "poker machine*" OR "lottery machine*" OR "lotteries machine*" OR "gaming terminal*" OR "slot terminal*" OR "fruit terminal*" OR "poker terminal*" OR "lottery terminal*" OR "lotteries terminal*" OR pokies OR pokey OR puggy OR fruities) AND (interview* OR experience* OR qualitative* OR view OR views OR survey* OR "focus group*"))) Publication year: 2000-2022

Database: Cumulative Index to Nursing and Allied Health Literature (CINAHL)

Date of last search: 21/03/2022

#	Searches
S1	TI (gambl* or betting or bet or bets or wager* or "gaming machine*" or "slot machine*" or "fruit machine*" or "poker machine*" or "lottery machine*" or "lotteries machine*" or "gaming terminal*" or "slot terminal*" or "fruit terminal*" or "poker terminal*" or "lottery terminal*" or "lotteries terminal*" or pokies or pokey or puggy or fruities) Limiters - Publication Year: 2000-
S2	TI (interview* or experience* or qualitative* or view or views or survey* or "focus group*") Limiters - Publication Year: 2000-
S3	S1 and S2

Database: Applied Social Science Index and Abstracts (ASSIA)

Date of last search: 21/03/2022

#	Searches
	AB,TI (gambl* or betting or bet or bets or wager* or "gaming machine*" or "slot machine*" or "fruit machine*" or "poker machine*" or "lottery machine*" or "lotteries machine*" or "gaming terminal*" or "slot terminal*" or "fruit terminal*" or "poker terminal*" or "lottery terminal*" or "lotteries terminal*" or pokies or pokey or puggy or fruities)
AND	AB,TI (interview* or experience* or qualitative* or view or views or survey* or "focus group*")
AND	Additional limits - Date: From January 2000

Database: Social Care Online

Date of last search: 21/03/2022

#	Searches
	AllFields:'gamble or gambler or gamblers or gambling or gambled or betting or bet or bets or wager or wagers or "gaming machine" or "slot machine" or "fruit machine" or "poker machine" or "lottery machine" or "lotteries machine" or "gaming terminal" or "slot terminal" or "fruit terminal" or "poker terminal" or "lottery terminal" or "lotteries terminal" or pokies or pokey or puggy or fruities'
	AND AllFields:'Interview or experience or qualitative or view or views or survey or "focus group"'
	AND PublicationYear:'2000 2022'

Database: Social Sciences Citation Index

Date of last search: 21/03/2022

#	Searches
	(gambl* or betting or bet or bets or wager* or "gaming machine*" or "slot machine*" or "fruit machine*" or "poker machine*" or "lottery machine*" or "lotteries machine*" or "gaming terminal*" or "slot terminal*" or "fruit terminal*" or "poker terminal*" or "lottery terminal*" or "lotteries terminal*" or pokies or pokey or puggy or fruities) and (interview* or experience* or qualitative* or view or views or survey* or "focus group*") (Title) Timespan: 2000-01-01 to 2022-03-17

Other sources

All websites listed in the protocol were searched and browsed.

Date of last search: 21/03/2022

Economic searches

Please note that a combined literature search was undertaken to cover the economics aspects of all the review questions in a single search.

Database: Applied Social Science Index and Abstracts (ASSIA)

Date of last search: 04/04/2023

#	Searches
	AB,TI (gambl* or betting or bet or bets or wager* or "gaming machine*" or "slot machine*" or "fruit machine*" or "poker machine*" or "lottery machine*" or "lotteries machine*" or "gaming terminal*" or "slot terminal*" or "fruit terminal*" or "poker terminal*" or "lottery terminal*" or "lotteries terminal*" or pokies or pokey or puggy or fruities)
AND	AB,TI(budget* OR cost* OR economic* OR pharmaco-economic* OR price* OR pricing* OR financ* OR fee OR fees OR expenditure* OR saving* OR "value for money" OR "monetary value" OR "resourc* allocat*" OR "allocat* resourc*" OR fund OR funds OR funding* OR funded OR ration OR rations OR rationing* OR rationed or "quality of life" or "quality adjusted life" or "disability adjusted life" or "short form or shortform" or "health year equivalent*" or "nottingham health

#	Searches
	profile*" or "sickness impact profile*" or "health status indicator*" or "health utilit*" or "utilit* valu*" or "utilit* measur*" or "willingness to pay" or "standard gamble*" or "time trade off" or "time tradeoff" or "duke health profile" or "functional status questionnaire" or "dartmouth coop functional health assessment*")
AND	Additional limits - Date: From January 2000

Database: Cochrane Central Register of Controlled Trials (CENTRAL)

Date of last search: 04/04/2023

#	Searches
#1	MeSH descriptor: [Gambling] this term only
#2	gambl*:ti,ab
#3	betting:ti,ab
#4	(bet or bets):ti,ab
#5	wager*:ti,ab
#6	((gaming or gambling or slot or fruit or poker or lottery or lotteries) near/5 (machine* or terminal*)):ti,ab
#7	(pokies or pokey or puggy or fruities):ti,ab
#8	((dice or card or cards or roulette or blackjack or poker or baccarat or crap or craps or keno or casino* or bingo or bookmaker* or "book maker" or bookie* or lottery or lotteries or lotto or "scratch card*" or scratchcard* or raffle or raffles or sweepstak* or "amusement arcade*" or slot or slots) near/5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)):ti,ab
#9	((game or games or gaming or gamer*) near/5 (money or monetization or monetisation or monetary)):ti,ab
#10	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9
#11	#1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 with Cochrane Library publication date Between Jan 2000 and Mar 2022
#12	MeSH descriptor: [Economics] this term only
#13	MeSH descriptor: [Value of Life] this term only
#14	MeSH descriptor: [Costs and Cost Analysis] explode all trees
#15	MeSH descriptor: [Economics, Hospital] explode all trees
#16	MeSH descriptor: [Economics, Medical] explode all trees
#17	MeSH descriptor: [Resource Allocation] explode all trees
#18	MeSH descriptor: [Economics, Nursing] this term only
#19	MeSH descriptor: [Economics, Pharmaceutical] this term only
#20	MeSH descriptor: [Fees and Charges] explode all trees
#21	MeSH descriptor: [Budgets] explode all trees
#22	budget*:ti,ab
#23	cost*:ti,ab
#24	(economic* or pharmaco?economic*):ti,ab
#25	(price* or pricing*):ti,ab
#26	(financ* or fee or fees or expenditure* or saving*):ti,ab
#27	(value near/2 (money or monetary)):ti,ab
#28	resourc* allocat*:ti,ab
#29	(fund or funds or funding* or funded):ti,ab
#30	(ration or rations or rationing* or rationed):ti,ab
#31	#12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30
#32	MeSH descriptor: [Value of Life] this term only
#33	MeSH descriptor: [Quality of Life] this term only
#34	"quality of life":ti
#35	((instrument or instruments) near/3 "quality of life"):ab
#36	MeSH descriptor: [Quality-Adjusted Life Years] this term only
#37	"quality adjusted life":ti,ab
#38	(qaly* or qald* or qale* or qtime* or "life year" or "life years"):ti,ab
#39	"disability adjusted life":ti,ab
#40	daly*:ti,ab
#41	(sf36 or "sf 36" or "short form 36" or "shortform 36" or "short form36" or shortform36 or "sf thirtysix" or sfthirtysix or "sfthirty six" or "sf thirty six" or "shortform thirtysix" or "shortform thirty six" or "short form thirtysix" or "short form thirty six"):ti,ab
#42	(sf6 or "sf 6" or "short form 6" or "shortform 6" or "sf six" or sfsix or "shortform six" or "short form six" or shortform6 or "short form6"):ti,ab
#43	(sf8 or "sf 8" or "sf eight" or sfeight or "shortform 8" or "shortform 8" or shortform8 or "short form8" or "shortform eight" or "short form eight"):ti,ab
#44	(sf12 or "sf 12" or "short form 12" or "shortform 12" or "short form12" or shortform12 or "sf twelve" or sftwelve or "shortform twelve" or "short form twelve"):ti,ab
#45	(sf16 or "sf 16" or "short form 16" or "shortform 16" or "short form16" or shortform16 or "sf sixteen" or sfsixteen or "shortform sixteen" or "short form sixteen"):ti,ab
#46	(sf20 or "sf 20" or "short form 20" or "shortform 20" or "short form20" or shortform20 or "sf twenty" or sftwenty or "shortform twenty" or "short form twenty"):ti,ab

#	Searches
#47	(hql or hqol or "h qol" or hrqol or "hr qol"):ti,ab
#48	(hye or hyes):ti,ab
#49	(health* near/2 year* near/2 equivalent*):ti,ab
#50	(pqol or qls):ti,ab
#51	(quality of wellbeing or "quality of well being" or "index of wellbeing" or "index of well being" or qwb):ti,ab
#52	"nottingham health profile*":ti,ab
#53	"sickness impact profile":ti,ab
#54	MeSH descriptor: [Health Status Indicators] explode all trees
#55	(health near/3 (utilit* or status)):ti,ab
#56	(utilit* near/3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or weight)):ti,ab
#57	(preference* near/3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or instrument or instruments)):ti,ab
#58	disutilit*:ti,ab
#59	rosser:ti,ab
#60	"willingness to pay":ti,ab
#61	"standard gamble*":ti,ab
#62	("time trade off" or "time tradeoff"):ti,ab
#63	tto:ti,ab
#64	(hui or hui1 or hui2 or hui3):ti,ab
#65	(eq or euroqol or "euro qol" or eq5d or "eq 5d" or euroqual or "euro qual"):ti,ab
#66	"duke health profile":ti,ab
#67	"functional status questionnaire":ti,ab
#68	"dartmouth coop functional health assessment*":ti,ab
#69	#32 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64 or #65 or #66 or #67 or #68
#70	#11 and #31
#71	#11 and #69
#72	#70 or #71

Database: Cumulative Index to Nursing and Allied Health Literature (CINAHL)

Date of last search: 04/04/2023

#	Searches
S1	TI (gambl* or betting or bet or bets or wager* or "gaming machine*" or "slot machine*" or "fruit machine*" or "poker machine*" or "lottery machine*" or "lotteries machine*" or "gaming terminal*" or "slot terminal*" or "fruit terminal*" or "poker terminal*" or "lottery terminal*" or "lotteries terminal*" or pokies or pokey or puggy or fruities) Limiters - Publication Year: 2000-
S2	TI (budget* OR cost* OR economic* OR pharmaco-economic* OR price* OR pricing* OR financ* OR fee OR fees OR expenditure* OR saving* OR "value for money" OR "monetary value" OR "resourc* allocat*" OR "allocat* resourc*" OR fund OR funds OR funding* OR funded OR ration OR rations OR rationing* OR rationed or "quality of life" or "quality adjusted life" or "disability adjusted life" or "short form or shortform" or "health year equivalent*" or "nottingham health profile*" or "sickness impact profile*" or "health status indicator*" or "health utilit*" or "utilit* valu*" or "utilit* measur*" or "willingness to pay" or "standard gamble*" or "time trade off" or "time tradeoff" or "duke health profile" or "functional status questionnaire" or "dartmouth coop functional health assessment*") Limiters - Publication Year: 2000-
S3	S1 and S2

Database: Embase

Date of last search: 04/04/2023

#	Searches
1	GAMBLING/
2	PATHOLOGICAL GAMBLING/
3	(gambl* not standard gamble).ti,ab.
4	betting.ti,ab.
5	(bet or bets).ti,ab.
6	wager*.ti,ab.
7	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
8	(pokies or pokey or puggy or fruities).ti,ab.
9	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
10	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
11	or/1-10
12	limit 11 to english language

#	Searches
13	limit 12 to yr="2000 -Current"
14	letter.pt. or LETTER/
15	note.pt.
16	editorial.pt.
17	CASE REPORT/ or CASE STUDY/
18	(letter or comment*).ti.
19	or/14-18
20	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
21	19 not 20
22	ANIMAL/ not HUMAN/
23	NONHUMAN/
24	exp ANIMAL EXPERIMENT/
25	exp EXPERIMENTAL ANIMAL/
26	ANIMAL MODEL/
27	exp RODENT/
28	(rat or rats or mouse or mice).ti.
29	or/21-28
30	13 not 29
31	HEALTH ECONOMICS/
32	exp ECONOMIC EVALUATION/
33	exp HEALTH CARE COST/
34	exp FEE/
35	BUDGET/
36	FUNDING/
37	RESOURCE ALLOCATION/
38	budget*.ti,ab.
39	cost*.ti,ab.
40	(economic* or pharmaco?economic*).ti,ab.
41	(price* or pricing*).ti,ab.
42	(financ* or fee or fees or expenditure* or saving*).ti,ab.
43	(value adj2 (money or monetary)).ti,ab.
44	resourc* allocat*.ti,ab.
45	(fund or funds or funding* or funded).ti,ab.
46	(ration or rations or rationing* or rationed).ti,ab.
47	or/31-46
48	SOCIOECONOMICS/
49	exp QUALITY OF LIFE/
50	quality of life.ti,kw.
51	((instrument or instruments) adj3 quality of life).ab.
52	QUALITY-ADJUSTED LIFE YEAR/
53	quality adjusted life.ti,ab,kw.
54	(qaly* or qald* or qale* or qtime* or life year or life years).ti,ab,kw.
55	disability adjusted life.ti,ab,kw.
56	daly*.ti,ab,kw.
57	(sf36 or sf 36 or short form 36 or shortform 36 or short form36 or shortform36 or sf thirtysix or sfthirtysix or sfthirty six or sf thirty six or shortform thirtysix or shortform thirty six or short form thirtysix or short form thirty six).ti,ab,kw.
58	(sf6 or sf 6 or short form 6 or shortform 6 or sf six or sfsix or shortform six or short form six or shortform6 or short form6).ti,ab,kw.
59	(sf8 or sf 8 or sf eight or sfeight or shortform 8 or shortform 8 or shortform8 or short form8 or shortform eight or short form eight).ti,ab,kw.
60	(sf12 or sf 12 or short form 12 or shortform 12 or short form12 or shortform12 or sf twelve or sftwelve or shortform twelve or short form twelve).ti,ab,kw.
61	(sf16 or sf 16 or short form 16 or shortform 16 or short form16 or shortform16 or sf sixteen or sfsixteen or shortform sixteen or short form sixteen).ti,ab,kw.
62	(sf20 or sf 20 or short form 20 or shortform 20 or short form20 or shortform20 or sf twenty or sftwenty or shortform twenty or short form twenty).ti,ab,kw.
63	(hql or hqol or h qol or hrqol or hr qol).ti,ab,kw.
64	(hye or hyes).ti,ab,kw.
65	(health* adj2 year* adj2 equivalent*).ti,ab,kw.
66	(pqol or qls).ti,ab,kw.
67	(quality of wellbeing or quality of well being or index of wellbeing or index of well being or qwb).ti,ab,kw.
68	NOTTINGHAM HEALTH PROFILE/
69	nottingham health profile*.ti,ab,kw.
70	SICKNESS IMPACT PROFILE/
71	sickness impact profile.ti,ab,kw.
72	HEALTH STATUS INDICATOR/

#	Searches
73	(health adj3 (utilit* or status)).ti,ab,kw.
74	(utilit* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or weight)).ti,ab,kw.
75	(preference* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or instrument or instruments)).ti,ab,kw.
76	disutilit*.ti,ab,kw.
77	rosser.ti,ab,kw.
78	willingness to pay.ti,ab,kw.
79	standard gamble*.ti,ab,kw.
80	(time trade off or time tradeoff).ti,ab,kw.
81	tto.ti,ab,kw.
82	(hui or hui1 or hui2 or hui3).ti,ab,kw.
83	(eq or euroqol or euro qol or eq5d or eq 5d or euroqual or euro qual).ti,ab,kw.
84	duke health profile.ti,ab,kw.
85	functional status questionnaire.ti,ab,kw.
86	dartmouth coop functional health assessment*.ti,ab,kw.
87	or/48-86
88	30 and 47
89	30 and 87
90	88 or 89

Database: Emcare

Date of last search: 04/04/2023

#	Searches
1	GAMBLING/
2	PATHOLOGICAL GAMBLING/
3	(gambl* not standard gamble).ti,ab.
4	betting.ti,ab.
5	(bet or bets).ti,ab.
6	wager*.ti,ab.
7	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
8	(pokies or pokey or puggy or fruities).ti,ab.
9	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
10	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
11	or/1-10
12	limit 11 to english language
13	limit 12 to yr="2000 -Current"
14	letter.pt. or LETTER/
15	note.pt.
16	editorial.pt.
17	CASE REPORT/ or CASE STUDY/
18	(letter or comment*).ti.
19	or/14-18
20	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
21	19 not 20
22	ANIMAL/ not HUMAN/
23	NONHUMAN/
24	exp ANIMAL EXPERIMENT/
25	exp EXPERIMENTAL ANIMAL/
26	ANIMAL MODEL/
27	exp RODENT/
28	(rat or rats or mouse or mice).ti.
29	or/21-28
30	13 not 29
31	HEALTH ECONOMICS/
32	exp ECONOMIC EVALUATION/
33	exp HEALTH CARE COST/
34	exp FEE/
35	BUDGET/
36	FUNDING/
37	RESOURCE ALLOCATION/
38	budget*.ti,ab.

#	Searches
39	cost*.ti,ab.
40	(economic* or pharmaco?economic*).ti,ab.
41	(price* or pricing*).ti,ab.
42	(financ* or fee or fees or expenditure* or saving*).ti,ab.
43	(value adj2 (money or monetary)).ti,ab.
44	resourc* allocat*.ti,ab.
45	(fund or funds or funding* or funded).ti,ab.
46	(ration or rations or rationing* or rationed).ti,ab.
47	or/31-46
48	SOCIOECONOMICS/
49	exp QUALITY OF LIFE/
50	quality of life.ti,kw.
51	((instrument or instruments) adj3 quality of life).ab.
52	QUALITY-ADJUSTED LIFE YEAR/
53	quality adjusted life.ti,ab,kw.
54	(qaly* or qald* or qale* or qtime* or life year or life years).ti,ab,kw.
55	disability adjusted life.ti,ab,kw.
56	daly*.ti,ab,kw.
57	(sf36 or sf 36 or short form 36 or shortform 36 or short form36 or shortform36 or sf thirtysix or sfthirtysix or sfthirty six or sf thirty six or shortform thirtysix or shortform thirty six or short form thirtysix or short form thirty six).ti,ab,kw.
58	(sf6 or sf 6 or short form 6 or shortform 6 or sf six or sfsix or shortform six or short form six or shortform6 or short form6).ti,ab,kw.
59	(sf8 or sf 8 or sf eight or sfeight or shortform 8 or shortform 8 or shortform8 or short form8 or shortform eight or short form eight).ti,ab,kw.
60	(sf12 or sf 12 or short form 12 or shortform 12 or short form12 or shortform12 or sf twelve or sftwelve or shortform twelve or short form twelve).ti,ab,kw.
61	(sf16 or sf 16 or short form 16 or shortform 16 or short form16 or shortform16 or sf sixteen or sfsixteen or shortform sixteen or short form sixteen).ti,ab,kw.
62	(sf20 or sf 20 or short form 20 or shortform 20 or short form20 or shortform20 or sf twenty or sftwenty or shortform twenty or short form twenty).ti,ab,kw.
63	(hql or hqol or h qol or hrqol or hr qol).ti,ab,kw.
64	(hye or hyes).ti,ab,kw.
65	(health* adj2 year* adj2 equivalent*).ti,ab,kw.
66	(pqol or qls).ti,ab,kw.
67	(quality of wellbeing or quality of well being or index of wellbeing or index of well being or qwb).ti,ab,kw.
68	NOTTINGHAM HEALTH PROFILE/
69	nottingham health profile*.ti,ab,kw.
70	SICKNESS IMPACT PROFILE/
71	sickness impact profile.ti,ab,kw.
72	HEALTH STATUS INDICATOR/
73	(health adj3 (utilit* or status)).ti,ab,kw.
74	(utilit* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or weight)).ti,ab,kw.
75	(preference* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or instrument or instruments)).ti,ab,kw.
76	disutilit*.ti,ab,kw.
77	rosser.ti,ab,kw.
78	willingness to pay.ti,ab,kw.
79	standard gamble*.ti,ab,kw.
80	(time trade off or time tradeoff).ti,ab,kw.
81	tto.ti,ab,kw.
82	(hui or hui1 or hui2 or hui3).ti,ab,kw.
83	(eq or euroqol or euro qol or eq5d or eq 5d or euroqual or euro qual).ti,ab,kw.
84	duke health profile.ti,ab,kw.
85	functional status questionnaire.ti,ab,kw.
86	dartmouth coop functional health assessment*.ti,ab,kw.
87	or/48-86
88	30 and 47
89	30 and 87
90	88 or 89

Database: Health Information Management Consortium (HMIC)

Date of last search: 04/04/2023

#	Searches
1	GAMBLING/

#	Searches
2	GAMBLERS/
3	GAMBLING MACHINES/
4	AMUSEMENT ARCADES/
5	CASINOS/
6	BOOKMAKERS/
7	LOTTERIES/
8	NATIONAL LOTTERY/
9	(gambl* not standard gamble).ti,ab.
10	betting.ti,ab.
11	(bet or bets).ti,ab.
12	wager*.ti,ab.
13	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
14	(pokies or pokey or puggy or fruities).ti,ab.
15	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
16	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
17	or/1-16
18	limit 17 to yr="2000 -Current"
19	exp ECONOMICS/
20	exp COSTS/
21	exp FEES/
22	exp BUDGETS/
23	RESOURCE ALLOCATION/
24	budget*.ti,ab.
25	cost*.ti,ab.
26	(economic* or pharmaco?economic*).ti,ab.
27	(price* or pricing*).ti,ab.
28	(financ* or fee or fees or expenditure* or saving*).ti,ab.
29	(value adj2 (money or monetary)).ti,ab.
30	resourc* allocat*.ti,ab.
31	(fund or funds or funding* or funded).ti,ab.
32	(ration or rations or rationing* or rationed).ti,ab.
33	or/19-32
34	"QUALITY OF LIFE"/
35	QUALITY-ADJUSTED LIFE YEARS/
36	HEALTH STATUS MEASURES/
37	HEALTH SERVICE INDICATORS/
38	quality of life.ti.
39	((instrument or instruments) adj3 quality of life).ab.
40	quality adjusted life.ti,ab.
41	(qaly* or qald* or qale* or qtime* or life year or life years).ti,ab.
42	disability adjusted life.ti,ab.
43	daly*.ti,ab.
44	(sf36 or sf 36 or short form 36 or shortform 36 or short form36 or shortform36 or sf thirtysix or sfthirtysix or sfthirty six or sf thirty six or shortform thirtysix or shortform thirty six or short form thirtysix or short form thirty six).ti,ab.
45	(sf6 or sf 6 or short form 6 or shortform 6 or sf six or sfsix or shortform six or short form six or shortform6 or short form6).ti,ab.
46	(sf8 or sf 8 or sf eight or sfeight or shortform 8 or shortform 8 or shortform8 or short form8 or shortform eight or short form eight).ti,ab.
47	(sf12 or sf 12 or short form 12 or shortform 12 or short form12 or shortform12 or sf twelve or sftwelve or shortform twelve or short form twelve).ti,ab.
48	(sf16 or sf 16 or short form 16 or shortform 16 or short form16 or shortform16 or sf sixteen or sfsixteen or shortform sixteen or short form sixteen).ti,ab.
49	(sf20 or sf 20 or short form 20 or shortform 20 or short form20 or shortform20 or sf twenty or sftwenty or shortform twenty or short form twenty).ti,ab.
50	(hql or hqol or h qol or hrqol or hr qol).ti,ab.
51	(hye or hyes).ti,ab.
52	(health* adj2 year* adj2 equivalent*).ti,ab.
53	(pqol or qls).ti,ab.
54	(quality of wellbeing or quality of well being or index of wellbeing or index of well being or qwb).ti,ab.
55	nottingham health profile*.ti,ab.
56	sickness impact profile.ti,ab.
57	(health adj3 (utilit* or status)).ti,ab.
58	(utilit* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or weight)).ti,ab.

#	Searches
59	(preference* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or instrument or instruments)).ti,ab.
60	disutilit*.ti,ab.
61	rosser.ti,ab.
62	willingness to pay.ti,ab.
63	standard gamble*.ti,ab.
64	(time trade off or time tradeoff).ti,ab.
65	tto.ti,ab.
66	(hui or hui1 or hui2 or hui3).ti,ab.
67	(eq or euroqol or euro qol or eq5d or eq 5d or euroqual or euro qual).ti,ab.
68	duke health profile.ti,ab.
69	functional status questionnaire.ti,ab.
70	dartmouth coop functional health assessment*.ti,ab.
71	or/34-70
72	18 and 33
73	18 and 71
74	72 or 73

Database: International Health Technology Assessment Database (INAHTA)

Date of last search: 04/04/2023

#	Searches
	All:(gamble or gambler or gamblers or gambling or gambled or betting or bet or bets or wager or wagers)
	AND Publication Year: 2000-2022

Database: MEDLINE ALL

Date of last search: 04/04/2023

#	Searches
1	GAMBLING/
2	(gambl* not standard gamble).ti,ab.
3	betting.ti,ab.
4	(bet or bets).ti,ab.
5	wager*.ti,ab.
6	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
7	(pokies or pokey or puggy or fruities).ti,ab.
8	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
9	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
10	or/1-9
11	limit 10 to english language
12	limit 11 to yr="2000 -Current"
13	LETTER/
14	EDITORIAL/
15	NEWS/
16	exp HISTORICAL ARTICLE/
17	ANECDOTES AS TOPIC/
18	COMMENT/
19	CASE REPORT/
20	(letter or comment*).ti.
21	or/13-20
22	RANDOMIZED CONTROLLED TRIAL/ or random*.ti,ab.
23	21 not 22
24	ANIMALS/ not HUMANS/
25	exp ANIMALS, LABORATORY/
26	exp ANIMAL EXPERIMENTATION/
27	exp MODELS, ANIMAL/
28	exp RODENTIA/
29	(rat or rats or mouse or mice).ti.
30	or/23-29
31	12 not 30
32	ECONOMICS/

#	Searches
33	VALUE OF LIFE/
34	exp "COSTS AND COST ANALYSIS"/
35	exp ECONOMICS, HOSPITAL/
36	exp ECONOMICS, MEDICAL/
37	exp RESOURCE ALLOCATION/
38	ECONOMICS, NURSING/
39	ECONOMICS, PHARMACEUTICAL/
40	exp "FEES AND CHARGES"/
41	exp BUDGETS/
42	budget*.ti,ab.
43	cost*.ti,ab.
44	(economic* or pharmaco?economic*).ti,ab.
45	(price* or pricing*).ti,ab.
46	(financ* or fee or fees or expenditure* or saving*).ti,ab.
47	(value adj2 (money or monetary)).ti,ab.
48	resourc* allocat*.ti,ab.
49	(fund or funds or funding* or funded).ti,ab.
50	(ration or rations or rationing* or rationed).ti,ab.
51	ec.fs.
52	or/32-51
53	"VALUE OF LIFE"/
54	QUALITY OF LIFE/
55	quality of life.ti,kf.
56	((instrument or instruments) adj3 quality of life).ab.
57	QUALITY-ADJUSTED LIFE YEARS/
58	quality adjusted life.ti,ab,kf.
59	(qaly* or qald* or qale* or qtime* or life year or life years).ti,ab,kf.
60	disability adjusted life.ti,ab,kf.
61	daly*.ti,ab,kf.
62	(sf36 or sf 36 or short form 36 or shortform 36 or short form36 or shortform36 or sf thirtysix or sfthirtysix or sfthirty six or sf thirty six or shortform thirtysix or shortform thirty six or short form thirtysix or short form thirty six).ti,ab,kf.
63	(sf6 or sf 6 or short form 6 or shortform 6 or sf six or sfsix or shortform six or short form six or shortform6 or short form6).ti,ab,kf.
64	(sf8 or sf 8 or sf eight or sfeight or shortform 8 or shortform 8 or shortform8 or short form8 or shortform eight or short form eight).ti,ab,kf.
65	(sf12 or sf 12 or short form 12 or shortform 12 or short form12 or shortform12 or sf twelve or sftwelve or shortform twelve or short form twelve).ti,ab,kf.
66	(sf16 or sf 16 or short form 16 or shortform 16 or short form16 or shortform16 or sf sixteen or sfsixteen or shortform sixteen or short form sixteen).ti,ab,kf.
67	(sf20 or sf 20 or short form 20 or shortform 20 or short form20 or shortform20 or sf twenty or sftwenty or shortform twenty or short form twenty).ti,ab,kf.
68	(hql or hqol or h qol or hrqol or hr qol).ti,ab,kf.
69	(hye or hyes).ti,ab,kf.
70	(health* adj2 year* adj2 equivalent*).ti,ab,kf.
71	(pqol or qls).ti,ab,kf.
72	(quality of wellbeing or quality of well being or index of wellbeing or index of well being or qwb).ti,ab,kf.
73	nottingham health profile*.ti,ab,kf.
74	sickness impact profile.ti,ab,kf.
75	exp HEALTH STATUS INDICATORS/
76	(health adj3 (utilit* or status)).ti,ab,kf.
77	(utilit* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or weight)).ti,ab,kf.
78	(preference* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or instrument or instruments)).ti,ab,kf.
79	disutilit*.ti,ab,kf.
80	rosser.ti,ab,kf.
81	willingness to pay.ti,ab,kf.
82	standard gamble*.ti,ab,kf.
83	(time trade off or time tradeoff).ti,ab,kf.
84	tto.ti,ab,kf.
85	(hui or hui1 or hui2 or hui3).ti,ab,kf.
86	(eq or euroqol or euro qol or eq5d or eq 5d or euroqual or euro qual).ti,ab,kf.
87	duke health profile.ti,ab,kf.
88	functional status questionnaire.ti,ab,kf.
89	dartmouth coop functional health assessment*.ti,ab,kf.
90	or/53-89
91	31 and 52

#	Searches
92	31 and 90
93	91 or 92

Database: NHS Economic Evaluation Database (NHS EED)

Date of last search: 04/04/2023

#	Searches
1	MeSH DESCRIPTOR GAMBLING IN NHSEED
2	(gambl*) TI IN NHSEED
3	(betting) IN NHSEED
4	(bet or bets) IN NHSEED
5	(wager*) IN NHSEED
6	(((gaming or gambling or slot or fruit or poker or lottery or lotteries) near5 (machine* or terminal*))) IN NHSEED
7	(pokies or pokey or puggy or fruities) IN NHSEED
8	(((dice or card or cards or roulette or blackjack or poker or baccarat or crap or craps or keno or casino* or bingo or bookmaker* or book maker or bookie* or lottery or lotteries or lotto or scratch card* or scratchcard* or raffle or raffles or sweepstak* or amusement arcade* or slot*) near5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose))) IN NHSEED
9	(((game or games or gaming or gamer*) near5 (money or monetization or monetisation or monetary))) IN NHSEED
10	#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9

Database: PsycInfo

Date of last search: 04/04/2023

#	Searches
1	GAMBLING/
2	GAMBLING DISORDER/
3	(gambl* not standard gamble).ti,ab.
4	betting.ti,ab.
5	(bet or bets).ti,ab.
6	wager*.ti,ab.
7	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
8	(pokies or pokey or puggy or fruities).ti,ab.
9	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
10	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
11	or/1-10
12	limit 11 to english language
13	limit 12 to yr="2000 -Current"
14	(letter or editorial or comment reply).dt. or case report/
15	(letter or comment*).ti.
16	or/14-15
17	exp randomized controlled trial/
18	random*.ti,ab.
19	or/17-18
20	16 not 19
21	animal.po.
22	(rat or rats or mouse or mice).ti.
23	or/20-22
24	13 not 23
25	ECONOMICS/
26	HEALTH CARE ECONOMICS/
27	exp "COSTS AND COST ANALYSIS"/
28	RESOURCE ALLOCATION/
29	budget*.ti,ab.
30	cost*.ti,ab.
31	(economic* or pharmaco?economic*).ti,ab.
32	(price* or pricing*).ti,ab.
33	(financ* or fee or fees or expenditure* or saving*).ti,ab.
34	(value adj2 (money or monetary)).ti,ab.
35	resourc* allocat*.ti,ab.
36	(fund or funds or funding* or funded).ti,ab.

#	Searches
37	(ration or rations or rationing* or rationed).ti,ab.
38	or/25-37
39	"QUALITY OF LIFE"/
40	"HEALTH RELATED QUALITY OF LIFE"/
41	quality of life.ti.
42	((instrument or instruments) adj3 quality of life).ab.
43	quality adjusted life.ti,ab.
44	(qaly* or qald* or qale* or qtime* or life year or life years).ti,ab.
45	disability adjusted life.ti,ab.
46	daly*.ti,ab.
47	(sf36 or sf 36 or short form 36 or shortform 36 or short form36 or shortform36 or sf thirtysix or sfthirtysix or sfthirty six or sf thirty six or shortform thirtysix or shortform thirty six or short form thirtysix or short form thirty six).ti,ab.
48	(sf6 or sf 6 or short form 6 or shortform 6 or sf six or sfsix or shortform six or short form six or shortform6 or short form6).ti,ab.
49	(sf8 or sf 8 or sf eight or sfeight or shortform 8 or shortform 8 or shortform8 or short form8 or shortform eight or short form eight).ti,ab.
50	(sf12 or sf 12 or short form 12 or shortform 12 or short form12 or shortform12 or sf twelve or sftwelve or shortform twelve or short form twelve).ti,ab.
51	(sf16 or sf 16 or short form 16 or shortform 16 or short form16 or shortform16 or sf sixteen or sfsixteen or shortform sixteen or short form sixteen).ti,ab.
52	(sf20 or sf 20 or short form 20 or shortform 20 or short form20 or shortform20 or sf twenty or sftwenty or shortform twenty or short form twenty).ti,ab.
53	(hql or hqol or h qol or hrqol or hr qol).ti,ab.
54	(hye or hyes).ti,ab.
55	(health* adj2 year* adj2 equivalent*).ti,ab.
56	(pqol or qls).ti,ab.
57	(quality of wellbeing or quality of well being or index of wellbeing or index of well being or qwb).ti,ab.
58	nottingham health profile*.ti,ab.
59	sickness impact profile.ti,ab.
60	(health adj3 (utilit* or status)).ti,ab.
61	(utilit* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or weight)).ti,ab.
62	(preference* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or instrument or instruments)).ti,ab.
63	disutilit*.ti,ab.
64	rosser.ti,ab.
65	willingness to pay.ti,ab.
66	standard gamble*.ti,ab.
67	(time trade off or time tradeoff).ti,ab.
68	tto.ti,ab.
69	(hui or hui1 or hui2 or hui3).ti,ab.
70	(eq or euroqol or euro qol or eq5d or eq 5d or euroqual or euro qual).ti,ab.
71	duke health profile.ti,ab.
72	functional status questionnaire.ti,ab.
73	dartmouth coop functional health assessment*.ti,ab.
74	or/39-73
75	24 and 38
76	24 and 74
77	75 or 76
78	limit 77 to ("0100 journal" or "0110 peer-reviewed journal")

Database: Social Care Online

Date of last search: 04/04/2023

#	Searches
	AllFields: 'gamble or gambler or gamblers or gambling or gambled or betting or bet or bets or wager or wagers or "gaming machine" or "slot machine" or "fruit machine" or "poker machine" or "lottery machine" or "lotteries machine" or "gaming terminal" or "slot terminal" or "fruit terminal" or "poker terminal" or "lottery terminal" or "lotteries terminal" or pokies or pokey or puggy or fruities'
	AND AllFields: 'budget or cost or economic or pharmaco-economic or price or pricing or finance or fee or fees or expenditure or saving or "value for money" or "monetary value" or "allocate resource" or "resource allocation" or fund or funds or funding or funded or ration or rations or rationing or rationed' or "quality of life" or "quality adjusted life" or "disability adjusted life" or "short form or shortform" or "health year equivalent" or "sickness impact profile" or "health status indicator" or "health utility" or "utility value" or "utility measure" or "standard gamble" or "time trade off" or "time tradeoff"'
	AND PublicationYear:'2000 2020'

Database: Social Policy and Practice (SPP)

Date of last search: 04/04/2023

#	Searches
1	(gambl* not standard gamble).ti,ab.
2	betting.ti,ab.
3	(bet or bets).ti,ab.
4	wager*.ti,ab.
5	((gaming or gambling or slot or fruit or poker or lottery or lotteries) adj5 (machine? or terminal?)).ti,ab.
6	(pokies or pokey or puggy or fruities).ti,ab.
7	((dice or card? or roulette or blackjack or poker or baccarat or crap or craps or keno or casino? or bingo or bookmaker? or book maker or bookie? or lottery or lotteries or lotto or scratch card? or scratchcard? or raffle or raffles or sweepstak* or amusement arcade? or slot?) adj5 (money or monetization or monetisation or monetary or currency or currencies or cryptocurrency or cryptocurrencies or reward* or win or wins or winning* or loss or losses or lose)).ti,ab.
8	((game or games or gaming or gamer?) adj5 (money or monetization or monetisation or monetary)).ti,ab.
9	or/1-8
10	limit 9 to yr="2000 -Current"
11	budget*.ti,ab.
12	cost*.ti,ab.
13	(economic* or pharmaco?economic*).ti,ab.
14	(price* or pricing*).ti,ab.
15	(financ* or fee or fees or expenditure* or saving*).ti,ab.
16	(value adj2 (money or monetary)).ti,ab.
17	resourc* allocat*.ti,ab.
18	(fund or funds or funding* or funded).ti,ab.
19	(ration or rations or rationing* or rationed).ti,ab.
20	or/11-19
21	quality of life.ti.
22	((instrument or instruments) adj3 quality of life).ab.
23	quality adjusted life.ti,ab.
24	(qaly* or qald* or qale* or qtime* or life year or life years).ti,ab.
25	disability adjusted life.ti,ab.
26	daly*.ti,ab.
27	(sf36 or sf 36 or short form 36 or shortform 36 or short form36 or shortform36 or sf thirtysix or sfthirtysix or sfthirty six or sf thirty six or shortform thirtysix or shortform thirty six or short form thirtysix or short form thirty six).ti,ab.
28	(sf6 or sf 6 or short form 6 or shortform 6 or sf six or sfsix or shortform six or short form six or shortform6 or short form6).ti,ab.
29	(sf8 or sf 8 or sf eight or sfeight or shortform 8 or shortform 8 or shortform8 or short form8 or shortform eight or short form eight).ti,ab.
30	(sf12 or sf 12 or short form 12 or shortform 12 or short form12 or shortform12 or sf twelve or sftwelve or shortform twelve or short form twelve).ti,ab.
31	(sf16 or sf 16 or short form 16 or shortform 16 or short form16 or shortform16 or sf sixteen or sfsixteen or shortform sixteen or short form sixteen).ti,ab.
32	(sf20 or sf 20 or short form 20 or shortform 20 or short form20 or shortform20 or sf twenty or sftwenty or shortform twenty or short form twenty).ti,ab.
33	(hql or hqol or h qol or hrqol or hr qol).ti,ab.
34	(hye or hyes).ti,ab.
35	(health* adj2 year* adj2 equivalent*).ti,ab.
36	(pqol or qls).ti,ab.
37	(quality of wellbeing or quality of well being or index of wellbeing or index of well being or qwb).ti,ab.
38	nottingham health profile*.ti,ab.
39	sickness impact profile.ti,ab.
40	(health adj3 (utilit* or status)).ti,ab.
41	(utilit* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or weight)).ti,ab.
42	(preference* adj3 (valu* or measur* or health or life or estimat* or elicit* or disease or score* or instrument or instruments)).ti,ab.
43	disutilit*.ti,ab.
44	rosser.ti,ab.
45	willingness to pay.ti,ab.
46	standard gamble*.ti,ab.
47	(time trade off or time tradeoff).ti,ab.
48	tto.ti,ab.
49	(hui or hui1 or hui2 or hui3).ti,ab.
50	(eq or euroqol or euro qol or eq5d or eq 5d or euroqual or euro qual).ti,ab.
51	duke health profile.ti,ab.
52	functional status questionnaire.ti,ab.
53	dartmouth coop functional health assessment*.ti,ab.

#	Searches
54	or/21-53
55	10 and 20
56	10 and 54
57	55 or 56

Database: Social Science Citation Index (SSCI)

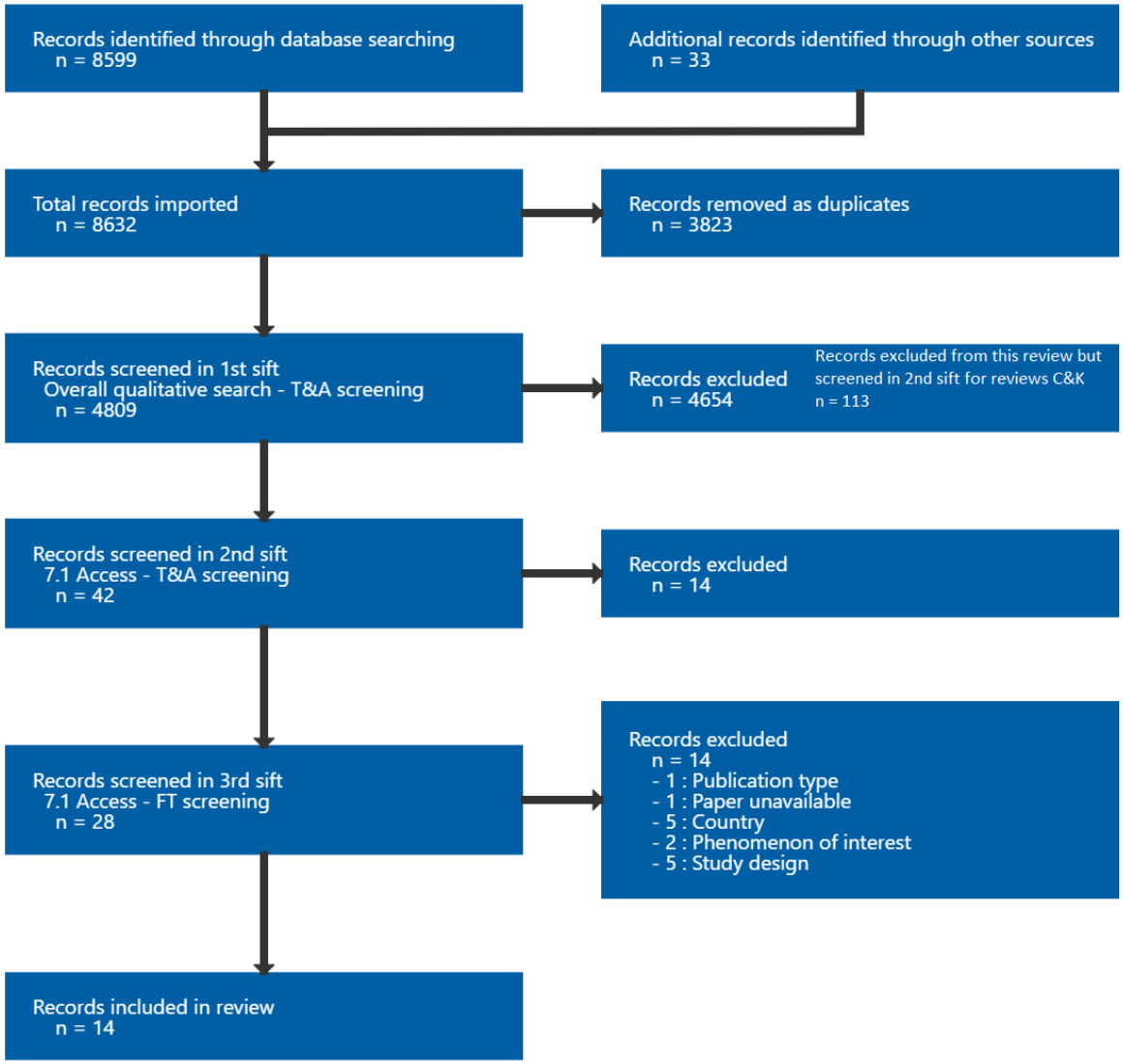
Date of last search: 04/04/2023

#	Searches
	(gambl* or betting or bet or bets or wager* or "gaming machine*" or "slot machine*" or "fruit machine*" or "poker machine*" or "lottery machine*" or "lotteries machine*" or "gaming terminal*" or "slot terminal*" or "fruit terminal*" or "poker terminal*" or "lottery terminal*" or "lotteries terminal*" or pokies or pokey or puggy or fruities) and (budget* OR cost* OR economic* OR pharmaco-economic* OR price* OR pricing* OR financ* OR fee OR fees OR expenditure* OR saving* OR "value for money" OR "monetary value" OR "resourc* allocat*" OR "allocat* resourc*" OR fund OR funds OR funding* OR funded OR ration OR rations OR rationing* OR rationed or "quality of life" or "quality adjusted life" or "disability adjusted life" or "short form or shortform" or "health year equivalent*" or "nottingham health profile*" or "sickness impact profile*" or "health status indicator*" or "health utilit*" or "utilit* valu*" or "utilit* measur*" or "willingness to pay" or "standard gamble*" or "time trade off" or "time tradeoff" or "duke health profile" or "functional status questionnaire" or "dartmouth coop functional health assessment*") (Title) Timespan: 2000-01-01 to 2022-03-24

Appendix C Qualitative evidence study selection

Study selection for: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

Figure 4: Study selection flow chart



Appendix D Evidence tables

Evidence tables for review question: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

Table 4: Evidence tables

Beckett, 2020

Bibliographic Reference	Beckett, Michelle; Keen, Brittany; Swanton, Thomas B; Blaszczynski, Alex; Staff Perceptions of Responsible Gambling Training Programs: Qualitative Findings.; Journal of gambling studies; 2020; vol. 36 (no. 1); 405-419

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	Australia
Setting and aim	**Setting** In the community, metropolitan registered club venue. **Aim** To explore the views and experiences of gambling venue employees regarding staff-customer interactions, and their suggestions to improve this aspect of customer service.
Data collection and analysis	**Data collection** Focus groups. 4 x focus groups of 4-6 people (2 groups were comprised of customer-facing gaming floor staff who did not have a supervisory or managerial roles, 1 group comprised of group team leaders overseeing junior staff, 1 group

	comprised of senior duty managers), conducted by 2 researchers. Participants received information on the nature and purpose of focus groups. Questions explored the nature of staff's roles when interacting with gaming venue clients, views on the indicators of gambling-related harms, what intervention protocols were established by the venue, and views and experiences of the responsible gambling training programme given to staff members. **Analysis** Inductive thematic analysis. Focus groups were audio-recorded and transcribed, before being upload to NVivo. 2 researchers independently generated preliminary themes after familiarising themselves with the transcripts and data, before coding into categories. After this stage, transcripts were double checked for potentially overlooked data. Themes were arranged into overarching themes. After this stage, researchers discussed their results, with any discrepancies resolved by a 3rd researcher. Lastly, themes were refined and finalised with descriptive headings.
Recruitment strategy	Convenience sampling. No further details reported.
Study dates	2017
Sources of funding	Any industry funding (deed from ClubsNSW)
Inclusion criteria	Participants had to be: • Aged over 18 years • Employed as gaming floor staff member • Proficient in English
Exclusion criteria	Not reported.
Sample size	N=20 employees from gambling venue
Participant characteristics	Age in years [Mean (SD)]: Not reported. Sex (n): Not reported. Gambling symptom severity scale and score [Mean (SD)]: Not applicable.

Results	**Author's themes** • Role Ambiguity Around Responsibilities and Procedures for Customer Assistance • Fear of Misidentification and Reprove • Feelings of Inadequate Legislative Support • Limitations and Potential Improvements to Current Training **Study findings** *Role Ambiguity Around Responsibilities and Procedures for Customer Assistance* Participants reported different experiences regarding protocols for helping gamblers. When they were being approached, senior staff understood their responsibilities, as well as those of their floor staff. However, if they were not actively solicited, floor staff were unsure how to help gamblers. Less experienced floor staff were under the impression that interventions could only be offered when gamblers were exhibiting severe signs of distress or aggression. Floor staff with more experience had conflicting views on this aspect – some felt comfortable if they shared an existing relationship with a gambler, while others felt that being the ones to approach could be unprecedented and jarring. "Are we [floor staff] allowed to hand them [patron] that card? I'm not sure if we see somebody that we thought has been here all day, can we go up and hand them a card?" (page 411) "What is the procedure, then, if you do see someone who's maybe exhibiting some sort of distress, or it looks like they're experiencing gambling-related harm?" (page 411) *Fear of Misidentification and Reprove* Floor staff reported senior management being reluctant to intervene as it could lead to complaints from patrons about unwanted interventions, which might result in disciplinary action or other repercussions for themselves. They also reported a perceived lack of consideration to their physical safety (for example, no training in managing physical aggression). Senior staff explained their reluctance to initiate interventions by citing various legislative harm-minimisation strategies and promotions throughout the venue.

	Participants were worried about mis-identifying people as experiencing gambling-related harm due to the subjective nature of signs, in contrast to someone who has drunk too much alcohol. A lack of knowledge of people's personal circumstances and a pressure to serve people quickly (which in turn means you are less able to build a rapport or relationship with patrons) exacerbated this fear. "We don't know what kind of financial background, situation different people are in; it's not really any of our business, into where they come from or what they do or how they spend their money, their hard-earned money. That's their choice" (page 412) "What [other staff member] sees as anger, I might see differently as anger so he might have told six patrons and I've gone "they're alright", so it's, who decides that?; We have some people who drink too much, it's easy to identify … because it's more black and white, where gambling's very grey" (page 412) "[the venue has] compliance signage, which is everywhere, so there's no shortage of, for the patrons, gambling patrons, to seek help. As soon as you walk onto the gaming floor you've got signs, posters, you've got the "think" cards at the end of each bank or machine, you've got a sticker for [each] machine, you've got the club's gaming policy there, plus also the harm minimisation, self-exclusions also" (page 412) *Feelings of Inadequate Legislative Support* All participants reported that their ability to help was impacted by current legislation, which allows people to claim defamation of character if they are offended by being approached by floor staff and offered assistance with harmful gambling. "You're sort of limited by law what you can do. Until the law changes, and what have you, and gives you whatever but, yeah, for now it's because you're limited." (page 412) "… just needs to be a bit of protection for us because I feel like the law's on their [patrons'] side; in general what the club wants us to do is on their [patrons'] side so there's not a point of helping if putting [sic]… helping them is putting us in a vulnerable position." (page 413) *Limitations and Potential Improvements to Current Training*

	Respondents reported different views on the adequacy of responsible gambling interventions. While some participants (especially senior management) felt satisfied, others felt as though not enough was being offered. Junior floor staff want more training that focuses on strategies to actively help at-risk gamblers. They felt as though current training was more aimed at informing them of their legislative and regulatory requirements, rather than approaching and interacting with patrons who may be experiencing harmful gambling. This is very different to the content of training they receive to cover the Responsible Service of Alcohol legislation. “I feel like laws and legislation don’t allow us to approach it especially when we see it destroy someone like in front of us and it’s a bit powerless, our role, and you [offer a drink] or just [say] ‘relax.’” (page 414)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Recruitment methods utilised convenience sampling.)*
Overall risk of bias and relevance	Relevance	Relevant *(Limited to views of gambling venue staff on responsible gambling training programmes.)*

Bjelde, 2008

Bibliographic Reference	Bjelde, Kristine; Chromy, Barbara; Pankow, Debra; Casino gambling among older adults in North Dakota: a policy analysis.; Journal of gambling studies; 2008; vol. 24 (no. 4); 423-40

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	US
Setting and aim	**Setting** Not reported. **Aim** To explore the views and experiences of gambling counsellors regarding the gambling behaviour of older adults in North Dakota.
Data collection and analysis	**Data collection** Semi-structured interviews. 1-2.5 hour face-to-face or telephone interviews consisting of 14 open-ended explored participants' views and experiences of scope, trends and policy issues surrounding harmful gambling in older adults in study state. **Analysis** Thematic analysis. Interviews were transcribed verbatim and combined with field notes to develop categories, which were them combined into final themes.
Recruitment strategy	Purposeful sampling. No further details reported.
Study dates	Not reported.
Sources of funding	Unclear funding source (funding not reported)
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=6 gambling counsellors practicing in North Dakota • Licensed addiction counsellors: n=4

	• Licensed professional counsellor: n=1 • Licensed social workers: n=1
Participant characteristics	Age in years [Mean (SD)]: Not reported. Sex (n): Not reported. Gambling symptom severity scale and score [Mean (SD)]: Not applicable.
Results	**Author's themes** • Mental Health Issues are Not Discussed or Recognized Among Older Adults **Study findings** *Mental Health Issues are Not Discussed or Recognized Among Older Adults* Participants commented that older people do not see gambling as an addiction or treatable disease, and that they experience increased levels of shame that can be difficult tom understand. "most older gamblers really have no concept of the idea of gambling as an addiction or treatable illness" (page 433)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Very poor reporting of recruitment, data collection and analysis methods.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Primarily exploring counsellors views on public health policies to prevent harmful gambling in older adults.)*

Bramley, 2020

Bibliographic Reference	Bramley, S; Norrie, C; Manthorpe, J; Exploring the support for UK migrants experiencing gambling-related harm: insights from two focus groups.; Public health; 2020; vol. 184; 22-27

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting and aim	**Setting** In the community. **Aim** To explore the views and experiences of recent immigrants and professionals offering support to this population. To explore immigrants' vulnerabilities to gambling-related harms and suggestions to improve support in this area.
Data collection and analysis	**Data collection** Focus groups. 2 x approximately 3 hour focus groups held in London and Leeds. Questions and discussions explored why migrants may be vulnerable to experiencing gambling-related harms, and how this impacts gambling participation, help-seeking behaviour and access to support. Particular emphasis was placed on identifying shared experiences between different migrant communities, and reflecting on how these can be addressed to improve access to harmful gambling services. **Analysis**

	Thematic analysis. Focus groups were audio recorded and field notes made by the research team. Researchers generated preliminary codes after familiarising themselves with the data, followed by searching for themes. These themes were finalised after reviewing and defining themes.
Recruitment strategy	Purposive and snowball sampling. Sampling strategy was devised to capture migrants from a variety of countries, as well as people working third sector and community groups supporting migrants. Participants were contacted personally using e-mail or telephone, and invited to participate. Social media and snowball sampling were also used for recruitment.
Study dates	2018
Sources of funding	No industry funding (funded by London School of Hygiene and Tropical Medicine and King's College London Interdisciplinary Research Fund and the National Institute for Health Research Policy Research Programme [reference number PR-PRU-1217-21002]).
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=32 migrants and staff from frontline agencies providing support for migrants • 1st or 2nd generation migrants: n=20 • Staff of frontline agencies providing support for migrants: n=12
Participant characteristics	Age in years [Mean (SD)]: Not reported. Sex (n): M=18, F=14 Gambling symptom severity scale and score [Mean (SD)]: • Migrant participants: Not reported. • Frontline staff participants: Not applicable.
Results	**Author's themes** • Barriers to help seeking

- Ways to improve current support

Study findings

Barriers to help seeking

Responses suggested that migrants have a limited awareness of support services that are available for harmful gambling (for example, what types of support, how to access it, if there are out-of-pocket expenses), which can negatively impact their help-seeking. Information on services available was not accessible if people were not proficient in English. Migrants may also be fearful of bringing shame on themselves, their family or community or being considered weak to seek help for their addiction. This is tied in with worried about confidentiality of formal healthcare services, especially in communities which prefer informal support networks. Additionally, migrants may not be aware of treatment format within the UK and expect to be prescribed medication rather than talking therapies. These therapies can be a barrier in themselves due to the potential stigma in participating in psychological treatment and wariness of group treatment. Finally, migrants might not be able to access services due to co-morbidities (for example, post-traumatic stress disorder).

“they don't know which door to knock on…there's a lack of trust, they're unsure if they have to pay for services and unsure of the quality of the services” (page 25)

Ways to improve current support

Participants suggested several ways to improve support for harmful gamblers in the migrant communities: pro-active screening for harmful gambling by public services (although it was acknowledged that this could offend certain people); considering harmful gambling as a public health concern in order to increase the amount of resources available and staff training; including gambling case studies in literature in order to share valuable information on practical concerns such as accessing financial assistance; and joint working between agencies and community groups to increase signposting of harmful gambling services.

‘working collaboratively with trusted organisations and faith groups who signposted individuals to the service helped, as once that initial trust was established it became easier to provide support’ (page 25)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Limited description of recruitment methods and how migrants with gambling-related harms were located; poor reporting of data analysis methods.)*
Overall risk of bias and relevance	Relevance	Relevant *(Lack of information given on how recruitment captured migrants with gambling-related harms, and no mention in inclusion criteria.)*

Campos, 2016

Bibliographic Reference	Campos, Michael D; Camacho, Alvaro; Pereda, Karina; Santana, Katricia; Calix, Iberia; Fong, Timothy W; Attitudes Towards Gambling, Gambling Problems, and Treatment Among Hispanics in Imperial County, CA.; Journal of gambling studies; 2016; vol. 32 (no. 3); 985-99

Study Characteristics

Study type	General qualitative inquiry (within mixed-methods study)
Country/ies where study was carried out	US
Setting and aim	**Setting** Within the healthcare system, publicly funded health centre with primarily Hispanic service users. **Aim** To explore the views and experiences of gambling and gambling-related harms in local Hispanic community.

Data collection and analysis	**Data collection** Semi-structured interviews and focus groups. Both methods of data collection used the same initial, broad questions which explored perceptions about why people gambling, personal beliefs about gambling, and views on treatment for harmful gambling. • People attending health centre: Semi-structured interviews. If people agreed to volunteer, they completed the survey and interviews in the same visit. Aside from the initial questions noted above, further questions explored types of gambling people participated in, the social context of gambling, how gambling can affect individuals and the community, perception of harmful gambling and treatment for harmful gambling. Participants were also asked whether they were aware of publicly funded treatment options for harmful gambling. Researchers took detailed notes of participant responses but discussions were not recorded. • Service providers and stakeholders: Focus groups. Aside from the initial questions noted above, further questions explored participants attitudes to gambling, personal views on people experiencing harmful gambling and their reasons for gambling, and the factors that encourage gambling in the community. Discussions were audio recorded and researchers took field notes during the sessions. **Analysis** Grounded theory approach. Audio recordings from the focus groups were transcribed and combined with the field notes and interviewer notes, before being groups by question addressed. 1 researcher generated emerging themes from the data, which was then reviewed by a 2nd researcher. No discrepancies were identified during this review process.
Recruitment strategy	Purposive sampling. • People attending health centre: Study was advertised using posters and word of mouth within the health centre. • Service providers and stakeholders: Participants were recruited from the waiting room of the health centre, where they were informed of the study details and procedures, and compensation.
Sources of funding	No industry funding (California Office of Problem Gambling [contract number 08-00143]).
Inclusion criteria	Participants had to be: • Age 21 years and over

	• Able to speak Spanish or English at 5th grade level
Exclusion criteria	Not reported.
Sample size	N=63 • People attending health centre: n=49 • Service providers and stakeholders: n=14
Participant characteristics	Age in years [Mean (SD)]: • People attending health centre: 42.7 (13.5) • Service providers and stakeholders: 42.6 (12.8) Sex (n): • People attending health centre: M=12, F=37 • Service providers and stakeholders: M=3, F=11 Gambling symptom severity scale and score [Mean (SD)]: • People attending health centre: Not reported. • Service providers and stakeholders: Not applicable.
Results	**Author's themes** • Staff Focus Groups • Patient Interviews **Study findings**

	Staff Focus Groups This method of data collection resulted in 3 main themes to answer why people gamble in the community: entertainment/recreation (most common reasoning); escape; and financial reasons. The danger of these themes for at-risk harmful gambling varied – entertainment reasons were not considered problematic but financial reasons were thought to be potentially dangerous. Participants believed that the lack of other recreational opportunities, combined with the other attractions found in casinos (for example, dining, drinking, and shopping), made gambling a favourable pastime. Elderly gamblers are particularly targeted by the casinos, who offer free transportation, play credits, and free food. However, respondents believed that recreational gamblers are still low risk as they tend to only spend small amounts of money and rarely participate in table games. Another motive identified was escaping from the real world, whereby casinos offer refuge from family problems and boredom. The final and most problematic reason for why people gamble in casinos is to win money and become rich, which might cause people to keep gambling even when losing money. Participants were of the view that gambling was a suitable activity for most people but acknowledged that this might not be the case for everyone. All members of the focus group agreed that harmful gambling was a form of addiction. It was also noted that people should only gamble if they can afford it, and that the industry should be subject to regulation in order to avoid as many of the negative consequences as possible. Services to address the addictive nature of gambling was also needed, as mental health issues were seen as being under-supported in the local area. The elderly and people on public benefits highlighted as 2 vulnerable populations that may need additional help. “a need for support groups and services for gambling problems” (page 994) *Patient Interviews* Participants commonly identified entertainment as a reason for people to gamble, providing a setting to socialise when other recreational activities were sparse in the local area. An additional reason was the need for people to be distracted from problems in other areas of their lives. The last reason to gamble was the promise of quick and big cash wins. Many respondents were aware that harmful gambling was a form of addiction and noted several indicators of gambling problems (for example, financial issues, relationship and family problems, preoccupation with gambling, and loss of control over gambling behaviour. Half of participants believed that harmful gambling was a problem amongst the local population, with some specifying that is was a particular concern in the elderly. This was due to the number of casinos and the lack of other recreational pursuits.

	Most people agreed that treatment options for harmful gambling was important, but none of the interviewees were aware of the State-funded treatment programme available. People would also appreciate services to be bi-lingual. “Gambling becomes a problem when all their money, time, and thoughts are about gambling. When there is not satisfaction in life without gambling, there is a problem.” (page 995)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(No consideration of interviewer/researcher relationship [important as interviews conducted after first treatment session]; 1 researcher performed coding.)*
Overall risk of bias and relevance	Relevance	Relevant *(No measurement or mention in inclusion criteria of participant gambling behaviour.)*

Dabrowska, 2017

Bibliographic Reference	Dabrowska, Katarzyna; Moskalewicz, Jacek; Wieczorek, Lukasz; Barriers in Access to the Treatment for People with Gambling Disorders. Are They Different from Those Experienced by People with Alcohol and/or Drug Dependence?.; Journal of gambling studies; 2017; vol. 33 (no. 2); 487-503

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Poland

Setting and aim	**Setting** Within addiction treatment services. **Aim** To explore the views and experiences regarding barriers to treatment for harmful gambling and how these differ from people accessing treatment for substance use disorders.
Data collection and analysis	**Data collection** Semi-structured interviews. Three different interview guides were developed for this study: people experiencing harmful gambling; social workers employed in addiction services; other professionals working with harmful gamblers. • People experiencing harmful gambling: Questions explored people's experiences with treatment for harmful gambling, recommendations for improvement of treatment services, and perceptions of the social stigma of people receiving treatment for harmful gambling. Further questions covering type of discrimination and when it was encountered were also asked. • Other professionals (therapists, general practitioners and psychiatrists) working with harmful gamblers: Questions explored potential motives for accessing treatment, the availability of treatment services for harmful gambling, recommendations for improvement of treatment services, and views on the social stigma experienced by people receiving treatment for harmful gambling. Further questions covering type of discrimination and when it was encountered were also asked. • Social workers employed in addiction services: Questions explored same themes as the other professions, but questions were 'adapted to the reality of their work' (page 185). Interviews were audio-recorded. **Analysis** Thematic analysis. Interviews were audio-recorded and transcribed. 2 researchers independently familiarised themselves with all transcripts and the data, before coding into categories and identifying overarching themes. Discrepancies were resolved through discussion, and a joint code matrix was created. Finally, transcripts were double checked for potentially overlooked data.

Recruitment strategy	Purposive sampling. • People experiencing harmful gambling. Recruited from alcohol and drug outpatient treatment services by therapists or from Gamblers Anonymous meetings by the group leader. Interested people were followed up by researchers. • Social workers employed in addiction treatment services: Recruited from their place of employment. No further details given. • Therapists employed in addiction treatment services: Recruited from their place of employment. No further details given. • General practitioners: Recruited from their place of employment. No further details given. • Psychiatrists: Recruited from their place of employment. No further details given.
Study dates	2015
Sources of funding	No industry funding (Fund of Solving of Gambling Problems being in disposal of the Ministry of Health [grant number 3/HEK/2015 and 72/HE/2014]).

Inclusion criteria	• People experiencing harmful gambling had to:
	  ○ Have a psychiatrist-diagnosed gambling disorder.
	• Professionals working with harmful gamblers:
	  ○ Social workers had to be currently working as social work in addiction services
	  ○ Therapists had to be currently working as a therapist in addiction services
	  ○ General practitioners had to be currently working as a general practitioner
	  ○ Psychiatrists had to be currently working as a psychiatrist

Exclusion criteria	Not reported.

Sample size	N=90
	• People experiencing harmful gambling: n=30
	• Professionals working with harmful gamblers: n=60
	  ○ Social workers employed in addiction treatment services: n=15
	  ○ Therapists employed in addiction treatment services: n=15
	  ○ General practitioners: n=15
	  ○ Psychiatrists: n=15

Participant characteristics	Age in years [Mean (SD)]:
	
	• People experiencing harmful gambling: 38.3 (10.8)
	• Professionals working with people experiencing harmful gambling: 42.9 (12.0)
	  ○ Social workers employed in addiction treatment services: 42.9 (12.3)
	  ○ Therapists employed in addiction treatment services: 40.0 (11.5)
	  ○ General practitioners: 43.7 (13.8)
	  ○ Psychiatrists: 44.4 (11.1)
	
	Sex (n):
	
	• People experiencing harmful gambling: M=12, F=3
	• Professionals working with people experiencing harmful gambling: M=18, F=42
	
	Gambling symptom severity scale and score [Mean (SD)]:
	
	• People experiencing harmful gambling: Not reported.
	• Professionals working with people experiencing harmful gambling: Not applicable.

Results	**Author's themes** • Individual barriers • Structural barriers **Study findings** *Individual barriers* Respondents reported that certain aspects of treatment may act as barriers to accessing treatment, in particular the fear of talking about their personal experiences, issues and feelings in a group environment with people they did not know. People receiving treatment for harmful gambling are often treated within groups dedicated to substance use disorder, causing them to feel marginalised, isolated, and misunderstood. Additionally, admitting an addiction can cause a sense of shame, which can also act as a barrier to treatment. There is also the disbelief that harmful gambling is an addition, and that self-recovery

	is possible. Another barrier is a lack of internal motivation, for example, if people do not believe they need help and instead enter treatment at the behest of other people in their lives. Fear of social stigma is another barrier to accessing treatment, as people have to accept a label of addict as well as potentially disclose personal information such as losing large amounts of money. Some treatment formats are more stigmatised than others, for example, psychiatric treatment. This is due to conflating addiction stigma with mental illness stigma. Another example of a more stigmatising intervention format is social welfare, which people can perceive as accepted by those who are poorly integrated in society and without prospects. “People do not trust us (people with gambling disorders—authors), and this is understandable. I also can not trust myself. No matter how long I do not play, I can never promise, that I will not play to the rest of my life. Recently a friend of my wife borrowed from her a little bit of money. Give this money back to me, she stressed that money should be returned to my wife personally. As if she warned me that I did not go to the casino. So it’s that kind of things.” (page 493) *Structural barriers* Many participants identified structural and organisational barriers to accessing harmful gambling treatment services. Treatment programmes were seldom designed for people experiencing harmful gambling, with content and information instead focused on substance and alcohol dependence. This can make people attending for their gambling behaviour to be distrustful of the programme and less likely to engage. Another organisational barrier is the nature of therapeutic relationships, when staff exhibit distrust and a personal control over patients, even when they have little experience with treating harmful gambling. With group treatment, large groups can act as a barrier to active participation as there is less time to devote to training practical skills. Waiting times for treatment was another barrier to access that was identified, with long waiting times causing some people to re-think their decision to start treatment. Sometimes, inflexible therapy hours mean that it is harder to balance work and life commitments with treatment attendance. Cost was another barrier identified for those participants without medical insurance, who are not reimbursed for harmful gambling treatment. Contrarily, people without insurance attending alcohol or substance disorder treatment do get reimbursed. Furthermore, some services do not have a contract for treating harmful gambling from the National Health Fund. While there are private organisations that can offer treatment, many participants cannot afford their services. Within primary healthcare, people may be unaware that they can present to General Practitioners for gambling concerns, as it is not a physical illness. Similarly, people might be unaware that they can bypass primary care and self-refer for a psychiatric consultation. When accessing social welfare services, harmful gambling is not considered in application paperwork or subsequent questionnaires, so the issue tends to

	only be identified through investigation of co-occurring issues and disorders. Similarly, harmful gambling is not formally recorded on paperwork due to concerns that people with misappropriate financial benefits. “I think there should be different therapeutic tools for people with alcohol dependence and gambling disorders, for example those brochures which we get are mainly for people with alcohol dependence. People with gambling disorders are not able to translate the language which is] addressed to alcohol dependence into their own dependence. They say ‘‘it is not for me because it does not concern me’’ (page 494) “gambling is not included in the list of reasons that predispose to benefit from social support. So gambling is not included in the questionnaire of interview; in any internal diagnoses. It is really by chance only if social worker notices gambling disorders, because for example the family report a problem or because there was comorbid dependencies.” (page 495) “It seems to me, that Social Welfare Center will be one of the last places where people with gambling disorders apply for help. Social Welfare Center is the institution of control, and is perceived in such a way. So they know very well, if they turn to us for help, they will be under supervision. The Center will be the last place where they come, because they have enough control, for example from their families. They do not contribute themselves another source of control.” (page 495)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns *(No mention of independent coding.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Dabrowska, 2021

Bibliographic Reference	Dabrowska, Katarzyna; Wieczorek, Lukasz; Patients' and professionals' beliefs about the impact of social stigmatization on treatment of gambling-related disorders.; Psychiatria polska; 2021; vol. 55 (no. 1); 181-196

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Poland
Setting and aim	**Setting** See Dabrowska 2017 **Aim** To explore the views and experiences of social stigma related to harmful gambling, and how this can affect people accessing treatment services.
Data collection and analysis	See Dabrowska 2017
Recruitment strategy	See Dabrowska 2017
Study dates	See Dabrowska 2017
Sources of funding	See Dabrowska 2017
Inclusion criteria	See Dabrowska 2017
Exclusion criteria	See Dabrowska 2017
Sample size	See Dabrowska 2017
Participant characteristics	See Dabrowska 2017
Results	**Author's themes** • Attribution of responsibility • Perception by the "wise" and the "normal"

- Fear of stigmatization. Negative feelings associated with taking treatment
- Gender
- Type of help/treatment

Study findings

Attribution of responsibility

Participants reported different reactions when people attend treatment for harmful gambling. Some people are supportive, some are ambivalent, some people blame those experiencing harmful gambling for simply being too greedy and do not view it as a disease. This last view leads to people thinking that a person's problems are solely their own fault. These thoughts are not limited to the general public but can be shared by healthcare professionals too. This increased burden of responsibility on harmful gamblers may make those people less likely to access formal treatment services, and instead try to fix their problems alone as they believe that it is a personality defect.

"First of all, other people do not understand that this is a disease and they do not believe in the success of therapy. I also encountered opinions that it's a waste of money, that the treatment does not work, and that strong will is enough." (page 187)

Perception by the "wise" and the "normal"

One participant reflected that an evaluator's familiarity with the addiction model may affect their interactions with people experiencing harmful gambling. The more familiar people are (for example, through their professional role or through family and friends) are, the more understanding and benevolent they can be. Accessing and undergoing treatment is often perceived positively by external support networks, with family, friends and employers acting as sources of assistance for people experiencing harmful gambling.

"My boss knows about my problem, because I told him when I started going to the meetings for treatment. He accepted it with such equanimity that I was surprised by his reaction. I thought he would fire me from the workplace. But no, he even offered me his help; it made me pleasantly surprised." (page 188)

	Fear of stigmatization. Negative feelings associated with taking treatment Participants reflected that stigmatisation can be a large factor in why people experiencing harmful gambling do not access treatment services, as this is an acceptance of the addict label in itself. There is also the fear of other people's reactions and potential social shame. However, this negative perception and stigma was not experienced by all respondents. "When I was a gambler, but without a diagnosis, I was treated as such a nice man who could talk about something in the company of others, who knew all about cards and the casino, and that was a curiosity. Well, there's a guy who likes to play. And then when I started treatment, I became a man with a problem, but I got used to it, I only laugh. I know that people treat it that way." (page 188) *Gender* Participants comments that women may have greater concerns about accepting help for their harmful gambling, as they can face greater stigma about addiction than their male counterparts. "Women are more ashamed of starting treatment than men. For women, there is an even greater fear of social stigma; it is similar as in the case of alcohol. When a man is drunk, it evokes at most a smile, but when a woman is drunk, it is not so liberally treated." (page 189) *Type of help/treatment* Social workers reflected that the common stereotype of people using social assistance as being of a lower social status or having severe mental and social issues was a particular barrier in seeking help for harmful gambling. This is exacerbated by the fact that it can be hard to keep usage of these services secret in smaller communities. Similarly, accessing psychiatric treatments is also prone to greater stigma, due to additional labelling of mental illness. In order to receive a psychiatrist's sign-off for sick leave, people will have to disclose their harmful gambling to both healthcare professionals and employers. "There is something in our society that people do not want to be placed on sick leave by a psychiatrist. I have such patients, who bring me confirmation of the diagnosis of gambling disorder from the psychiatrist, asking me for sick leave. They do not want a stamp of a psychiatrist on the form, because they are afraid of association of their problems with psychiatric problems. They do not want anyone at work to find out about it." (page 190)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns *(See Dabrowska 2017.)*
Overall risk of bias and relevance	Relevance	Highly relevant *(See Dabrowska 2017.)*

Hing, 2014

Bibliographic Reference	Hing, Nerilee; Tolchard, Barry; Nuske, Elaine; Holdsworth, Louise; Tiyce, Margaret; A process evaluation of a self-exclusion program: A qualitative investigation from the perspective of excluders and non-excluders.; International Journal of Mental Health and Addiction; 2014; vol. 12 (no. 4); 509-523

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting and aim	**Setting** Within harmful gambling treatment services, gambling venue self-exclusion program in Queensland. **Aim**

	To explore the views and experiences of people who participate in gambling regarding the Queensland self-exclusion programme for gambling venues, and suggestions for improving the service.
Data collection and analysis	**Data collection** Semi-structured interviews. 40-60 minutes semi-structured telephone interviews. 2 different interview guides were developed for this study: self-excluders and non-self-excluders. • Self-excluders: Questions explored people's experiences with self-exclusions, and their motivators and barriers to self-excluding. • Non-self-excluders: Questions explored people's knowledge of the self-exclusion process, as well as their perceptions of the effectiveness of the programme. Interviews were audio-recorded. **Analysis** Grounded theory thematic analysis. Interviews were audio-recorded and transcribed before being uploaded to NVivo software. 2 researchers iteratively coded the transcripts and identified recurring codes. Similarities, differences and relationships between codes were explored, building into sub-themes and main, overarching themes. These themes were compared against transcripts to ensure that the interpretation was grounded in the original data. Example quotes were selected to support themes, as well as an indicator of how many participants shared particular views and experiences.
Recruitment strategy	Purposive sampling. Participants were recruited over 4 months, based on whether they had self-excluded or not. Recruitment was via several methods: posters in 8 gambling help agencies; information given to self-excluders a 2 casino; information mailed to 142 people meeting the inclusion criteria and who had participated in previous studies of the authors; people meeting the inclusion criteria and who had called into the Queensland Gambling Helpline and Gambling Help Online agreed to recruit appropriate callers; adverts placed on Queensland Gambling Helpline website, Gambling Help Online website, Facebook and Google.
Study dates	Not reported.
Sources of funding	No industry funding (Responsible Gambling Research Grant from the Queensland Department of Justice and Attorney General).
Inclusion criteria	Participants had to:

	• Be aged 18 years or over • Have experience (historical or current) of harmful gambling • Live in Queensland
Exclusion criteria	Not reported.
Sample size	N=103 people accessing harmful gambling services • People who are self-excluded: n=53 • People who are not self-excluded: n=50
Participant characteristics	Age in years [Mean (SD)]: 43.8 (SD not reported) • People who are self-excluded: 42.3(14.49) • People who are not self-excluded: 49.53(13.82) Sex (n): • People who are self-excluded: M=34, F=19 • People who are not self-excluded: M=24, F=26 Gambling symptom severity scale and score [Mean (SD)]: Not reported.
Results	**Author's themes** • Motivations • Barriers • Availability and accessibility • Registration • Links with counselling **Study findings**

	Motivations Several motivations for self-exclusion were mentioned: financial; interpersonal relationships; employment; legal concerns; health conditions. Financial reasoning was the most common reason given, although some respondents reported a combination of reasons. The majority of people who self-excluded and undertook counselling mentioned other people as factors in their decision making (for example, counsellors, family members and colleagues). Fewer participants who self-excluded but did not have counselling identified other people as part of their decision-making. "I knew I had a problem with gambling. It was affecting my mental health. It was very stressful and I was desperate … and I promised my children I would do it" (page 513) "I had a few reckless nights and it was a decision between me and my partner to do something about it. We had like a heated discussion and that was followed by me excluding myself. It was the next day. It was sort of an ultimatum, basically, to do something about it or …" (page 513). *Barriers* The majority of participants also identified barriers to self-exclusion, including denial, lack of knowledge, lack of confidence in the intervention, and embarrassment. "I just didn't know self-exclusion existed" (page 514) *Availability and Accessibility* Participants reported that self-exclusion was available and accessible to people but that the process was time-consuming, especially if they had to complete the process for several different venues. Additionally, other gambling venues and formats still remained available to them, so this intervention wasn't comprehensive. Allowing people to self-exclude from multiple venues at once would reduce shame and embarrassment, as well as reducing resources required (for example, time and money). "It takes a half-hour to 40 min straight to fill out the forms. So if you do five a day, well that's two and a half hours to 3 h a day you're spending trying to self-exclude from all the places you go, or might go … There's got to be a quicker way of

	banning yourself from many places, because otherwise it's just too easy to go somewhere else when you are feeling down" (page 514) *Registration* Participants reported conflicting experiences with the self-exclusion registration process. Over half of the respondents found the process to be relatively easy, with supportive venue staff to assist them. However, privacy and confidentiality were not always respected which was a particular concern in smaller communities. To prevent this, respondents suggested allowing people to self-exclude remotely (for example, online). This would also solve another issue that was commented on, which was the exposure to gambling triggers when presenting at gambling venues to self-exclude. Some participants did not find gambling staff to be particularly knowledgeable about the self-exclusion process, or that they were not supportive or empathetic during the process. "It's not good enough, for sure. I've seen the occasional sign here and there, but I really had to look for it. It wasn't on display. Instead of just having a little card hidden away somewhere, they need to really get it out there. People don't know enough about it. Whether it be more television coverage, more online information … Just make the whole thing a bit more visible to the general public" (page 514) "It's very embarrassing because my life now is common knowledge in a very small town" (page 515) *Links with Counselling* Most, but not all, of the people who self-excluded felt as though they were given adequate and appropriate information on counselling options during the self-exclusion application. Excluders generally believed they were given appropriate information about counselling services when self-excluding, including all but two of those who had not taken up counselling. "I was provided with counselling information. I was given a lot of booklets to read and they offered for me to just sit and talk. It was very appropriate and very, very helpful" (page 518)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Brief description of data collection methods; no consideration of researcher/participant relationship; lack of detailed statement of findings.)*
Overall risk of bias and relevance	Relevance	Relevant *(Specific to self-exclusion programme in Australia.)*

Hing, 2015

Bibliographic Reference	Hing, Nerilee; Nuske, Elaine; Tolchard, Barry; Russell, Alex; What influences the types of help that problem gamblers choose? A preliminary grounded theory model.; International Journal of Mental Health and Addiction; 2015; vol. 13 (no. 2); 241-256

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting and aim	**Setting** See Hing 2014 **Aim** To explore what factors are important in choosing a treatment format for people seeking help for their harmful gambling.

Data collection and analysis	See Hing 2014
Recruitment strategy	See Hing 2014
Study dates	See Hing 2014
Sources of funding	See Hing 2014
Inclusion criteria	See Hing 2014
Exclusion criteria	See Hing 2014
Sample size	See Hing 2014
Participant characteristics	See Hing 2014
Results	**Author's themes** • Confidence in and Knowledge About the Intervention • Encouragement or Pressure to Take up the Intervention • Assistance to Take up and Adhere to the Intervention • Attitude to Problem Disclosure • Independence and Pride • Ease and Effectiveness of the Intervention **Study findings** *Confidence in and Knowledge About the Intervention* Respondents noted several internal barriers in reluctance to self-exclude, including lac of knowledge of self-exclusion, not wanting to stop gambling, disbelieving they needed help, embarrassment, and pride. Both people who self-excluded and those that did not shared views on the effectiveness of self-exclusion as a treatment option. Self-exclusion could be thought of as a short-term intervention which needed to be combined with more long-term treatments in order to be effective. Additionally, self-exclusion was not thought of as being a complete treatment because it is not always possible to exclude from all nearby venues, meaning that people experiencing harmful gambling still have

	casinos available to them. Furthermore, several participants were not confident in a venue's ability to detect self-exclusion breaches due to unreliable facial recognition from photos, staff apathy, frequent changes in staff and businesses commitment to monitoring the exclusion. Although noted by both groups, this lack of confidence was stronger in the people that did not self-exclude. People felt more confident in the effectiveness of self-exclusion when their goal was to restrict access to larger venues (rather than complete abstinence) and were more confident in venues ability to monitor self-exclusion programmes. In the people who self-excluded but did not attend counselling, respondents remained reticent to the idea of counselling but acknowledged that it was an option if self-exclusion failed. Knowledge of self-exclusion programmes was lowest in participants who did not self-exclude and did not attend counselling. These people remained committed to treating their addiction themselves and were unlikely to attend in formal treatment services. "I needed to see a counsellor while I was self-excluding. Self-exclusion stops the elephant. It pulled me up in my tracks so that we could then concentrate on the other counselling as to the how, when, where and why" (page 245) "I don't think it's all that effective. Number one, how do all the staff know you? Do they really check every person that goes in there? I think not. Also, I currently live on the Gold Coast and work in Brisbane three nights a week. There are literally hundreds of places I could stop at. Am I going to go to every single venue to self-exclude? I can tell you that I have probably visited 50 venues in Queensland alone, do I have to go to every single one and self-exclude myself from every single one? Yes. So it's not going to work for me" (page 246) *Encouragement or Pressure to Take up the Intervention* People were more likely to sign-up to self-exclusion agreements or attend counselling if they had encouragement from friends, family. Counsellors were often identified as a source of referral to self-exclusion programmes. Of those attended counselling but did not self-exclude, participants reported that their counsellor's only had limited knowledge of the intervention. Respondents who wished to remain more independent in their recovery often chose to self-exclude without any external motivation. In order to increase the number of people registering with self-exclusion programmes, people thought that venues should actively promote these options to gamblers.

	"Receiving counselling helped the decision about self-exclusion. Yes, definitely, definitely that has made it easier. I think it would be very hard, for me anyway, just to find out about it online and just go out there and just do it. Confronting it with a counsellor, just talking with her about it and putting it on paper how much money was spent, making it real, talking about it and just deciding to go and do it, to self-exclude, helped" (page 246) "My sister was very adamant that I go and see someone. I probably wouldn't have if she hadn't pushed me into going to do it." (page 247) "The information should be more easy to find – people should know what it is, what it includes, what it entails, how it works" (page 247) *Assistance to Take up and Adhere to the Intervention* Participants reported that direct assistance was needed to promote registration for self-exclusion, not just encouragement, with some counsellors physically helping people through the administration process. One participant noted that this prevented them knowing which venues they were and were not excluded from, which meant they did not try access any. Counsellors could also support adherence to the self-exclusion programmes by making people feel accountable to someone. In a similar vein, people reflected that self-exclusion gave them accountability, although this view was not held by all participants. "I think the counsellor helps you accept the fact that, you know, there is a hell of a problem here, even though you know it … But the counsellor sort of eases you into the fact that you've got to do something about it. And then he oversaw that I, in fact, went and did it [self-exclusion]" (page 248) *Attitude to Problem Disclosure* The type of treatment a participant chose was closely linked to how willing they were to share their harmful gambling, and with whom. Disclosure relied upon confidentiality, relationships with affected others, previous experiences with sharing harmful gambling status, and personal preferences. People who self-excluded were willing to share their harmful gambling with venue staff. However, they did highlight the feelings of shame when they continually had to re-share in new environments. People who received formal counselling only were worried about lack of confidentiality outside of this therapist-client relationship and were concerned about disclosure from gambling venue staff (although 1 respondent was concerned about exactly the opposite). Some people were not comfortable disclosing their gambling behaviour to friends

and family, which limited the amount of support they received. Some people would confide in professional counsellors but would not feel comfortable sharing their experiences in a group support setting.

“I’m a bit of a closed person. I don’t like being the centre of attention. When you’re in Gamblers Anonymous, there are people sitting all around the table. You have to speak up. You have to speak in front of all these people. You’ve got all these people looking at you. People are judging you. Even though they might not be saying anything, they’re judging you…with counselling, since its one-on-one, it’s not so intimidating. You don’t have those feelings so much. You can just talk to one person and get into it and relax” (page 249)

Independence and Pride

Participants who did not attend counselling for their harmful gambling noted several barriers to participating in this intervention: a perception that this was a weakness; embarrassment; pride; and fear. These people also tended to value their independence by being able to treat their gambling behaviour themselves.

“I am embarrassed about getting help. I think it’s going to eventually come to that stage, but I just feel like I’m going to be less of a person because I haven’t sorted this out myself, like I want to stick to it myself, but it’s not working too well.” (page 250)

Ease and Effectiveness of the Intervention

Initial experiences of a treatment format impacted the continued use of it. Some people heavily utilised informal support networks, while others did not talk about gambling with their family after poor initial conversations. Self-help was similarly varied, with some people finding it very useful for learning new skills and techniques (for example, budgeting, avoiding gambling triggers, limiting access to money), while others did not find it helpful. If people had positive self-exclusion experiences, they were more likely to continue to self-exclude from other venues, while poor initial experiences deterred further self-exclusion attempts. Likewise, a good connection with therapists, alignment of beliefs and their encouragement of continued therapy, encouraged ongoing counselling. Attending peer support meetings such as Gambler’s Anonymous was also reflected on with mixed feelings. Some people found it helpful as it allowed connections with people who were in similar positions and shared similar experiences, while others felt it was unhelpful to dwell on past experiences.

	"I did four or five visits [to a counsellor]. Then he said that there's not much more that he can do to help me, as far as gambling goes. He suggested things to try and keep my mind off it, as far as doing hobbies and engaging in other activities, but that it was down to me to stop" (page 252) "It was very embarrassing because it was done out in public, I think it should be done in a private office. Yes, it was humiliating and un-nerving … it was something I would not do again." (page 252)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(See Hing 2014.)*
Overall risk of bias and relevance	Relevance	Relevant *(See Hing 2014.)*

Itapuisto, 2019

Bibliographic Reference	Itapuisto, Maritta; Problem Gambler Help-Seeker Types: Barriers to Treatment and Help-Seeking Processes.; Journal of gambling studies; 2019; vol. 35 (no. 3); 1035-1045

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Finland
Setting and aim	**Setting**

	Within harmful gambling treatment services. **Aim** To explore the views and experiences of people experiencing harmful gambling in relation to barriers to accessing treatment.
Data collection and analysis	**Data collection** Semi-structured interviews. 1.5-2 hour interviews interviews located either in homes or treatment setting after initial appointment. Questions explored participant's views of gambling in general, the potential consequences of gambling, and their life history, as well as experiences with the help-seeking process. Questions were intentionally kept broad, and repeated if participants went off-topic. Interviews were audio-recorded. **Analysis** Thematic content analysis. Interviews were recorded, transcribed verbatim and checked against the original recording. Treatment barriers and help-seeking facilitators (motivators, activators and actors) mentioned during interviews were listed and grouped, before being classified and categorised. These were then combined to form different type of help-seeking behaviour.
Recruitment strategy	Purposive sampling. Professionals in gambling treatment services asked new clients if they were interested in participating in the study during their first appointment, and informed of the study procedure and aims. Phone numbers of interested parties were passed on to the researchers, who then contacted participants in the next few days.
Study dates	January - June 2009
Sources of funding	No industry funding (funding not reported but paper includes a disclaimer stating the author has no conflicts of interest).
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=12 people attending treatment for harmful gambling

Participant characteristics	Age in years [Mean (SD)]: Not reported, paper notes 'most were between 20-40'. Sex (n): M=10, F=2 Gambling symptom severity scale and score [Mean (SD)]: Not reported.
Results	**Author's themes** • Barriers to treatment • Help-Seeking Process • Types of Help-Seeker Identified by Combinations of Barriers and Actualised Help-Seeking **Study findings** *Barriers to treatment* Many participants reflected that they had made many attempts to treat their harmful gambling over the years, before contacting their current treatment provider. Five barriers to treatment seeking were identified in the sample: psychological; family and social pressures; gambling culture; general cultural factors; and treatment-specific factors. Psychological barriers included emotions and thoughts that deterred people from seeking help (for example, anger, denial, embarrassment and loss of control). These psychological factors are not always experienced in insolation, and can be mixed with family and social context barriers (for example, shame is a psychological factor but informed by society, and secrecy can impact familial relations and relationship satisfaction). Treatment-related factors include structural and physical barriers associated with treatment services. Gambling culture acts as a barrier as it does not differentiate between recreational and harmful gambling, and gambling venues reassure visitors that it is normal behaviour. The is also the presence of gambling machine outside of gambling venues (for example, pubs and motorway service stations), which reinforces a belief gambling is a recreational activity. Cultural factors include prejudice against treatment (for example, the belief that treatment involves speaking extensively about emotions within a group setting) that is based on media representation and hearsay. "I'm not a problem gambler, I don't go to gambling venues. I just put a few coins in when I go shopping." (page 1039) *Help Seeking Process*

	A ‘motivator’ is the main reason a person’ cites to seek help for their harmful gambling. Motivators include financial issues, family related matters and relationships, or even improvements in quality of life. An ‘activator’ is a person or factor that encourages the process of help-seeking but doesn’t result in the first contact with treatment services. Activators typically include family members and significant others, and can be supportive or threatening. Financial concerns can also be an activator, or anticipation of future problems. An ‘actor’ is an individual who turns a decision into an action. Actors are again family and significant others, who can have initial conversations and make arrangements directly with treatment services. “The last straw was when I was gambling in “Täyspotti” and my father tried to call me… a bit sarcastically he asked: “Are you in town” and he could hear the noise of slot machines and jingle of coins from the background… I just carried on gambling and then he came down to “Täyspotti”… and he said, “look here, start calling, dude, anywhere, look for the place on the internet. I don’t care where you get it, as long as you get help for yourself.” (page 1040) *Types of Help Seeker Identified by Combinations of Barriers and Actualised Help Seeking* There are 3 types of help-seeker: individualistic, multi-problematic and family-centric. For individualistic help-seekers, both barriers and facilitators to accessing treatment services are connected to the person experiencing harmful gambling. People in this class felt as though help-seeking was easy after admitting to themselves that they had a problem, acting as their own activators and actors in their recovery. For multi-problematic help-seekers, harmful gambling was just 1 of the problems they reported experiences, with others including alcohol misuse, substance misuse and mental health problems. This led to their harmful gambling often not being adequately treated, lost among other concerns. This group also tended to be involved in harmful relationships, leading to a lack of support for their help-seeking. Multi-problematic help-seekers were not in denial of their harmful gambling. Motivators such as positive life changes or improvements in the quality of life could precipitate their accessing of treatment services. For family -centre help-seekers, barriers were varied and ranged from individual factors, treatment factors or cultural factors. They tended to be secretive of their harmful gambling, being afraid of losing their families, which negatively impacted their ability to access treatment services. However, family and significant others were also motivators, activators and actors in their help-seeking. No first-order quotes provided for this theme.

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Participants recruited within first consultation; very poor reporting of data collection and analysis methods.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Jindani, 2021

Bibliographic Reference	Jindani, Farah; Cook, Steve; Shi, Jing; McAvoy, Steve; Myers, Chris; Matheson, Flora I; van der Maas, Mark; Sanchez, Sherald; Ferentzy, Peter; Turner, Nigel E; Exploring the Gaps in Programming for Men and Women with a Gambling Disorder in the Correctional System in Canada.; International journal of offender therapy and comparative criminology; 2021; 306624x211013743

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting and aim	**Setting** Within criminal justice system. **Aim** To explore the views and experiences of professionals working in the criminal justice system on the barriers to accessing treatment services for harmful gambling, and how these differ between men and women prisoners.

Data collection and analysis	**Data collection** Semi-structured interviews. Face-to-face, telephone or e-mail interviews were conducted, depending on participant preference. No further details reported. Face-to-face and telephone interviews were audio-recorded. **Analysis** Thematic analysis. Verbal interviews were audio-recorded and transcribed verbatim. Transcripts were combined with e-mail interview responses and interviewer notes using Microsoft Word software. Researchers familiarised themselves with all the data, before open coding key points. These were them grouped into concepts and compared continuously with previously identified codes. Researchers iteratively organised concepts into 3 over-arching themes by, each with multiple sub-themes. Finally, participants were sent a draft of the final report to check the interpretation of findings and feedback any inconsistencies.
Recruitment strategy	Purposive and snowball sampling. Participants were recruited by identifying a range of professionals with expertise on at least 1 area of harmful gambling in the criminal justice system. Areas included diversion, education, treatment, preparation for re-entry, and program management in correctional settings. Snowball sampling was used to supplement this sampling method, by asking participants if they could recommend other participants to the study.
Study dates	September 2011 - February 2013
Sources of funding	Unclear funding source (Grant from the Ontario Problem Gambling Research Centre [ID number 3290]).
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=16 professionals with criminal justice involvement
Participant characteristics	Age in years [Mean (SD)]: Not reported. Sex (n): M=5, F=11 Gambling symptom severity scale and score [Mean (SD)]: Not applicable.

Results	**Author's themes** • Barriers to Treating Problem Gambling: Program Availability and Accessibility • Barriers to Treating Problem Gambling: Lack of Awareness • Barriers to Treating Problem Gambling: Institutional and Structural Issues • Barriers to Treating Problem Gambling: Stigma, Resistance, and Fear of Repercussions • Sex and Gender Differences: Types of Gambling **Study findings** *Barriers to Treating Problem Gambling: Program Availability and Accessibility* Participants reported that a major barrier to accessing treatment for harmful gambling was the limited availability of treatment services within correctional institutions. In turn, this affected the ability of people to achieve parole, especially if treatment was a condition of receiving it. Although treatment services are available outside of the correctional system, there are further barriers in place for these settings. The number of places available are also limited, and there is a staffing implication in chaperoning prisoners to these venues. There was also a concern about sending too many people to services able to accommodate people from the justice system and using up all the resources. [Problem gambling services are] "generally not available in prison" (page 1373) *Barriers to Treating Problem Gambling: Lack of Awareness* Several interviewees noted a lack of awareness amongst criminal justice professionals regarding harmful gambling in the prison setting. Participants reflected that many people see people experiencing harmful gambling as weak of will rather than suffering from a disease, in direct contradiction to how they may view people with substance or alcohol use disorder. Part of this is because gambling is a legal activity and does not show up in conviction records. Instead, it is noted as fraud or drug-related behaviour. The lack of knowledge is exacerbated by the lack of harmful gambling screening during intake. "people look at other addictions and say those people are sick." (page 1373) *Barriers to Treating Problem Gambling: Institutional and Structural Issues*

	Interviewees reflected on the impact of institutional processes (for example, security procedures and lock-downs) had on the availability of harmful gambling treatment services within the justice system. Specific barriers that were mentioned included security concerns, institutional routines, scheduling conflicts, and poor recognition of the value of treatment for harmful gambling. “sometimes the guards were not supportive and might arrive to transport the offender to programming 45 minutes late because something else was going on at the jail.” *Barriers to Treating Problem Gambling: Stigma, Resistance, and Fear of Repercussions* Interviewees identified stigma and access to gambling activities as barriers to effective treatment for harmful gambling. Not only does gambling have a greater stigma attached to it, but other people are also less believing of it as a disease. This increased stigma may explain the lack of Gambler’s Anonymous groups within the prison setting, as people are less inclined to come forward due to people’s perceptions about harmful gambling and there are concerns about other prisoner’s having leverage over an individual if they are aware. These considerations lead to an increased resistance to treatment. Mandatory treatment groups were seen as unnecessary hurdles to overcome before being eligible for parole, whereas voluntary groups were seen more favourably. “never heard of a GA meeting started in a prison without the help of contacts from outside to get the ball rolling.” (page 1374) *Sex and Gender Differences: Types of Gambling* Participants noted that the difference in gambling formats between men and women may also affect the format of preferred therapy. For example, males tend to prefer more risk-taking gambling formats (for example, betting on sports or card playing), seeing themselves as potential poker stars rather than participating in harmful gambling, which may link to therapies covering erroneous beliefs rather than emotions. “men are more apt to be risk-takers and involve themselves in. . .sports betting, card playing, stocks, high-risk sort of things. . .as opposed to slot machines and bingo (that women prefer).” (page 1376)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Poor reporting of data collection methods.)*
Overall risk of bias and relevance	Relevance	Relevant *(Canadian criminal justice system similar to UK.)*

Kaufman, 2017

Bibliographic Reference	Kaufman, Anna; Jones Nielsen, Jessica D; Bowden-Jones, Henrietta; Barriers to Treatment for Female Problem Gamblers: A UK Perspective.; Journal of gambling studies; 2017; vol. 33 (no. 3); 975-991

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	UK
Setting and aim	**Setting** Within harmful gambling treatment services, the National Problem Gambling Clinic. Note: At the time of the study, this was the only NHS multi-disciplinary treatment centre for treatment of harmful gambling and offered CBT therapy (either individual or group format). **Aim** To explore the views and experiences of women who have received treatment for harmful gambling regarding barriers to access and receiving treatment.

Data collection and analysis	**Data collection** Semi-structured interviews. The interview guide was designed to allow sessions to be collaborative, for participants to feel as comfortable as possible, and to emphasise their role as experts. Questions explored participants' experiences (both positive and negative) of treatment for harmful gambling, barriers to treatment, self-reflections on the meaning of being in treatment, and how perceptions of themselves had changed since entering/finishing treatment. **Analysis** Interpretative phenomenological analysis. Researchers familiarised themselves with the interview transcripts and data, making summaries and descriptive labels alongside raw data before assigning themes. Relationships between themes were identified and over-arching themes created. Emerging themes were continuously checked against transcripts to ensure that they were grounded in the original data. To ensure consistency and structure, a summary table of themes (along with cluster themes and illustrative quotes) was created, before creating summary tables for each individual participant. A narrative summary was created, and quotes representing each theme were identified.
Recruitment strategy	Purposive sampling. A standardised pamphlet was given to people who attended the centre for an assessment, and had either completed treatment or where nearing completion of treatment programmed. Interested individuals were screened by telephone and invited to participate in the study.
Study dates	Not reported.
Sources of funding	Unclear funding source (funding not reported).
Inclusion criteria	Participants had to: • Be female • Be aged over 18 years • Be able to speak fluent English • Have received treatment at National Problem Gambling Clinic
Exclusion criteria	Not reported.
Sample size	N=8 women with experience (current or historical) of treatment for harmful gambling • Individual CBT: n=7

	• Group CBT: n=1
Participant characteristics	Age in years [Mean (SD)]: Not reported, age range 30-55. Sex (n): M=0, F=8 Gambling symptom severity scale and score [Mean (SD)]: Not reported.
Results	**Author's themes** • External Barriers to Treatment • Internal Barriers to Treatment **Study findings** *External Barriers to Treatment* Participants reported the barriers of waiting times when accessing initial treatment services. This led to feelings of uncertainty, frustration, anxiety, disempowerment, and disillusionment during the waiting periods. Additionally, after waiting for such a time, there was the risk that formal treatment was no longer needed. The need to dedicate so much time to applying for and attending treatment was another barrier. Distance from treatment services was highlighted as another issue, as was a lack of flexibility in opening times. This made it harder for participants to fit treatment into their schedule, especially with additional factors such as childcare. Remote therapy was suggested as a way to potentially overcome this barrier. Finally, cost was raised by some participants who were unaware of the existence of NHS clinics. "There was a long waiting list and then unfortunately three months on the trot I lost everything each time so the only negative thing is that this isn't, there's only one clinic with a waiting list." (page 981) "It's going to take your time and so on…like I'm going to have to….I know it sounds silly but I'm going to have to fill out some forms and then make my way to X or give X hours a week." (page 982)

	"I think being a single female has because of the childcare side of it and also I've got a very big fear of separation anxiety over my children so….unless there was something available at meetings I wouldn't want to leave them with anybody." (page 982) *Internal Barriers to Treatment* Participants reported several internal barriers to accessing treatment services for harmful gambling, including denial, fear, guilt, stigma and ambivalence. Sometimes people focused on other people's problems in an effort to forget about their own. Other people were uncomfortable with divulging what they say as embarrassing and guilty information about themselves or saw harmful gambling as their own problem to fix. Still others were unsure and mistrustful of the effectiveness of therapy, as well as concerned about what they perceived as handing over control of their recovery to someone else. Most women reported feeling the pressure of sociocultural expectations, although to differing degrees. Many participants reported gambling to be a male dominated space, and this carried over to treatment services where they felt as though women were not catered for. Women had additional barriers to accessing services, such as childcare. However, this gender disparity was not reported as strongly by younger women. Younger women also seemed to report less of a feeling of stigma and shame, although were frustrated with feeling misunderstood and isolated. Finally, ambivalence was described by some respondents as a major barrier to accessing treatment services, in that they were not mentally ready to quit (possibly due to still seeing benefits from their gambling behaviour). "I've never seen a female in recovery in a GA meeting…initially they look at you and they said you're female you should be in the partner's room, and I'm not a partner, I'm a gambler, I need to be in this room, so you get rejected a lot." (page 984) "I think the hardest thing to cope with is that it's not understood very well. One social worker said to my face that she doesn't see why I do it either, which hurt a lot." (page 985) "'I am very shy, but then I was never shy in gambling…I do miss the confidence I had with it, I could walk into any casino and feel confident….I don't think I'll ever stop completely." (page 986)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Lack of information on data collection formats.)*
Overall risk of bias and relevance	Relevance	Relevant *(Limited to women who had received cognitive behavioural therapy from NHS services.)*

Pickering, 2019

Bibliographic Reference	Pickering, Dylan; Nong, Zhenzhen; Gainsbury, Sally M; Blaszczynski, Alex; Consumer perspectives of a multi-venue gambling self-exclusion program: A qualitative process analysis.; Journal of Gambling Issues; 2019; vol. 41; 20-39

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting and aim	**Setting** In the community, **s**elf-exclusion programme for ClubsNSW (a representative body for not-for-profit social venues containing gambling machines and services). **Aim** To explore the views and experiences of people experiencing harmful gambling with a self-exclusion programme from land-based venues.
Data collection and analysis	**Data collection**

	Semi-structured interviews. Face-to-face (n=16), telephone (n=3) and virtual (n=1) semi-structured interviews lasting an average of 52-minutes. Questions revolved around reasons for joining the programme, what worked well in the programme ,what could be improved, what support people engaging in self-exclusion programme might need and how to revoke self-exclusion. **Analysis** Thematic analysis. Interviews were audio recorded and transcribed verbatim before being uploaded to a qualitative software programme (NVivo). Data was inductively analysed by 2 authors after familiarising themselves with the data, organising them into potential themes. These were then reviewed by the same researchers to ensure themes accurately reflected the data, before being cross-references against transcripts to ensure any overlooked data were included in the finalised version of themes. Any disagreements were discussed until agreement was achieved.
Recruitment strategy	Convenience sampling. Current and previously listed self-excluders from the ClubsNSW MVSE database who noted they were interested in participating in research were e-mailed to explain the study and see if they were interested in the study. Interested participants were then contacted to schedule interviews until data saturation was achieved.
Study dates	Not reported.
Sources of funding	Any industry funding (ClubsNSW and Australian Research Council Discovery Early Career Research Award [DE1060100459]).
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=20 gamblers with a history of self-exclusion: • Currently self-excluded: n=13 • Previously self-excluded: n=7
Participant characteristics	Age in years [Mean (SD)]: 46.2 (11.23) Sex (n): M=11, F=9 Gambling symptom severity scale and score [Mean (SD)]: Not reported.

	• Classified as experiencing harmful gambling in previous 12 months* (n [%]): 18 (90) *No details given on how this was measured
Results	**Author's themes** • Access to Information • Additional Help • Revocation and Renewal **Study findings** *Access to Information* Respondents mentioned the scarcity of self-exclusion information available to the public, and suggested more active promotion of the intervention (for example, through a information packet available at gambling venues or online). Participants also thought that people working at gambling venues should be responsible for approaching at-risk gamblers with information on self-exclusion, with counsellors also mentioned as a source of programme referral. Lastly, family and friends were noted as potential reasons for accessing the programme. "He came over and said, ''Look, if it's a problem we have a program.'' I agreed immediately." (page 7) "'My daughter knew I had a problem. She was really distressed about me. She came home and said, ''This is what we have to do mum.''" (page 7) *Additional Help* The most commonly cited services used in conjunction with self-exclusion were face-to-face counselling and 24-hour support services (either telephone on online).These were seen to be better at addressing underlying psychological reasons behind gambling behaviour, which self-exclusion is not designed to do. It was suggested that these counselling services could be provided in-house at gambling venues, as a way of increasing access.

	"Self-exclusion is kind of a Band-Aid or bandage around the problem. Why you need the bandage or the Band-Aid has to be addressed." (page 10) *Revocation and Renewal* Participants had conflicting views on early withdrawal from the self-exclusion programme. The majority believed that this should not be allowed, as self-exclusions are legally binding contracts. People believed that the ability to withdraw early reduced the effectiveness of the intervention. However, some people believed that you should be able to withdraw at any time, either with counsellor agreement or as a personal decision. Regarding renewal, most respondents believed that there should be a notification shortly before the current self-exclusion agreement ends. This could be done via telephone or email and should contain information on how to renew the agreement. Other people suggested that renewal should be automatic unless a person explicitly opts-out of it. Further suggestions included an exit counselling session at the end of an agreement period, or a brief probationary period after self-exclusion. "Everyone has a weak moment where they think, ''oh, I wish I hadn't done this.'' But I think ultimately, you'd regret it." (page 10)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Convenience sampling with limited inclusion/exclusion criteria; no mention of independent analysis.)*
Overall risk of bias and relevance	Relevance	Relevant *(Limited to self-exclusion programmes for land-based gambling.)*

Scull, 2005

Bibliographic Reference	Scull, Sue; Woolcock, Geoffrey; Problem Gambling in Non-English Speaking Background Communities in Queensland, Australia: A Qualitative Exploration.; International Gambling Studies; 2005; vol. 5 (no. 1); 29-44

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting and aim	**Setting** Within the community. **Aim** To explore the development of harmful gambling and the impact it has on immigrant communities, as well as the views and experiences of barriers to access treatment for harmful gambling services that these communities may experience.
Data collection and analysis	**Data collection** Semi-structured interviews. The interview guide was developed from the findings of a literature review and preliminary interviews with people who had experience of harmful gambling in non-English speaking background communities. Questions explored how participants had been affected by harmful gambling (either their own or that of a family member), experiences with help-seeking, and views on how treatment services can be improved. **Analysis** Thematic analysis. No further details reported.
Recruitment strategy	Purposive and snowball sampling. This study targeted people experiencing harmful gambling and their affected others in local Chinese, Greek and Vietnamese communities, although participants were not restricted to these backgrounds. The study was advertised in English, Chinese, Greek and Vietnamese in community media outlets (including radio, newspapers

	and community newsletters) and posters placed within communities. Subsequent snowball sampling used a network of personal project contacts (including gambling venue self-excluders, prisoners, doctors, bilingual community assistants, community care workers, international student support services, and the Gambling Help Services). Initially, recruitment was focused on people who had already recognised they were experiencing harmful gambling but had yet to access government-funded treatment services. However, this proved difficult and therefore the inclusion criteria was expanded to include people with a history of harmful gambling, people who had sought help from harmful gambling treatment services, and former prisoners. Note: This study also reported the recruitment methods for another group of participants (65 individuals with first-hand experience of gambling and harmful gambling in non-English speaking background communities) that were used during the development of the interview guide. However, data from these interviews were not reported.
Study dates	Not reported.
Sources of funding	No industry funding (Research and Community Engagement Division, Queensland Treasury).
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=8 • People with experience (either current or historical) of harmful gambling: n=5 • Affected others of people experiencing harmful gambling: n=3
Participant characteristics	Age in years [Mean (SD)]: Not reported, age range: • People with experience of harmful gambling: 30-72 • Affected others: 33-in their 50s Sex (n): • People with experience of harmful gambling: M=3, F=2 • Affected others: M=0, F=3

	Gambling symptom severity scale and score [Mean (SD)]: • People with experience of harmful gambling: Not reported. • Affected others: Not applicable.
Results	**Author's themes** • Help Seeking Behaviour and Barriers to Help • Addressing the Barriers **Study findings** *Help Seeking Behaviour and Barriers to Help* While there are people experiencing harmful gambling within the Chinese, Greek and Vietnamese communities, few seek help for their addiction. Community workers reported the difficulties experienced in encouraging people to access treatment, highlighting denial as a major factor. Many people acknowledge that they gambled but do not classify it as harmful gambling, instead viewing it as a recreational activity. Shame and stigma were also noted to be involved in the lack of recognition of harmful gambling within these communities. This extended past the person experiencing harmful gambling, to the family and even the wider community. Another cultural aspect is the reliance on informal support networks (mainly the extended family) in many non-English speaking communities, with help-seeking outside of this unit perceived as family failure. This is compounded by the tight-knit aspect of non-English speaking communities, where everyone knows each other, and personal information can be spread very quickly. Language barriers and lack of information in these communities also impacts access to treatment services by limiting education about available resources. Even if people are aware of organisations, they may be prevented from contacting them if they believe that no one can help them. Another large barrier is the lack of appropriate services, with treatment formats not being available in languages other than English and people experiencing harmful gambling not being confident in using translators. Levels of cultural understanding is another factor, with people in non-English speaking communities perceiving addiction treatment as Westernised and forcing people to forced to conform to this format. "Now they [gambling help services] have access using interpreters, but they still focus on the Australian way. With the Chinese, [you] don't go straight to the point, don't say have you a gambling problem" (page 39)

	"…can offer help, counselling support, referral to gambling help services, but most [clients] have difficulties with language, and are not comfortable using an interpreter" (page 39) *Addressing the Barriers* Respondents noted that a lack of cultural appropriate community education needed to be addressed, increasing the amount of clear, multi-lingual information on harmful gambling and available help-seeking harmful gambling services. This will help to set expectations on how treatment is offered, in what formats (for example, bilingual counsellors or informal interventions other than counselling), and stress that confidentiality is assured. This information should de given to community members and workers (for example, via local radio, newspapers, or seminars). A wider information dissemination campaign should target stigma of harmful gambling in non-English speaking communities. This could be assisted by building relationships between communities and community workers to help promote services and foster trust. There is also a need to increase the availability of appropriate services, particularly bilingual and bicultural counsellors who can converse in native languages and understand cultural contexts. Existing counsellors should also be trained in the needs experienced by people experiencing harmful gambling within non-English speaking communities. Interpreters should also be available, with the possibility of nominating preferred interpreters available to people. Early treatment should be less directed towards harmful gambling specific issues, and more general concerns and practical assistance (for example, financial advice). Services should be more flexible and delivered in community settings. Telephone counselling is also an option for this population, provided it is available in multiple languages, as it can be an anonymous way of providing treatment. Socialisation needs should be addressed by settlement organisations in order to help prevent harmful gambling developing in the first place by proving alternative recreational activities. "Vietnamese, they would expect to be given decisions if they went for counselling, not options as is normally happens. If they are simply given options and have to make the decisions for themselves, they won't go back. There is an expectation that people will tell them what to do. They would be looking for practical things they can do straight away, such as self-exclusion, and help in arranging finances." (page 40)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Recruitment methods utilised convenience sampling.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Wieczorek, 2018

Bibliographic Reference	Wieczorek, Lukasz; Dabrowska, Katarzyna; What makes people with gambling disorder undergo treatment? Patient and professional perspectives.; Nordisk alkohol- & narkotikatidskrift : NAT; 2018; vol. 35 (no. 3); 196-214

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Poland
Setting and aim	**Setting** See Dabrowska 2017 **Aim** To explore the support and treatment needs of people experiencing both harmful gambling and alcohol/drug misuse, from the perspective of people undergoing treatment and healthcare professionals providing treatment.
Data collection and analysis	See Dabrowska 2017
Recruitment strategy	See Dabrowska 2017
Study dates	See Dabrowska 2017

Sources of funding	See Dabrowska 2017
Inclusion criteria	See Dabrowska 2017
Exclusion criteria	See Dabrowska 2017
Sample size	See Dabrowska 2017
Participant characteristics	See Dabrowska 2017
Results	**Author's themes** • Motives that trigger change • Factors determining choice of facility: Availability and access **Study findings** *Motives that trigger change* Interviewees reflected that the decision to seek treatment for their harmful gambling was made when they started to experience consequences in multiple areas of their life and were unable to cope alone anymore. People experiencing harmful gambling that they sought treatment after internal reflection of their actions (for example, when their gambling behaviour resulted in being unable to fulfil parenting roles or a lack of security for their family). However, professionals disagreed with this assessment and thought that, even at these crisis points, external motivations (for example, pressure from family or friends) was needed to promote change. Both people experiencing harmful gambling and professionals involved harmful gambling services reported that finances were a big motivator to seek help (for example, not paying debts to banks or loan sharks and rent arrears), as were legal problems (for example, if people have resorted to illegal means to obtain funds for gambling). Finally, physical and mental health issues can trigger people to access treatment for harmful gambling. Examples of physical health issues acting as a motivator for change include unexplained headaches, abdominal pain, sleep problems, and palpitations. Examples of mental health acting as a motivator for change include depression, anxiety, suicide attempts, and substance use disorder. "I think it [taking treatment] could be in various situations. I actually treat people who are in huge crises, for example when they have lost their jobs, homes, or contact with the family, who can no longer stand the debts and the creditors who bother them. These are situations when their whole lives have started to collapse." (page 202)

	Factors determining choice of facility: Availability and access Participants reported that practical issues (for example, distance from home, flexibility of times, price of treatment) often influenced their choice of treatment venue. “The main reason I chose the facility was that the treatment was free of charge. My debts did not allow me to start treatment in different places, far away from home.” (page 204) “I got a referral to a facility near my home. I would ride on my bike for about 15 minutes, which was quite close.” (page 204)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns *(See Dabrowska 2017.)*
Overall risk of bias and relevance	Relevance	Highly relevant *(See Dabrowska 2017.)*

Appendix E Forest plots

Forest plots for review question: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

No meta-analysis was conducted for this review question and so there are no forest plots.

Appendix F GRADE-CERQual tables

GRADE tables for review question: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

I1 Accessing gambling treatment services - from studies receiving no industry funding

Table 5: Evidence profile for theme I1.1 Availability of treatment options

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.1.1 Knowledge of treatment options						
1 study reported in 2 papers • Hing 2014 (General qualitative inquiry, semi-structured interviews) • Hing 2015 (General qualitative inquiry, semi-structured interviews)	People who experience harmful gambling were not aware of all the treatment options available to them. All treatment programmes should be actively promoted for people to make an informed decision about which option or combination of options might suit them best. *'The information should be more easy to find – people should know what it is, what it includes, what it entails, how it works' (Hing 2015, p247)*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings were derived from a study exploring land-based self-exclusion programmes)	Moderate concerns (Findings only derived from 2 studies with moderately rich data)	LOW

Table 6: Evidence profile for theme I1.2 Acceptability

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.2.1 Time required to access treatment						

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
1 study • Hing 2014 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling found long and complicated registration processes to be tiresome and discouraging. This barrier to access is compounded for people who may wish to access multiple treatment options at a given time. *'It takes a half-hour to 40 min straight to fill out the forms. So if you do five a day, well that's two and a half hours to 3 h a day you're spending trying to self-exclude from all the places you go, or might go … There's got to be a quicker way of banning yourself from many places, because otherwise it's just too easy to go somewhere else when you are feeling down' (Hing 2014, p514)*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings were derived from a study exploring land-based self-exclusion programmes)	Serious concerns (Findings derived from 1 study without rich data)	LOW
Sub-theme I1.2.2 Treatment limitations						
1 study • Hing 2015 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling were deterred from accessing certain treatment options because they were not convinced about the effectiveness of the intervention, or they believed it did not address all the causes of their harmful gambling behaviour. One method of limiting this barrier was the use of multiple treatment formats to supplement the perceived shortcomings of each option.	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings were derived from a study exploring land-based self-exclusion programmes)	Moderate concerns (Findings only derived from 1 study with moderately rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	'I needed to see a counsellor while I was self-excluding. Self-exclusion stops the elephant. It pulled me up in my tracks so that we could then concentrate on the other counselling as to the how, when, where and why' (Hing 2015, p245)					

Table 7: Evidence profile for theme I1.3 Affordability

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.3.1 Price of treatment						
3 studies reported in 4 papers • Bramley 2020 (General qualitative inquiry, focus groups) • Campos 2016 (General qualitative inquiry [within mixed-methods study], semi-structured interviews and focus groups) • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews) • Wieczorek 2018 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling and professionals involved in treatment for harmful gambling cited the price of treatment as an important consideration when accessing treatment services. In some healthcare systems, publicly funded treatment for harmful gambling may not be covered, meaning people will have to pay for the treatment themselves. Alternatively, options of which treatment service to attend may be limited due to the cost of treatment. In universal healthcare systems, this cost may be a perceived one (for example, populations that are unaware of their eligibility) but this does not negate the barrier.	No or very minor concerns	Minor concerns (Findings derived from different healthcare systems with different pricing considerations)	Moderate concerns (Findings included data from an insurance-based healthcare system)	Minor concerns (Findings derived from 3 studies with moderately rich data)	MODERATE

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	'The main reason I chose the facility was that the treatment was free of charge. My debts did not allow me to start treatment in different places, far away from home.' (Weiczorek 2018, p204)					

Table 8: Evidence profile for theme I1.4 Knowledge and awareness of routes into treatment services

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.4.1 Knowledge and awareness of routes into treatment services						
1 study • Bramley 2020 (General qualitative inquiry, focus groups)	People experiencing harmful gambling were helped to access treatment services when they looked at case studies about ways in which other people had accessed services. *No quotes to support this theme*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW
Sub-theme I1.4.2 Awareness among professionals						
1 study • Scull 2005 (General qualitative inquiry, semi-structured interviews)	Access to treatment for harmful gambling would be improved if all professionals working within gambling treatment services knew what services were available locally. These data were derived from the views of people experiencing harmful gambling and they thought that community workers as well as healthcare professionals should have this knowledge.	Serious concerns (Serious concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	VERY LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	No quotes to support this theme					
Sub-theme I1.4.3 Initial access						
2 studies • Bramley 2020 (General qualitative inquiry, focus groups) • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews)	Initial access to treatment was made difficult because people did not know what options were available to them. For example, people in one study had not realised they could be referred for treatment from primary care, since they did not know primary care dealt with addictions. These data were derived from the views of people experiencing harmful gambling and practitioners in gambling treatment services. *'they don't know which door to knock on…there's a lack of trust, they're unsure if they have to pay for services and unsure of the quality of the services' (Bramley 2020, p25)*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 2 studies without rich data)	LOW
Sub-theme I1.4.4 Knowledge among venue staff						
1 study • Hing 2014 (General qualitative inquiry, semi-structured interviews)	There were mixed opinions about knowledge among gambling venue staff. Some felt that staff were not knowledgeable about the registration process, which affected their confidence in the intervention. Other people felt as though staff were efficient and had a good knowledge of how to access other treatment services for harmful gambling. Data were derived from the views of people	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	Moderate concerns (Findings included contradicting views on theme)	Minor concerns (Findings were derived from a study exploring land-based self-exclusion programmes)	Serious concerns (Findings derived from 1 study without rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	with experience of self-exclusion programmes. *'I was provided with counselling information. I was given a lot of booklets to read and they offered for me to just sit and talk. It was very appropriate and very, very helpful' (Hing 2014, p518)*					
Sub-theme I1.4.5 Self-referral						
1 study • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews)	People were prevented from accessing treatment via self-referral because they did not know this was an option. This was a view shared by people experiencing harmful gambling and professionals involved in gambling treatment services. *No quotes to support this theme*	No or very minor concerns	No or very minor concerns	Minor concerns (Findings were derived from evidence exploring self-referral to psychiatric services)	Serious concerns (Findings derived from 1 study without rich data)	LOW

Table 9: Evidence profile for theme I1.5 Equalities considerations

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.5.1 Age						
1 study • Campos 2016 (General qualitative inquiry [within mixed-methods study], semi-structured	Older people may have decreased access to harmful gambling treatment services because they see gambling as a recreational pursuit and do not see harmful gambling as a mental health diagnosis. This view was	Moderate concerns (Moderate concerns about methodological limitations, as per	No or very minor concerns	Minor concerns (Findings derived from studies that did not measure gambling behaviour, nor specify it as in inclusion criterion)	Serious concerns (Findings derived from 1 study without rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
interviews and focus groups)	expressed by professionals from gambling treatment services. *No quotes for this theme*	CASP qualitative checklist)				
Sub-theme I1.5.2 Culturally appropriate treatment options						
2 studies • Itapuisto 2019 (General qualitative inquiry, semi-structured interviews) • Scull 2005 (General qualitative inquiry, semi-structured interviews)	Access to treatment is enabled when culturally appropriate options are made available. This view was expressed by people experiencing harmful gambling and professionals involved in gambling treatment. They pointed out that counselling and group therapies may not be acceptable in some cultures, where people may feel more comfortable in one-to-one sessions and where they are given tangible tasks to complete. In order to make counselling and group therapies more acceptable, it was suggested that people should be informed of what it entails and how it can help. Words such as 'counselling' or gambling specific terms should be avoided. Finally, building relationships with communities can help services become more legitimised and therefore easier to access for community members. *'Vietnamese, they would expect to be given decisions if they went for counselling, not options as is normally*	Serious concerns (Serious concerns about methodological limitations, as per CASP qualitative checklist)	Minor concerns (Findings include a variety of suggestions improving availability of culturally appropriate services)	No or very minor concerns	Moderate concerns (Findings derived from 2 studies with rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	happens. If they are simply given options and have to make the decisions for themselves, they won't go back. There is an expectation that people will tell them what to do. They would be looking for practical things they can do straight away, such as self-exclusion, and help in arranging finances.' (Scull 2005, p40)					
Sub-theme I1.5.3 Language barriers						
3 studies • Bramley 2020 (General qualitative inquiry, focus groups) • Campos 2016 (General qualitative inquiry [within mixed-methods study], semi-structured interviews and focus groups) • Scull 2005 (General qualitative inquiry, semi-structured interviews)	People without a good understanding of English were being prevented from accessing treatment services. This view, expressed by people experiencing harmful gambling, applied to both written information and verbal communication (for example, lack of translators or bi-lingual professionals). *'…can offer help, counselling support, referral to gambling help services, but most [clients] have difficulties with language, and are not comfortable using an interpreter' (Scull 2005, p39)*	Serious concerns (Serious concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Minor concerns (Findings derived from 3 studies with relatively rich data)	MODERATE
Sub-theme I1.5.4 Migrants						
2 studies • Bramley 2020 (Focus groups) • Scull 2005 (Semi-structured interviews)	Migrants may face several additional barriers when accessing treatment services for harmful gambling. Migrants may be unaware of what treatment is available locally and may not be used to accessing group or talking therapies. Migrants may also	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings derived from studies that did not measure gambling behaviour, nor specify it as in inclusion criterion)	Minor concerns (Findings derived from 2 studies with rich data)	MODERATE

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	be more comfortable with accessing informal support from friends and family members rather than outside formal treatment services. Additionally, addiction services may be compared with psychological treatment, which faces additional stigma within certain populations. This aspect is conflated by a fear of breaches of confidentiality. *No quotes provided for this theme*					
Sub-theme I1.5.5 People with co-morbidities						
• 2 studies • Bramley 2020 (General qualitative inquiry, focus groups) • Campos 2020 (General qualitative inquiry [within mixed-methods study], semi-structured interviews and focus groups)	People experiencing harmful gambling felt that mental health co-morbidities (for example, post-traumatic stress disorder or anxiety) may act as a barrier to accessing harmful gambling treatment. It was suggested that people with mental co-morbidities might be more vulnerable to harmful gambling and their co-morbid conditions can impact their ability to access services. *No quotes provided for this theme*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings derived from studies that did not measure gambling behaviour, nor specify it as in inclusion criterion)	Serious concerns (Findings derived from 2 studies without rich data)	LOW
Sub-theme I1.5.6 Socio-economic factors						
2 studies • Campos 2020 (General qualitative inquiry [within mixed-methods study], semi-structured	People receiving government assistance may face an additional barrier to accessing treatment services because disclosure of their harmful gambling may affect their continued eligibility for financial aid.	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 2 studies without rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
interviews and focus groups) • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews)	This view was shared by people experiencing harmful gambling and professionals involved in gambling treatment services. *'In every case we are looking for the causes of the financial troubles. We consider, why this family is in the difficult situation. In this particular situation, people have a reason to hide gambling, because regulations of the Act on Social Welfare says that waste of any resources causes a refusal of benefits.' (Dabrowska 2017, p495)*					

Table 10: Evidence profile for theme I1.6 Fear of treatment services

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.6.1 Confidentiality and privacy						
3 studies reported in 4 papers • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews) • Hing 2014 (General qualitative inquiry, semi-structured interviews)	People can be prevented from accessing treatment services due to concerns over privacy and confidentiality. This view was shared by people experiencing harmful gambling and professionals working within gambling treatment services. . This lack of confidentiality may be a direct consequence of the format of treatment (for example, group therapy). A way of addressing this	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Minor concerns (Findings derived from 3 studies with some rich data)	MODERATE

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
• Hing 2015 (General qualitative inquiry, semi-structured interviews) • Scull 2005 (General qualitative inquiry, semi-structured interviews)	barrier is to stress the confidentiality of treatment services, as well as offering individual, remote treatment options so people do not have to share their experiences with wider groups or risk being seen attending in-person treatment services. *'It's very embarrassing because my life now is common knowledge in a very small town' (Hing 2014, p515)*					
Sub-theme I1.6.2 Discrimination						
1 study • Dabrowska 2021 (General qualitative inquiry, semi-structured interviews)	Women may face greater stigma and social judgement when seeking treatment for addiction, compared with their male counterparts. This view was shared by people experiencing harmful gambling and professionals working within gambling treatment services. *'Women are more ashamed of starting treatment than men. For women, there is an even greater fear of social stigma; it is similar as in the case of alcohol. When a man is drunk, it evokes at most a smile, but when a woman is drunk, it is not so liberally treated.' (Dabrowska 2021, p190)*	No or very minor concerns	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW
Sub-theme I1.6.3 Experiences of past services						
2 studies	Previous experiences of treatment services directly impacted current help-seeking behaviour. If previous	Serious concerns	Moderate concerns	No or very minor concerns	Moderate concerns	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
• Hing 2015 (General qualitative inquiry, semi-structured interviews) • Itapuisto 2019 (General qualitative inquiry, semi-structured interviews)	experiences were positive, people were more likely to re-engage with treatment services. However, if previous experiences were negative, people were less likely to seek help for harmful gambling again. These previous experiences did not have to be specifically related to harmful gambling treatment but could be concerning access to other addiction or mental health services. *'It was very embarrassing because it was done out in public, I think it should be done in a private office. Yes, it was humiliating and un-nerving … it was something I would not do again.' (Hing 2015, p252)*	(Serious concerns about methodological limitations, as per CASP qualitative checklist)	(Findings including families and significant others acting as both a facilitator and barrier to accessing treatment)		(Findings derived from 2 studies with rich data)	
Sub-theme I1.6.4 Lack of trust in services						
2 studies • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews) • Hing 2014 (General qualitative inquiry, semi-structured interviews)	People may be prevented from accessing treatment services due to a lack of trust in them. This view was shared by people experiencing harmful gambling and professionals involved in treatment services. Examples of factors causing distrust include concerns about staff attitudes or the belief that services were making people 'jump through hoops' to receive treatment. *'It seems to me, that Social Welfare Center will be one of the last places*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	Moderate concerns (Findings included wide range of different factors that might cause lack of trust in services)	No or very minor concerns	Serious concerns (Findings derived from 2 studies without rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	where people with gambling disorders apply for help. Social Welfare Center is the institution of control, and is perceived in such a way. So they know very well, if they turn to us for help, they will be under supervision. The Center will be the last place where they come, because they have enough control, for example from their families. They do not contribute themselves another source of control.' (Dabrowska 2017, p495)					
Sub-theme I1.6.5 Shame and stigma						
1 study reported in 2 papers • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews) • Dabrowska 2021 (General qualitative inquiry, semi-structured interviews)	The shame and stigma of being labelled as 'an addict' often prevents people from seeking treatment for their harmful gambling. Additionally, seeking treatment for harmful gambling may require people to disclose information of past behaviour that face additional stigma (for example, stealing money or lying to family members). Stigma can also extend to the type of treatment offered, with psychological treatment being associated with a greater sense of stigma compared to pharmacological treatment, as it can add an additional social label of being 'mentally ill'. These data are based on the views of people experiencing harmful gambling and professionals working within gambling treatment services.	No or very minor concerns	No or very minor concerns	No or very minor concerns	Moderate concerns (Findings derived from 1 study with rich data)	MODERATE

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	'People do not trust us (people with gambling disorders—authors), and this is understandable. I also can not trust myself. No matter how long I do not play, I can never promise, that I will not play to the rest of my life. Recently a friend of my wife borrowed from her a little bit of money. Give this money back to me, she stressed that money should be returned to my wife personally. As if she warned me that I did not go to the casino. So it's that kind of things.' (Dabrowska 2017, p493)					

Table 11: Evidence profile for theme I1.7 Information and awareness

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.7.1 Lack of understanding about gambling as an addiction						
2 studies • Dabrowska 2021 (General qualitative inquiry, semi-structured interviews) • Hing 2015 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling felt that other people viewed their addiction as a personal failing or lifestyle choice rather than a disease. It was proposed that this can increase barriers to help-seeking in 2 ways. It places the burden of responsibility and pressure on the person experiencing harmful gambling, leading to avoidance or reluctance to access treatment options.	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	Minor concerns (Findings including differing explanations of how lack of understanding is a barrier)	No or very minor concerns	Moderate concerns (Findings derived from 2 studies with moderately rich data)	MODERATE

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	Alternatively, it may lead people to believe that harmful gambling will not respond to treatment. *No quotes provided for this theme*					
Sub-theme I1.7.2 Understanding gambling harms and risks						
5 studies • Bramley 2020 (General qualitative inquiry, focus groups) • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews) • Hing 2014 (General qualitative inquiry, semi-structured interviews) • Itapuisto 2019 (General qualitative inquiry, semi-structured interviews) • Scull 2005 (General qualitative inquiry, semi-structured interviews)	People do not access treatment because they are unaware of the harms and risks associated with gambling, and the potential for addiction. Instead, they insist that they gamble for recreation and enjoyment. This is reinforced by the lack of distinction between harmful and recreational gambling, a message perpetrated by the gambling industry, and it was view shared by people experiencing harmful gambling and professionals in gambling treatment services. *'I'm not a problem gambler, I don't go to gambling venues. I just put a few coins in when I go shopping.' (Itapuisto 2019, p1039)*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	No or very minor concerns	HIGH

Table 12: Evidence profile for theme I1.8 Organisation of services

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.8.1 Harmful gambling screening						

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
2 studies • Bramley 2020 (General qualitative inquiry, focus groups) • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews)	Professionals working with harmful gambling services believed that a lack of routine screening for harmful gambling in non-specialist settings was a barrier to accessing treatment. If it was disclosed, it was generally through discussion of other difficulties people were facing. Screening should not just be limited to healthcare services but should encompass auxiliary services (for example, social services or financial services). *'gambling is not included in the list of reasons that predispose to benefit from social support. So gambling is not included in the questionnaire of interview; in any internal diagnoses. It is really by chance only if social worker notices gambling disorders, because for example the family report a problem or because there was comorbid dependencies.' (Dabrowska 2017, p495)*	Minor concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 2 studies without rich data)	LOW

Table 13: Evidence profile for theme I1.9 Individual facilitators

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.9.1 External motivators						
3 studies reported in 4 papers	There are a range of external motivators that can act as facilitators	Minor concerns (Moderate concerns about	Moderate concerns	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
• Hing 2014 (General qualitative inquiry, semi-structured interviews) • Hing 2015 (General qualitative inquiry, semi-structured interviews) • Itapuisto 2019 (General qualitative inquiry, semi-structured interviews) • Wieczorek 2018 (General qualitative inquiry, semi-structured interviews)	to help-seeking. This view was shared by people experiencing harmful gambling and professionals involved in gambling treatment services. Examples included co-morbidities, financial reasons and legal concerns. *'I knew I had a problem with gambling. It was affecting my mental health. It was very stressful and I was desperate … and I promised my children I would do it' (Hing 2014, p513)*	methodological limitations, as per CASP qualitative checklist)	(Findings including a variety of external motivators which were not supported by all studies)			
Sub-theme I1.9.2 Families and significant others						
2 studies • Hing 2015 (General qualitative inquiry, semi-structured interviews) • Itapuisto 2019 (General qualitative inquiry, semi-structured interviews)	Families and significant others often prompt the decision to access treatment services. This view was expressed by people experiencing harmful gambling. *'My sister was very adamant that I go and see someone. I probably wouldn't have if she hadn't pushed me into going to do it.' (Hing 2015, p247)*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	Moderate concerns (Findings including families and significant others acting as both a facilitator and barrier to accessing treatment)	No or very minor concerns	Serious concerns (Findings derived from 2 studies without rich data)	LOW
Sub-theme I1.9.3 Therapists and practitioners						
1 study • Hing 2015 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling saw therapists and practitioners as key to accessing other treatment options. *'Receiving counselling helped the decision about self-exclusion. Yes,*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	Minor concerns (Findings included views on gambling venue staff and counsellors)	Moderate concerns (Findings limited to people receiving different parallel treatments)	Serious concerns (Findings derived from 1 study without rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	definitely, definitely that has made it easier. I think it would be very hard, for me anyway, just to find out about it online and just go out there and just do it. Confronting it with a counsellor, just talking with her about it and putting it on paper how much money was spent, making it real, talking about it and just deciding to go and do it, to self-exclude, helped' (Hing 2015, p246)					

Table 14: Evidence profile for theme I1.10 Individual barriers

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I1.10.1 Psychological barriers						
5 studies • Bramley 2020 (General qualitative inquiry, focus groups) • Dabrowska 2021 (General qualitative inquiry, semi-structured interviews) • Hing 2015 (General qualitative inquiry, semi-structured interviews) • Itapuisto 2019 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling can experience a variety of psychological barriers which may impact their decision to seek help. These barriers can be related to the individual, such as anger, loss of control, embarrassment, or shame. For people experiencing this type of psychological barrier, they may find it easier to access treatment services once they have accepted they are experiencing harmful gambling. Psychological barriers may also be directed towards a larger cultural or religious group, where they are reluctant to talk about harmful	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	Minor concerns (Findings included psychological barriers directed at internal and external factors)	No or very minor concerns	No or very minor concerns	MODERATE

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
• Scull 2005 (General qualitative inquiry, semi-structured interviews)	gambling for fear the whole community may become stigmatised, which acts as a barrier to accessing formal treatment services. *'I am embarrassed about getting help. I think it's going to eventually come to that stage, but I just feel like I'm going to be less of a person because I haven't sorted this out myself, like I want to stick to it myself, but it's not working too well.' (Hing 2015, p 250)*					
Sub-theme I1.10.2 Lack of self-motivation						
2 studies • Dabrowska 2017 (General qualitative inquiry, semi-structured interviews) • Itapuisto 2019 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling recognise that a lack of self-motivation is an internal barrier to accessing treatment. *No quotes for this theme*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	Moderate concerns (Findings including families and significant others acting as both a facilitator and barrier to accessing treatment)	No or very minor concerns	Serious concerns (Findings derived from 2 studies without rich data)	VERY LOW

I2 Accessing gambling treatment services - from studies receiving any industry funding

Table 15: Evidence profile for theme I2.1 Availability of treatment options

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I2.1.1 Practical limitations						
1 study	Gambling venue staff felt that their ability to build rapport with customers	Minor concerns	Minor concerns	Minor concerns	Serious concerns	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
• Beckett 2020 (Phenomenological, focus groups)	was limited by practical considerations, which impacted their ability to offer support for harmful gambling. Limitations that were mentioned included a lack of time while working and fear of legislative repercussions from offended customers. *'You're sort of limited by law what you can do. Until the law changes, and what have you, and gives you whatever but, yeah, for now it's because you're limited.' (Beckett 2020, p412)*	(Minor concerns about methodological limitations, as per CASP qualitative checklist)	(Findings related to both legal and temporal limitations)	(Findings were derived from a study exploring responsible gambling training programmes in gambling venues)	(Findings derived from 1 study without rich data)	
Sub-theme I2.1.2 Training for venue staff						
1 study • Beckett 2020 (Phenomenological, focus groups)	Gambling venue staff had different opinions on current levels of training they receive for identifying and approaching people who may be experiencing harmful gambling. While senior managers felt that existing strategies were sufficient and well signposted, junior floor staff felt that they were still under-prepared after receiving training. Information focused around the legislative and regulatory requirements of their roles but did not adequately cover proactively approaching and interacting with patrons who may be exhibiting signs of harmful gambling.	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	Moderate concerns (Findings included evidence from a range of professionals with differing views on adequacy of training offered)	Minor concerns (Findings were derived from a study exploring responsible gambling training programmes in gambling venues)	Moderate concerns (Findings only derived from 1 study with moderately rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	'What [other staff member] sees as anger, I might see differently as anger so he might have told six patrons and I've gone "they're alright", so it's, who decides that?; We have some people who drink too much, it's easy to identify … because it's more black and white, where gambling's very grey (Beckett 2020, p412)					

Table 16: Evidence profile for theme I2.2 Knowledge and awareness of routes into treatment services

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I2.2.1 Knowledge of venue staff						
1 study • Pickering 2019 (General qualitative inquiry, semi-structured interviews)	People with experience of gambling self-exclusion programmes felt that these programmes were not well promoted within treatment services. Opportunities for self-exclusion should be more actively promoted, with venue staff and counsellors noted as potential sources of information. *'He came over and said, "Look, if it's a problem we have a program."' (Pickering 2019, p7)*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings were derived from a study exploring land-based self-exclusion programmes)	Serious concerns (Findings derived from 1 study without rich data)	LOW

Table 17: Evidence profile for theme I2.3 Information and awareness

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I2.3.1 Clear messaging about available help						
1 study • Beckett 2020 (Phenomenological, focus groups)	Gambling venue staff felt that adequate signage with information on responsible gambling initiatives and messages in gambling venues encouraged people to seek treatment for harmful gambling if needed. *'[the venue has] compliance signage, which is everywhere, so there's no shortage of, for the patrons, gambling patrons, to seek help. As soon as you walk onto the gaming floor you've got signs, posters, you've got the "think" cards at the end of each bank or machine, you've got a sticker for [each] machine, you've got the club's gaming policy there, plus also the harm minimisation, self-exclusions also' (Beckett 2020, p412)*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings were derived from a study exploring responsible gambling training programmes in gambling venues)	Serious concerns (Findings derived from 1 study without rich data)	LOW

Table 18: Evidence profile for theme I2.4 Organisation of services

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I2.4.1 Access to support in gambling venues						
1 study • Pickering 2019 (General qualitative inquiry, semi-structured interviews)	People with experience of gambling self-exclusion programmes felt that gambling venues should include in-house gambling counselling services to provide immediate access to	Moderate concerns (Moderate concerns about methodological limitations, as per	No or very minor concerns	Moderate concerns (Findings were derived from a study exploring land-based self-	Serious concerns (Findings derived from 1 study without rich data)	VERY LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	treatment for people experiencing harmful gambling. *No quotes to support this theme*	CASP qualitative checklist)		exclusion programmes)		
Sub-theme I2.4.2 Clarity of roles for venue staff						
1 study • Beckett 2020 (Phenomenological, focus groups)	Gambling venue staff were confident in their role in assisting people experiencing harmful gambling when they were approached by customers. However, they were less confident in their role when asked about actively approaching customers about possible harmful gambling indicators. *'What is the procedure, then, if you do see someone who's maybe exhibiting some sort of distress, or it looks like they're experiencing gambling-related harm?' (Beckett 2020, p411)*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	Minor concerns (Findings included evidence that differed depending on the role taken by gambling venue staff)	Minor concerns (Findings were derived from a study exploring responsible gambling training programmes in gambling venues)	Moderate concerns (Findings only derived from 1 study with moderately rich data)	MODERATE
Sub-theme I2.4.3 Re-accessing treatment options						
1 study • Pickering 2019 (General qualitative inquiry, semi-structured interviews)	People with experience of gambling self-exclusion programmes felt renewing self-exclusion programmes should be simplified and organised before the current agreement ends. *No quotes to support this theme*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings were derived from a study exploring land-based self-exclusion programmes)	Serious concerns (Findings derived from 1 study without rich data)	LOW

Table 19: Evidence profile for theme I2.5 Individual facilitators

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I2.5.1 External motivators						
1 study • Pickering 2019 (General qualitative inquiry, semi-structured interviews)	Some people experiencing harmful gambling reported that family members and friends were the ones to convince them to self-exclude from venues. *'My daughter knew I had a problem. She was really distressed about me. She came home and said, ''This is what we have to do mum.'' (Pickering 2019, p7)*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings were derived from a study exploring land-based self-exclusion programmes)	Serious concerns (Findings derived from 1 study without rich data)	LOW

I3 Accessing gambling treatment services - from studies receiving funding from an unclear funding source

Table 20: Evidence profile for theme I3.1 Availability of treatment options

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I3.1.1 Criminal justice system						
1 study • Jindani 2021 (General qualitative inquiry, semi-structured interviews)	The availability of harmful gambling treatment services within the criminal justice system was severely limited (for example, due to security concerns or institutional routines). Treatment services outside of this system could be accessed, but there were additional barriers to accessing community programmes (for example, additional staff needed to escort people to off-site treatment sessions).	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	Data were derived from criminal justice system practitioners. *No quotes to support this theme*					
Sub-theme I3.1.2 Waiting times						
1 study • Kaufman 2017 (Phenomenological, semi-structured interviews)	People experiencing harmful gambling were prevented from accessing treatment when they needed it, due to very long waiting lists for services. Data were derived from the views of people experiencing harmful gambling. *'There was a long waiting list and then unfortunately three months on the trot I lost everything each time so the only negative thing is that this isn't, there's only one clinic with a waiting list.' (Kaufman 2017, p981)*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW

Table 21: Evidence profile for theme I3.2 Acceptability

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I3.2.1 Flexibility of treatment options						
1 study • Kaufman 2017 (Phenomenological, semi-structured interviews)	People experiencing harmful gambling would be more likely to access treatment services if they were flexible around their needs and responsibilities. Examples included childcare arrangements for parents,	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	Minor concerns (Findings included a variety of needs that were not supported by all evidence)	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	time taken for treatment, and cost of travel. *'I think being a single female has because of the childcare side of it and also I've got a very big fear of separation anxiety over my children so….unless there was something available at meetings I wouldn't want to leave them with anybody.' (Kaufman 2017, p982)*					
Sub-theme I3.2.2 Time required to access treatment						
1 study • Kaufman 2017 (Phenomenological, semi-structured interviews)	People experiencing harmful gambling found the time taken to access treatment services (for example, filling out forms) was a consideration when accessing treatment services, separate from the time taken to participate in treatment sessions. *'It's going to take your time and so on…like I'm going to have to….I know it sounds silly but I'm going to have to fill out some forms and then make my way to X or give X hours a week.' (Kaufman 2017, p981)*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW

Table 22: Evidence profile for theme I3.3 Equalities considerations

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I3.3.1 Sex						
1 study • Kaufman 2017 (Phenomenological, semi-structured interviews)	Women accessing harmful gambling treatment services felt under-represented, and therefore less likely to access group services. *'I've never seen a female in recovery in a GA meeting…initially they look at you and they said you're female you should be in the partner's room, and I'm not a partner, I'm a gambler, I need to be in this room, so you get rejected a lot. (Kaufman 2017, p984)*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW
Sub-theme I3.3.2 Socio-economic factors						
1 study • Bjelde 2008 (General qualitative inquiry, semi-structured interviews)	People receiving government assistance are less likely to access treatment services as disclosure of their harmful gambling may affect their continued eligibility for financial aid. *No quotes to support this theme*	Serious concerns (Serious concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	Serious concerns (Findings were primarily exploring counsellors' views on public health policies for older adults)	Serious concerns (Findings derived from 1 study without rich data)	VERY LOW

Table 23: Evidence profile for theme I3.4 Fear of treatment services

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I3.4.1 Fear of treatment services						
1 study	People experiencing harmful gambling were concerned about the	Minor concerns	Minor concerns	No or very minor concerns	Serious concerns	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
• Kaufman 2017 (Phenomenological, semi-structured interviews)	treatment services not being able to help them with their gambling. They were also worried about the prospect of giving control of their psychological well-being to counsellors or therapists. *No quotes to support this theme*	(Minor concerns about methodological limitations, as per CASP qualitative checklist)	(Findings derived from external and internal fears of gambling treatment services)		(Findings derived from 1 study without rich data)	
Sub-theme I3.4.2 Confidentiality and privacy						
1 study • Jindani 2021 (General qualitative inquiry, semi-structured interviews)	Professionals working in the criminal justice system believed some people did not access treatment services for harmful gambling to avoid exploitation by fellow prisoners. *No quotes to support this theme*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW
Sub-theme I3.4.3 Shame and stigma						
1 study • Jindani 2021 (General qualitative inquiry, semi-structured interviews)	People involved in the criminal justice system avoid accessing treatment for harmful gambling because they are worried about being negatively judged. Data are based on the views of professionals working in the criminal justice system. *No quotes to support this theme*	Moderate concerns (Moderate concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW

Table 24: Evidence profile for theme I3.5 Information and awareness

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I3.5.1 Lack of understanding about gambling as an addiction						
1 study • Kaufman 2017 (Phenomenological, semi-structured interviews)	People experiencing harmful gambling did not feel as though their addiction was understood by other people, which left them feeling unsupported and un-motivated to seek treatment. *'I think the hardest thing to cope with is that it's not understood very well. One social worker said to my face that she doesn't see why I do it either, which hurt a lot.' (Kaufman 2017, p985)*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 1 study without rich data)	LOW
Sub-theme I3.5.2 Understanding gambling harms and risk						
2 studies • Bjelde 2008 (General qualitative inquiry, semi-structured interviews) • Kaufman 2017 (Phenomenological, semi-structured interviews)	Some people experiencing harmful gambling did not access treatment services because they were not aware that harmful gambling is a disease that can be treated by the healthcare system. *'most older gamblers really have no concept of the idea of gambling as an addiction or treatable illness' (Bjelde 2008, p433)*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Serious concerns (Findings derived from 2 studies without rich data)	LOW

Table 25: Evidence profile for theme I3.6 Individual barriers

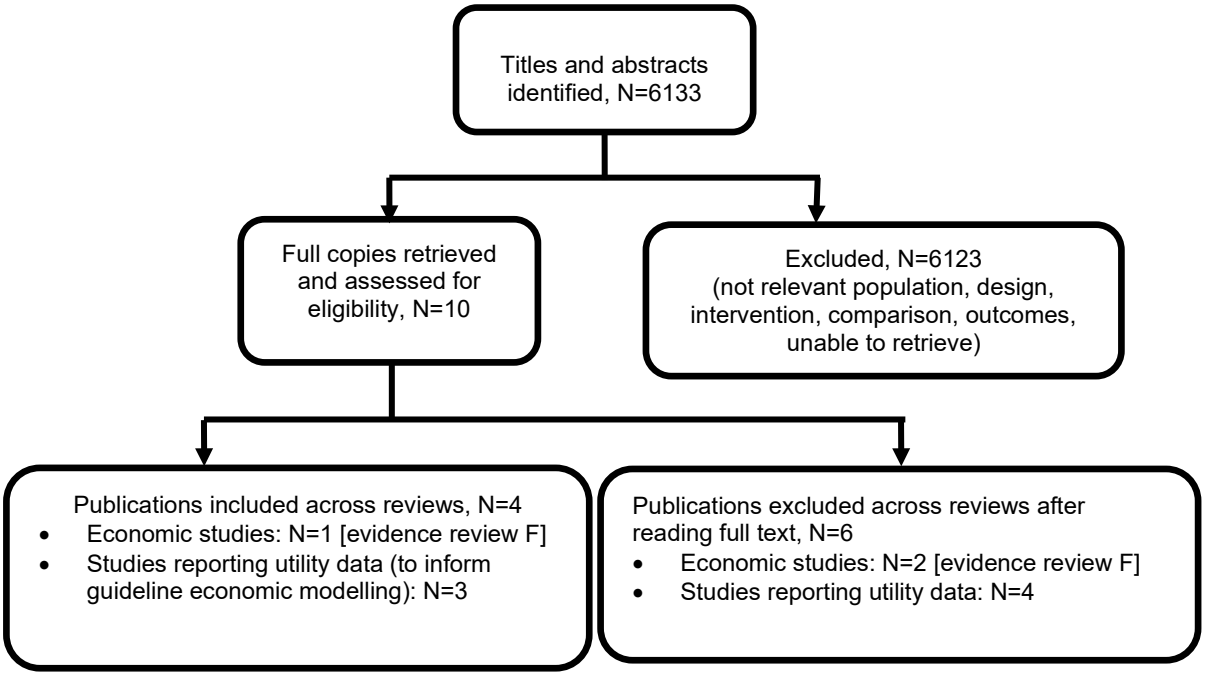
Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
Sub-theme I3.6.1 Reluctance to address gambling behaviour						
2 studies • Jindani 2021 (General qualitative inquiry, semi-structured interviews) • Kaufman 2017 (Phenomenological, semi-structured interviews)	People may choose to not access treatment for their harmful gambling because it formed a central part of their identity. They associate gambling with happy times in their lives. These data were derived from the views of women experiencing harmful gambling and professionals involved in the criminal justice system. *'I am very shy, but then I was never shy in gambling…I do miss the confidence I had with it, I could walk into any casino and feel confident….I don't think I'll ever stop completely.' (Kaufman 2017, p986)*	Minor concerns (Minor concerns about methodological limitations, as per CASP qualitative checklist)	Minor concerns (Findings related to a range of factors that impacted desire to seek treatment)	No or very minor concerns	Moderate concerns (Findings only derived from 2 studies with moderately rich data)	MODERATE

Appendix G Economic evidence study selection

Study selection for: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

A global health economics search was undertaken for all areas covered in the guideline. Figure 5 shows the flow diagram of the selection process for economic evaluations of interventions and strategies associated with the care of people experiencing harmful gambling, their families, friends and others close to them, and studies reporting gambling-related health state utility data.

Figure 5: Study selection flow chart



Appendix H Economic evidence tables

Economic evidence tables for review question: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

No economic evidence was identified which was applicable to this review question.

Appendix I Economic model

Economic model for review question: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

No economic analysis was conducted for this review question.

Appendix J Excluded studies

Excluded studies for review question: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

Excluded qualitative studies

Table 26: Excluded studies and reasons for their exclusion

Study	Reason for exclusion
Bellringer M, Pulford J, Abbott M et al. (2008) Problem gambling - Barriers to help seeking behaviours.	- Country Study conducted in New Zealand
Evans, Lyn and Delfabbro, Paul H (2005) Motivators for change and barriers to help-seeking in Australian problem gamblers. Journal of gambling studies 21(2): 133-55	- Study design Quantitative analysis of open-ended questions
Gavriel-Fried, Belle and Lev-El, Niva (2022) Negative Recovery Capital in Gambling Disorder: A Conceptual Model of Barriers to Recovery. Journal of gambling studies 38(1): 279-296	- Country Study conducted in Israel
Hing, Nerilee, Tiyce, Margaret, Holdsworth, Louise et al. (2013) All in the family: Help-seeking by significant others of problem gamblers. International Journal of Mental Health and Addiction 11(3): 396-408	- Study design Quantitative analysis of open-ended questions
Khayyat-Abuaita, Ula, Ostojic, Dragana, Wiedemann, Ashley et al. (2015) Barriers to and Reasons for Treatment Initiation Among Gambling Help-line Callers. The Journal of nervous and mental disease 203(8): 641-5	- Study design Quantitative analysis of open-ended questions
Landon, J.; Grayson, E.; Roberts, A. (2018) An Exploratory Study of the Impacts of Gambling on Affected Others Accessing a Social Service. International Journal of Mental Health and Addiction 16(3): 573-587	- Country Study conducted in New Zealand
Li, Wendy Wen and Tse, Samson (2015) Problem gambling and help seeking among Chinese international students: narratives of place identity transformation. Journal of health psychology 20(3): 300-12	- Country Study conducted in New Zealand
McCartney, Laura E, Northe, Vicky, Gordon, Susannah et al. (2019) Promoting cross-sector collaboration and input into care planning via an integrated problem gambling and mental health service. Journal of Gambling Issues 42: 130-145	- Paper unavailable
Rodda, S.N., Dowling, N.A., Thomas, A.C. et al. (2019) Treatment for Family Members of People Experiencing Gambling Problems: Family Members Want Both Gambler-Focused and	- Phenomenon of interest No themes relating to accessing treatment for harmful gambling

Study	Reason for exclusion
Family-Focused Options. International Journal of Mental Health and Addiction	
Sorochuk, G. (2011) Female Views of Access to Help for Problem Gambling. INTERNATIONAL JOURNAL OF QUALITATIVE METHODS 10(4): 473-474	- Publication type Conference abstract
Suurvali, Helen, Hodgins, David C, Toneatto, Tony et al. (2012) Hesitation to seek gambling-related treatment among Ontario problem gamblers. Journal of addiction medicine 6(1): 39-49	- Study design Quantitative analysis of open-ended questions
Suurvali, Helen, Hodgins, David C, Toneatto, Tony et al. (2012) Motivators for seeking gambling-related treatment among Ontario problem gamblers. Journal of gambling studies 28(2): 273-96	- Study design Quantitative analysis of open-ended questions
Tse, Samson, Wong, John, Chan, Pauline et al. (2007) Needs and gaps analysis: Problem gambling interventions among New Zealand Asian peoples. International Journal of Mental Health and Addiction 5(1): 81-88	- Country Study conducted in New Zealand
Woodall, J and Freeman, C (2021) Emerging lessons from the commissioning and delivery of a gambling treatment service. Public health 196: 69-73	- Phenomenon of interest No themes relating to accessing treatment for harmful gambling

Excluded economic studies

No economic evidence was reviewed at full text and excluded from this review.

Appendix K Research recommendations – full details

Research recommendations for review question: What are the barriers and facilitators to accessing treatment for harmful gambling from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

No research recommendations were made for this review question.