National Institute for Health and Care Excellence

Final

Gambling-related harms: identification, assessment and management

[K] Improving gambling treatment services

NICE guideline NG248

Evidence review underpinning recommendations 1.5.1 to 1.5.11 and a recommendation for research in the NICE guideline

January 2025

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Improving gambling treatment services

Review question

What works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

Introduction

Gambling treatment services in England are currently delivered by a number of organisations and providers, including the NHS and a variety of third sector organisations. With the planned reconfiguration of treatment services, it is important to build on current knowledge of good practice and to learn from aspects of services that do not meet people's needs, so that future services deliver optimal care.

The aim of this qualitative review is to determine what works well in gambling treatment services for people experiencing gambling that harms and affected others, and what can be improved.

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 the identification, assessment and management 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	What works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention. Themes will be identified from the literature. The committee identified the following potential themes (however, not all of these themes may be found in the literature, and additional themes may be identified): • Acceptability – data may relate to people's experiences of using treatment services and may suggest ways of improving various aspects of the way it is delivered. • Content – there may be data on people's views about the relevance and appropriateness of treatment services provided or about the nature of the treatment being offered, for example whether service planning and design involved people with lived experience. • Delivery – data may relate to the delivery of treatment including for example, treatment quality, language and communication, stigma

	and discrimination, role of outreach, consistency and care continuity. • Diversity – data may relate to people's experience of services being set up to meet the needs of different genders, ethnicities, cultures and languages. • Practitioners and peer supporters – data may relate to people's perspectives of practitioners and peer supporters including communication, issues around fear, and apprehensions and trust, skills, training and values of practitioners and peer supporters. • Significant others – data may relate to people's experience of the involvement of significant others in the treatment process • Funding of services – data may relate to people's views on the funding of gambling treatment, for example whether funded by the gambling industry either directly or indirectly. • Organisation of services – perceptions about what works well and what could be improved may be influenced by the configuration and organisation of services.

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 the development of this guideline: (see evidence review C 'Information and support needs' and evidence review I 'Barriers and facilitators in accessing gambling treatment services').

Twenty-three studies were included for this review: 15 were general qualitative inquiries (Flores-Pajot 202, Forsstrom 2017, Guilcher 2016, Heiskanen 2017, Kourgiantakis 2018, Marionneau 2021, Penfold 2021, Pickering 2019a, Pickering 2019b, Piquette 2013, Piquette-Tomei 2008, Rodda 2019, Smith 2016, Wieczorek 2018, Woodall 2021); 5 were general qualitative inquiries within mixed methods studies (Dunn 2012, Lee 2008, Nilsson 2021, Shandley 2008, Wood 2007); and 3 were phenomenological (Riley 2018, Syvertsen 2020, Tremblay 2017).

Seven studies were conducted in Australia (Dunn 2012, Kourgiantakis 2018, Pickering 2019a, Pickering 2019b, Riley 2018, Shandley 2008, Smith 2016); 7 were conducted in Canada (Flores-Pajot 2021, Guilcher 2016, Lee 2008, Piquette 2013, Piquette-Tomei 2008, Rodda 2019, Tremblay 2017); 3 studies were conducted in the UK (Penfold 2021, Wood 2007, Woodall 2021); 2 studies were conducted in Sweden (Forsstrom 2017, Nilsson 2021); 2 studies were conducted in Finland (Heiskanen 2017, Marionneau 2021); 1 study was conducted in Norway (Syvertsen 2020) and 1 in Poland (Wieczorek 2018).

The included studies are summarised in Table 2.

Four studies recruited participants based on their gambling involvement. One study recruited people currently experiencing harmful gambling (Dunn 2012); 1 study recruited people with

experience (either current or historical) of harmful gambling (Syvertsen 2020); 1 study recruited people who are currently gambling (Pickering 2019a); 1 study recruited people who reported gambling in the previous 12 months (Flores-Pajot 2021). Two studies recruited participants based on a combination of gambling involvement and other characteristics. One study recruited men with experience (either current or historical) of harmful gambling plus a history of housing instability (Guilcher 2017) and the other study recruited people who have experience (either current or historical) of harmful gambling plus a history of financial difficulties (Heiskanen 2017). Seven studies recruited participants based on their experience of certain treatments for harmful gambling. Two studies recruited women attending a single-sex group therapy programme (Piquette 2013, Piquette-Tomei 2008); 1 study recruited people who were registered with a responsible gambling tool (Forsstrom 2017); 1 study recruited people who were active members of Gambler's Anonymous UK (Penfold 2021); 1 study recruited people who have self-excluded from gambling venues (Pickering 2019b); 1 study recruited people calling into a helpline for harmful gambling (Shandley 2008); 1 study recruited people receiving either exposure or cognitive therapy (Smith 2016). One study recruited professionals working within harmful gambling services (Woodall 2021). The remaining 8 studies recruited a combination of participants. Five studies recruited people experiencing harmful gambling and affected others (Kourgiantakis 2018, Marionneau 2021, Nilsson 2021, Tremblay 2017, Wood 2007); 1 study recruited people experiencing harmful gambling, affected others and professionals involved in the treatment of harmful gambling (Lee 2008); 1 study recruited people experiencing harmful gambling, gambling venue staff, advocates with a history of harmful gambling, professionals employed by gambling venues, and professionals involved in the treatment of harmful gambling (Riley 2018); 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 (Wieczorek 2018).

The data provided evidence about the following themes: content; delivery; diversity; practitioners and peer supporters; significant others; 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
Dunn 2012 General qualitative inquiry (within mixed methods study) Australia Unclear funding source **Study aim**	N=10 people who received CBT for harmful gambling. • Early withdrawal group: n=5 • Therapy completion group: n=5 Age in years [Mean (SD)]: 47.7 (SD not reported)	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Content of therapy: Cue exposure • Content of therapy: Understanding addiction and treatment • Content of therapy: Real-world context • Content of therapy: Relapse planning and prevention

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
To explore views and experiences relating to treatment cessation in people experiencing harmful gambling.	Sex: Not reported. Gambling symptom severity scale and score: Not reported.		• Content of therapy: Personalised goals • Delivery: Flexibility and convenience
Flores-Pajot 2021 General qualitative inquiry Canada Unclear funding source **Study aim** To explore views and experiences of self-control strategies employed by people experiencing harmful gambling (including which ones, when, and why they are used).	N=56 people reporting gambling in previous 12 months. Age in years [Mean (SD)]: 51.9(14.9) Sex (n): M=27, F=29 Gambling symptom severity scale and score [Mean (SD)]: PGSI, 2.9 (5.0)	**Data collection** Focus groups and semi-structured interviews. **Data analysis** Thematic analysis.	• Delivery: Format of therapy
Forsstrom 2017 General qualitative inquiry Sweden Any industry funding **Study aim** To explore Playscan users' experiences and views of the behaviour tracking tool.	N=20 people registered with Playscan (a responsible gambling tool). Age in years [Mean (SD)]: 42.15 (12.70) Sex (n): M=19, F=1 Gambling symptom severity scale and score [Mean (SD)]: PGSI, 2.65 (3.36)	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Delivery: Communication and feedback
Guilcher 2016 Canada General qualitative inquiry Any industry funding **Study aim** To explore the health and social care experiences of men	N=30 males with a history of housing instability as well as at-risk, problem, or pathological gambling as defined by NODS or NODS-CLiP. Age in years [Mean (SD)]: 48 (SD not reported). Sex: Not reported.	**Data collection** Semi-structured interviews. **Data analysis** Grounded theory.	• Content of therapy: Empowerment • Content of therapy: Personalised goals • Content of therapy: Real-world context • Delivery: Format of therapy • Practitioners and peer supporters: Training and values of practitioners

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
with a history of housing instability and harmful gambling.	Gambling symptom severity scale and score [Mean (SD)]: Not reported, PGSI score in previous 12 months (n): • Problem gambling: 23 • Moderate problem gambling: 4 • Low-level/no problem gambling: 3		• Organisation of services: Crisis intervention • Organisation of services: Physical attributes • Organisation of services: Treatment of co-morbidities and social issues
Heiskanen 2017 General qualitative inquiry Finland Unclear funding source **Study aim** To explore the views and experiences of people experiencing harmful gambling with financial support, particularly financial social assistance from public services.	N=17 people receiving or previously received treatment for harmful gambling, and history of financial difficulties due to gambling. Age in years [Mean (SD)]: Not reported, age categories (n): • 20-39: 8 • 40-59: 6 • 60-70:3 Sex (n): M=5, F=12 Gambling symptom severity scale and score: Not reported.	**Data collection** Semi-structured interviews. **Data analysis** Thematic content analysis.	• Delivery: Format of therapy • Practitioners and peer supporters: Training and values of practitioners • Organisation of services: Treatment of co-morbidities and social issues
Kourgiantakis 2018 General qualitative inquiry Canada No industry funding **Study aim** To explore the views and experiences of people experiencing harmful gambling and their affected others on family involvement in harmful gambling treatment.	N=22 people experiencing harmful gambling and their affected others. • People experiencing harmful gambling: n=11 • Affected others: n=11 Age in years [Mean (SD)]: • People experiencing harmful gambling: 50 (14.20) • Affected others: 48 (15.09) Sex (n): • People experiencing harmful gambling: M=5, F=6	**Data collection** Semi-structured interviews. **Data analysis** Grounded theory.	• Practitioners and peer supporters: Issues around fear, apprehensions, and trust • Affected others: Relationships

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	• Affected others: M=3, F=8 Gambling symptom severity scale and score [Mean (SD)]: • People experiencing harmful gambling: Not reported beyond inclusion criteria stating PGSI score equal to or above 3. • Affected others: Not applicable.		
Lee 2008 General qualitative inquiry (within mixed methods study) Canada Unclear funding source **Study aim** To explore views and experiences of Congruence Couple Therapy, from the perspective of people experiencing harmful gambling, their affected significant other, and counsellors delivering the therapy.	N=69 counsellors, people experiencing harmful gambling and their affected others participating in CCT intervention study. • CCT counsellors: n=21 • People experiencing harmful gambling: n=24 • Affected others: n=24 Age in years [Mean (SD)]: • CCT counsellors: Not reported. • People experiencing harmful gambling: Not reported beyond 76% above 40 years old. • Affected others: Not reported. Sex (n): • CCT counsellors: Not reported. • People experiencing harmful gambling: M=18, F=6 • Affected others: Not reported. Gambling symptom severity scale and score [Mean (SD)]: • CCT counsellors: Not applicable.	**Data collection** Free-text questionnaires and focus groups. **Data analysis** Thematic content analysis.	• Practitioners and peer supporters: Training and values of practitioners • Content of therapy: Personalised goals

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	• People experiencing harmful gambling: G-SAS, 15.87(10.20)* • Affected others: Not applicable. *Data only available for 16 participants		
Marionneau 2021 General qualitative inquiry Finland Unclear funding source **Study aim** To explore the experiences and views of help-seeking and treatment for harmful gambling during the COVID-19 pandemic, from the perspective of people experiencing harmful gambling and their affected others.	N=847 people experiencing harmful gambling and, or affected others. • People experiencing harmful gambling: n=688 • Affected others: n=97 • Both: n=62 Age in years [Mean (SD)]: Not reported, age categories (n)*: • 15-24: 69 • 25-34: 88 • 35-49: 205 • 50-64: 143 • 65-74: 64 • Not reported: 270 Sex (n)*: M=282, F=278, unknown=278 Gambling symptom severity scale and score: • People experiencing harmful gambling: Not reported. • Affected others: Not applicable. • Both: Not reported. *Reported as per study but adds up to 839.	**Data collection** Free-text questionnaires. **Data analysis** Thematic content analysis.	• Delivery: Format of therapy • Practitioners and peer supporters: Training and values of practitioners • Organisation of services: Consistency and care continuity • Organisation of services: Integration
Nilsson 2021 General qualitative inquiry (within mixed methods study) Sweden	N=16 people experiencing harmful gambling and their affected others who participated in internet-based harmful gambling intervention study.	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Delivery: Format of therapy • Practitioners and peer supporters: Training and values of practitioners

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Any industry funding **Study aim** To explore the experiences and views of harmful gambling treatment and reasons for drop-out, from the perspective of people experiencing harmful gambling and their affected significant other.	• People experiencing harmful gambling: n=8 • Affected others: n=8 Age in years [Mean (SD)]: Not reported, age range: • People experiencing harmful gambling: 23-58 • Affected others: 30-63 Sex (n): • People experiencing harmful gambling: M=6, F=2 • Affected others: M=2, F=6 Gambling symptom severity scale and score [Mean (SD)]: • People experiencing harmful gambling: PGSI, 19.93 (5.57) • Affected others: Not applicable.		
Penfold 2021 General qualitative inquiry UK Unclear funding source **Study aim** To explores the views and experiences of people attending Gambler's Anonymous meetings throughout the COVID-19 pandemic.	N=21 active members of Gambler's Anonymous UK. Age in years: Not reported. Sex (n): M=18, F=3 Gambling symptom severity scale and score: Not reported.	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Delivery: Format of therapy
Pickering 2019a General qualitative inquiry Australia	N=32 people in a self-exclusion programme and gambling counselling services. Age in years [Mean (SD)]: 43.59 (11.51)	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Content of therapy: Empowerment • Content of therapy: Personalised goals • Content of therapy: Relapse planning and prevention

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Unclear funding source **Study aim** To explore how people experiencing harmful gambling conceptualize and define recovery.	Sex (n): M=20, F=12 Gambling symptom severity scale and score [Mean (SD)]: Not reported, PGSI categories (n): • Non-problem gamblers: 2 • Moderate risk gamblers: 2 • Problem gamblers: 28		• Content of therapy: Understanding addiction and treatment
Pickering 2019b General qualitative inquiry Australia Unclear funding source **Study aim** To explore the views and experiences of people experiencing harmful gambling with a self-exclusion programme from land-based venues.	N=20 people with a history of self-exclusion. • Currently self-excluded gamblers: n=13 • Previously self-excluded gamblers: 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% classified as experiencing harmful gambling in previous 12 months	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Delivery: Flexibility and convenience • Practitioners and peer supporters: Practitioners and peer supporters • Organisation of services: Training and values of practitioners • Organisation of services: Treatment of co-morbidities and social issues
Piquette 2013 General qualitative inquiry Canada Unclear funding source **Study aim** To explore the views and experiences of women experiencing harmful gambling with a gender-specific	N=5 women attending single-sex group therapy for harmful gambling. • Focus groups and semi-structured interviews: n=4 • Focus group only: n=1 Age in years [Mean (SD)]: Not reported, age range 30-50. Sex (n): M=0, F=5.	**Data collection** Semi-structured interviews and focus groups. **Data analysis** Grounded theory.	• Delivery: Format of therapy • Content of therapy: Relapse planning and prevention • Content of therapy: Understanding addiction and treatment

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
group counselling programme.	Gambling symptom severity scale and score: Not reported.		
Piquette-Tomei 2008 General qualitative inquiry Canada No industry funding **Study aim** To explore the views and experiences of women experiencing harmful gambling with a gender-specific group counselling programme.	N=14 women attending single-sex group therapy for harmful gambling. Age in years [Mean (SD)]: 46.5 (SD not reported). Sex (n): M=0, F=14. Gambling symptom severity scale and score [Mean (SD)]: Not reported beyond inclusion criteria of SOGS score equal to or above 5.	**Data collection** Semi-structured interviews and focus groups. **Data analysis** Grounded theory.	• Content of therapy: Nature of therapy • Delivery: Flexibility and convenience • Diversity: Service needs for different genders • Practitioners and peer supporters: Issues around fear, apprehensions, and trust • Practitioners and peer supporters: Training and values of practitioners • Peer support: Lived experiences and safe spaces • Organisation of services: Availability

Riley 2018
 	
Phenomenological
 	
Australia
 	
No industry funding
 	
Study aim
To explore the views and experiences of help-seeking, identification and response measures to harmful gambling within gambling venues from the perspective of people experiencing harmful gambling, people involved in treatment of harmful gambling and venue staff.
	N=41 people experiencing harmful gambling, gambling venue staff and practitioners in gambling treatment service.
	• People experiencing harmful gambling: n=17
	• Gambling venue staff: n=10
	• Advocates with lived experience of harmful gambling: n=7
	• Harmful gambling counsellors: n=7
	
	Age in years [Mean (SD)]: Not reported, age categories (n):
	• People experiencing harmful gambling:
	  ○ 18-29: 0
	  ○ 30-39: 5
	  ○ 40-49: 5
	  ○ 50-59: 3
	  ○ Over 60: 2
		Data collection
		Semi-structured interviews and focus groups.
		
		Data analysis
		Interpretive phenomenological analysis.
			• Peer support: Lived experiences and safe spaces
			• Organisation of services: Partnership between services

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	• Gambling venue staff: ○ 18-29: 1 ○ 30-39: 5 ○ 40-49: 1 ○ 50-59: 3 ○ Over 60: 0 • Advocates with lived experience of harmful gambling: ○ 18-29: 0 ○ 30-39: 0 ○ 40-49: 4 ○ 50-59: 3 ○ Over 60: 0 • Harmful gambling counsellors: ○ 18-29: 0 ○ 30-39: 4 ○ 40-49: 2 ○ 50-59: 1 ○ Over 60: 0 Sex (n): • People experiencing harmful gambling: M=6, F=11 • Gambling venue staff: Not reported. • Advocates with lived experience of harmful gambling: M=4, F=3 • Harmful gambling counsellors: Not reported. Gambling symptom severity scale and score [Mean (SD)]: Not reported, length of time experiencing harmful gambling (n). • People experiencing harmful gambling: ○ Under 12 months: 1 ○ 1-2 years: 2 ○ 2-5 years: 4 ○ 5-7 years: 3 ○ 7-10 years: 3 ○ Over 10 years: 4		

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	• Gambling venue staff: Not applicable. • Advocates with lived experience of harmful gambling: Not reported. • Harmful gambling counsellors: Not applicable.		
Rodda 2019 General qualitative inquiry Canada Unclear funding source **Study aim** To explore the views and experiences of therapists regarding the feasibility and acceptability of iCBT integration into harmful gambling services.	N=7 harmful gambling therapists participating in iCBT harmful gambling intervention study. Age in years: Not reported. Sex (n): M=2, F=5 Gambling symptom severity scale and score: Not applicable.	**Data collection** Semi-structured interviews. **Data analysis** Thematic content analysis.	• Delivery: Format of therapy • Practitioners and peer supporters: Communication and feedback
Shandley 2008 General qualitative inquiry (within mixed methods study) Australia Unclear funding source **Study aim** To explore views and experiences of people accessing Gambler's Helpline.	N=90 people calling into Gambler's Helpline. • Gamblers: n=64 • Non-gambler: n=26 Age in years: Not reported. Sex (n): M=33, F=57 Gambling symptom severity scale and score: • Gamblers: Not reported. • Non-gambler: Not applicable.	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Delivery: Expectations • Practitioners and peer supporters: Training and values of practitioners
Smith 2016 General qualitative inquiry Australia	N=8 people participating in harmful gambling intervention study Age in years [Mean(SD)]: Not	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Content of therapy: Personalised goals • Content of therapy: Real-world context • Delivery: Flexibility and convenience

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
Unclear funding source **Study aim** To explore views and treatment experiences of exposure therapy compared to cognitive therapy in people experiencing harmful gambling.	reported, age range 29-65. Sex (n): M=4, F=4 Gambling symptom severity scale and score [Mean(SD)]: Not reported.		
Syvertsen 2020 Phenomenological Norway No industry funding **Study aim** To explore the views and experiences of people attending Gambling Addiction Norway self-help groups.	N=9 people attending self-help groups for harmful gambling. • Currently experiencing harmful gambling: n=4 • History of harmful gambling: n=5 Age in years [Mean (SD)]: Not reported, age range 29-52 Sex (n): M=8, F=1 Gambling symptom severity scale and score: Not reported.	**Data collection** Semi-structured interviews. **Data analysis** Thematic analysis.	• Content of therapy: Nature of therapy • Peer support: Lived experiences and safe spaces • Peer support: Practical advice
Tremblay 2017 Phenomenological Canada No industry funding **Study aim** To explore the views and experiences with individual therapy compared to couple therapy in people experiencing harmful gambling and their affected partners, participating in a RCT.	N=42 people experiencing harmful gambling and their affected others participating in harmful gambling intervention study. • People experiencing harmful gambling: n=21 • Affected others: n=21 Age in years: Not reported. Sex (n): • People experiencing harmful gambling: M=18, F=3 • Affected others: M=2, F=19	**Data collection** Semi-structured interviews. **Data analysis** Descriptive phenomenological analysis.	• Affected others: Relationships

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	Gambling symptom severity scale and score: Not reported.		

Wieczorek 2018
 	
General qualitative inquiry
 	
Poland
 	
No industry funding
 	
Study aim
To explore the support and treatment needs of people experiencing both harmful gambling and alcohol/drug misuse, both from the perspective of people undergoing treatment and healthcare professionals providing treatment.
	N=90 people experiencing harmful gambling and co-morbid substance use disorder, and health- and social care professionals involved in the treatment of harmful gambling.
	• People experiencing harmful gambling and co-morbid substance use disorder: n=30
	• Health- and social care professionals:
	  ○ General practitioners: n=15
	  ○ Psychiatrists: n=15
	  ○ Therapists: n=15
	  ○ Social workers: n=15
	
	Age in years [Mean (SD)]:
	• People experiencing harmful gambling and co-morbid substance use disorder: 38.3 (SD not reported)
	• Health- and social care professionals: 42.9 (SD not reported)
	
	Sex (n):
	• People experiencing harmful gambling and co-morbid substance use disorder: M=27, F=3
	• Health- and social care professionals: M=42, F=18
	
	Gambling symptom severity scale and score:
	• People experiencing harmful gambling
		Data collection
		Semi-structured interviews.
		
		Data analysis
		Thematic analysis.
			• Content of therapy: Relevance and appropriateness of treatment offered
			• Delivery: Flexibility and convenience
			• Practitioners and peer supporters: Training and values of practitioners
			• Organisation of services: Availability
			• Organisation of services: Integration
			• Organisation of services: Wait times

Study and aim of the study	Participants	Methods	Themes applied after thematic synthesis
	and co-morbid substance use disorder: Not reported. • Health- and social care professionals: Not applicable.		
Wood 2007 General qualitative inquiry (within mixed methods study) UK Any industry funding **Study aim** To evaluate a GamAid pilot service against its stated aims and objectives, as well as review user's views and experiences of the service.	N=33 people experiencing harmful gambling and affected others attending GamAid treatment service. Age in years [Mean (SD)]*: 36 (11) Sex (n)*: M=36, F=33, unknown=11. Gambling symptom severity scale and score: Not reported. *From the larger sample of people filling out online questionnaire (n=80)	**Data collection** Free-text questionnaires. **Data analysis** Thematic content analysis.	• Delivery: Flexibility and convenience • Delivery: Format of therapy • Practitioners and peer supporters: Training and values of practitioners • Organisation of services: Clarity
Woodall 2021 General qualitative inquiry UK Any industry funding **Study aim** To explore the views and experiences of designing, commissioning, and delivery of a new metropolitan gambling treatment service.	N=9 professionals working in a gambling treatment service. Age in years: Not reported. Sex: Not reported. Gambling symptom severity scale and score: Not reported.	**Data collection** Semi-structured interviews and free-text questionnaires. **Data analysis** Framework analysis.	• Delivery: Flexibility and convenience • Organisation of services: Clarity • Organisation of services: Partnership between services

CBT: Cognitive behavioural therapy; CCT: Congruence couple therapy; COVID-19: Coronavirus; iCBT: Internet-based cognitive behavioural therapy; G-SAS: Gambling symptom assessment scale; N/n: Number; NODS (CLiP); National Opinion Research Center diagnostic and statistical manual of mental disorders screen for gambling problems (control, lying, and preoccupation); PGSI: Problem Gambling Severity Index; RCT: Randomised controlled trial

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 14 themes and 37 further sub-themes about what works well and what could be improved in gambling treatment services.

K1 Improving gambling treatment services - from studies receiving no industry funding

- K1.1 Content of therapy
  - K1.1.1 Nature of therapy
  - K1.1.2 Relevance and appropriateness of treatment offered
- K1.2 Delivery
  - K1.2.1 Flexibility and convenience
- K1.3 Diversity
  - K1.3.1 Service needs for different genders
- K1.4 Practitioners and peer supporters
  - K1.4.1 Issues around fear, apprehensions, and trust
  - K1.4.2 Training and values of practitioners
- K1.5 Peer support
  - K1.5.1 Lived experiences and safe spaces
  - K1.5.2 Practical advice
- K1.6 Affected others
  - K1.6.1 Support with relationships
- K1.7 Organisation of services
  - K1.7.1 Improving availability
  - K1.7.2 Improving integration
  - K1.7.3 Referrals from gambling services
  - K1.7.4 Wait times

K2 Improving gambling treatment services - from studies receiving any industry funding

- K2.1 Delivery
  - K2.1.1 Communication and feedback
  - K2.1.2 Flexibility and convenience
  - K2.1.3 Format of therapy
- K2.2 Practitioners and peer supporters
  - K2.2.1 Training and values of practitioners
- K2.3 Organisation of services
  - K2.3.1 Clear service descriptions
  - K2.3.2 Partnership between services

K3 Improving gambling treatment services - from studies receiving funding from an unclear funding source

- K3.1 Content of therapy
  - K3.1.1 Cue exposure
  - K3.1.2 Supporting empowerment
  - K3.1.3 Personalised goals
  - K3.1.4 Real-world context
  - K3.1.5 Relapse planning and prevention

- K3.1.6 Understanding addiction and treatment
- K3.2 Delivery
  - K3.2.1 Inadequate provisions
  - K3.2.2 Flexibility and convenience
  - K3.2.3 Format of therapy – range of formats
  - K3.2.4 Format of therapy – advantages of group therapy
  - K3.2.5 Format of therapy – role of online options
- K3.3 Practitioners and peer supporters
  - K3.3.1 Communication and feedback
  - K3.3.2 Training and values of practitioners
- K3.4 Organisation of services
  - K3.4.1 Crisis intervention
  - K3.4.2 Consistency and care continuity
  - K3.4.3 Improving integration
  - K3.4.4 Physical attributes
  - K3.4.5 Treatment of co-morbidities and social issues

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

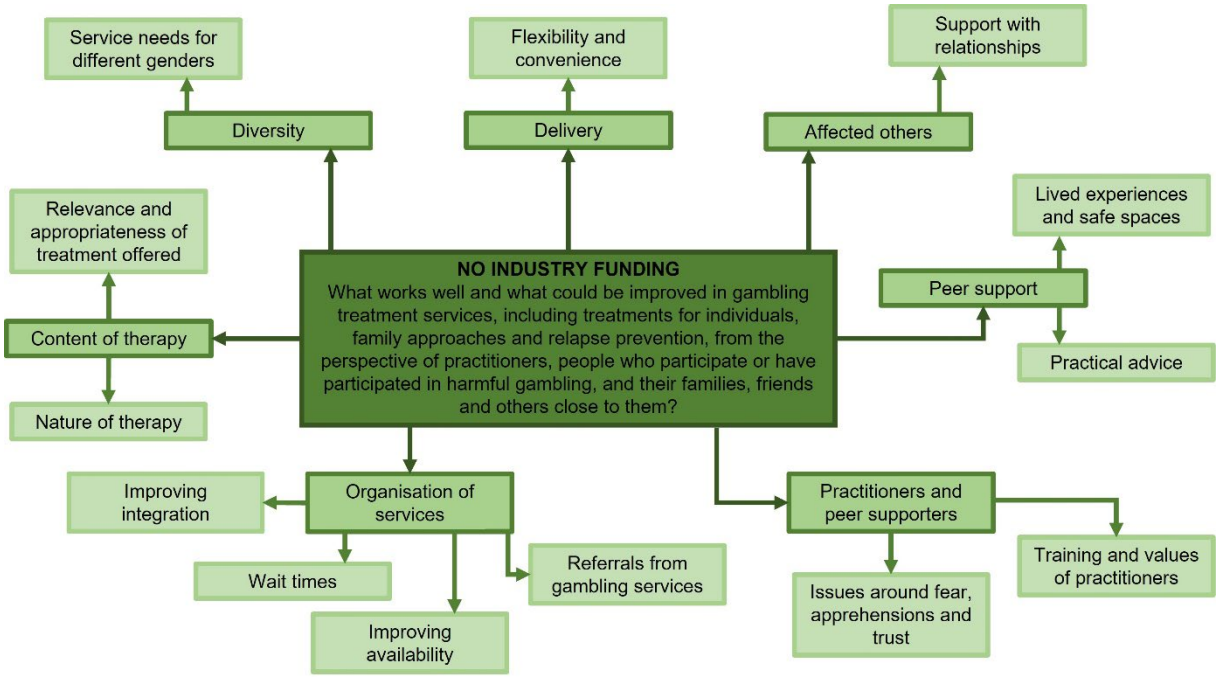


Figure 2: Theme map for themes identified from studies receiving any industry funding

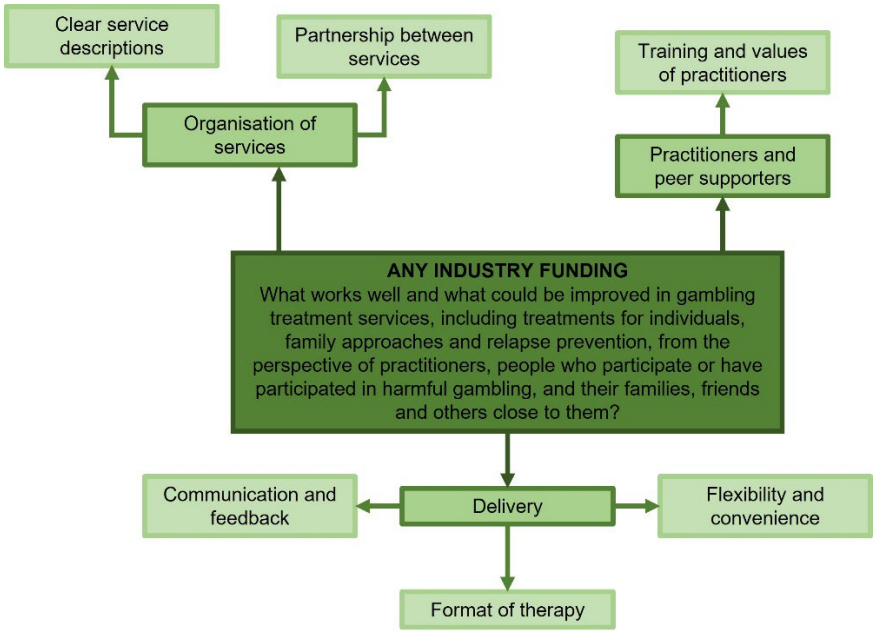
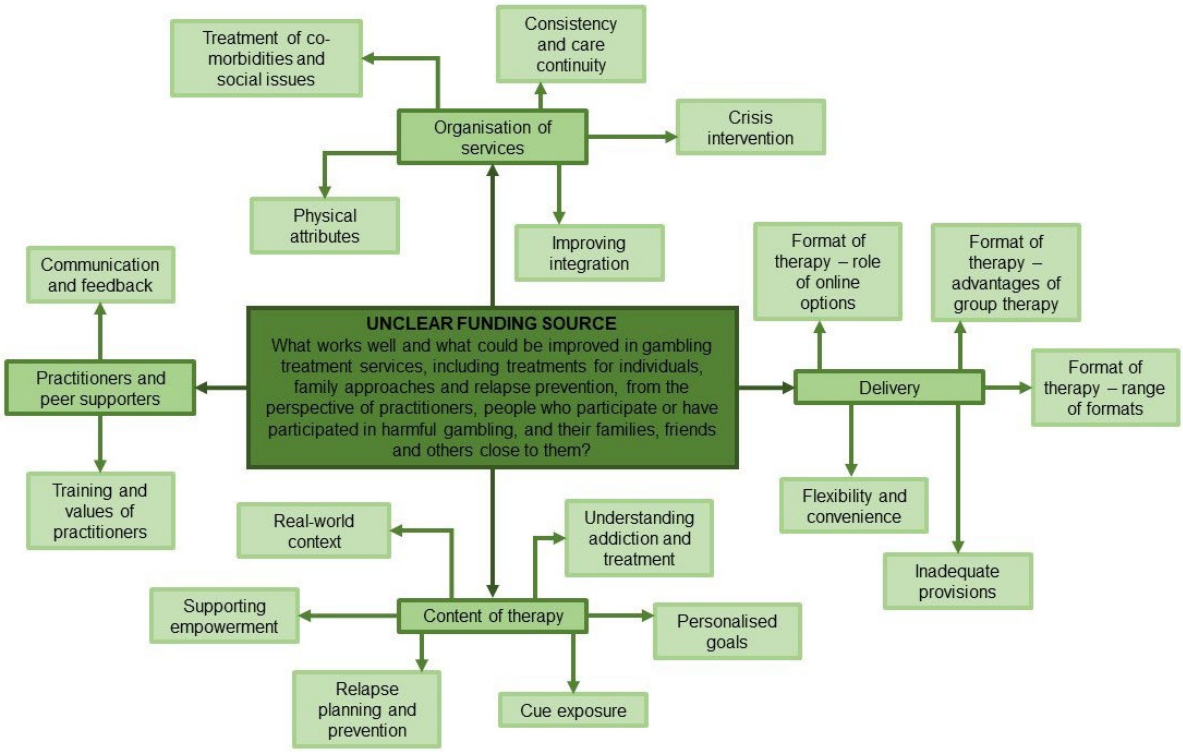


Figure 3: Theme map for themes identified from studies receiving funding from an unclear funding source



Improving gambling treatment services - from studies receiving no industry funding

Within the stratification of studies receiving no industry funding, 7 main themes were identified: content of therapy; delivery; diversity; practitioners and peer supporters; peer support; affected others; and organisation of services.

Content of therapy:

Two sub-themes were identified. In the ‘nature of therapy’ sub-theme, evidence from 3 studies showed that offering a range of therapies and delivery formats allowed people to choose the treatment that suited them best and increase skills important in their recovery. Confidence in this sub-theme was judged to be high. In the ‘relevance and appropriateness of treatment offered’ sub-theme, evidence from 1 study showed that people were more likely to engage in treatments specifically for harmful gambling, rather than with services that were designed for other addictions. Confidence in this sub-theme was judged to be high.

Delivery:

One sub-theme of ‘flexibility and convenience’ was identified. Evidence from 2 studies showed that people preferred services that were flexible around their daily lives and commitments. Confidence in this sub-theme was judged to be moderate.

Diversity:

One sub-theme of ‘service needs for different genders’ was identified. Evidence from 1 study showed that women felt more comfortable participating in single-gender group therapies. They reported feeling less judged and more confident in sharing their experiences. Confidence in this sub-theme was judged to be low.

Practitioners and peer supporters:

Two sub-themes were identified. In the ‘issues around fear, apprehensions, and trust’ sub-theme, evidence from 2 studies showed that people were more likely to share their experiences with harmful gambling when they were comfortable and relaxed in their therapeutic environment. Confidence in this sub-theme was judged to be low. In the ‘training and values of practitioners’ sub-theme, evidence from 2 studies showed that the attitudes and knowledge level of therapists helped foster good working relationships and increase engagement in treatment. This is important at all stages of the treatment journey. Confidence in this sub-theme was judged to be moderate.

Peer support:

Two sub-themes were identified. In the ‘lived experiences and safe spaces’ sub-theme, evidence from 3 studies showed that peer support was an important aspect of treatment for harmful gambling. It allowed people to share their stories in an accepting environment, as well as aspects of recovery that may be considered shameful (for example, relapsing). Confidence in this sub-theme was judged to be high. In the ‘practical advice’ sub-theme, evidence from 1 study showed that peers were often a good source of practical information (for example, financial issues or help-seeking services). Confidence in this sub-theme was judged to be low.

Affected others:

One sub-theme of ‘support with relationships’ was identified. Evidence from 2 studies showed that people experiencing harmful gambling and their affected others found techniques to promote better and calmer communication was helpful. However, this did not extend to people who were estranged from their families. Confidence in this sub-theme was judged to be moderate.

Organisation of services:

Four sub-themes were identified. In the ‘improving availability’ sub-theme, evidence from 2 studies showed that limited availability of services decreased the amount of trust people had in them. Confidence in this sub-theme was judged to be moderate. In the’ improving integration’ sub-theme, evidence from 1 study showed that integration of services was preferable for people receiving treatment for harmful gambling (for example, scheduling

appointments on the same day), as it decreased the amount of time spent at appointments. Confidence in this sub-theme was judged to be low. In the 'referrals from gambling services' sub-theme, evidence from 1 study showed that a close working relationship between gambling venues and treatment services was beneficial to increase the number and quality of referrals. Confidence in this sub-theme was judged to be low. In the 'wait times' sub-theme, evidence from 1 study showed that shorter wait times in harmful gambling treatment services meant that more people progressed to starting treatment. Confidence in this sub-theme was judged to be high.

Improving gambling treatment services - from studies receiving any industry funding

Within the stratification of studies receiving any industry funding, 3 main themes were identified: delivery; practitioners and peer supporters; and organisation of services.

Delivery:

Three sub-themes were identified. In the 'communication and feedback' sub-theme, evidence from 1 study showed that regular communication from treatment services was important to maintain engagement throughout an individual's rehabilitation journey. Services should ensure that this is in an acceptable format. Confidence in this sub-theme was judged to be very low. In the 'flexibility and convenience' sub-theme, evidence from 2 studies showed that harmful gambling services should be convenient to use (for example, local services or services that can be accessed at different times of the day). Confidence in this sub-theme was judged to be very low. In the 'format of therapy' sub-theme, evidence from 2 studies showed that people had mixed views about which format is most suitable for harmful gambling treatments. Some people found that online services increased participation in therapy by reducing mental barriers. However, other people felt as though they made fewer emotional connections via this format, which meant fewer barriers to dropping out of treatment. Confidence in this sub-theme was judged to be very low.

Practitioners and peer supporters:

One sub-theme of 'training and values of practitioners' was identified. Evidence from 2 studies showed that practitioners delivering treatments for harmful gambling should be understanding, supportive and helpful. Confidence in this sub-theme was judged to be very low.

Organisation of services:

Two sub-themes were identified. In the 'clear service descriptions' sub-theme, evidence from 2 studies showed that services should be explicit about what stage of the pathway they are serving, and what treatments or services they offer. Confidence in this sub-theme was judged to be low. In the 'partnership between services' sub-theme, evidence from 1 study showed that an effective harmful gambling treatment service should have a good partnership between all elements. Confidence in this sub-theme was judged to be very low.

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

Within the stratification of studies receiving funding from an unclear funding source, 4 main themes were identified: content of therapy; delivery; practitioner and peer supporters and organisation of services.

Content of therapy:

Six sub-themes were identified. In the 'cue exposure' sub-theme, evidence from 1 study showed that some people experiencing harmful gambling found cue exposure as a helpful therapy. However, others were worried that this might increase early perceptions of gambling

control which could lead to people leaving treatment before they are ready. Confidence in this sub-theme was judged to be low. In the 'supporting empowerment' sub-theme, evidence from 2 studies showed that engagement was increased in people who were empowered to take responsibility of their recovery journey and act as an active participant. Confidence in this sub-theme was judged to be moderate. In the 'personalised goals' sub-theme, evidence from 5 studies showed that treatment goals should be set by people participating in treatment, to accurately capture their long term aims of therapy. Confidence in this sub-theme was judged to be low. In the 'real-world context' sub-theme, evidence from 3 studies showed that relating treatment back to every-day life was seen as helpful to people receiving treatment for harmful gambling, giving them time to reflect and implement strategies within their normal routine. Treatment also should be realistic to implement and not interfere with people's daily life. Confidence in this sub-theme was judged to be moderate. In the 'relapse planning and prevention' sub-theme, evidence from 3 studies showed that people experiencing harmful gambling appreciated frank discussions about the possibility of relapse, to decrease the stigma associated with it and plan strategies to limit harms from it. Confidence in this sub-theme was judged to be moderate. In the 'understanding addiction and treatment' sub-theme, evidence from 3 studies showed that therapies were more effective when they included information on the development and treatment of addictions. Confidence in this sub-theme was judged to be high.

Delivery:

Five sub-themes were identified. In the 'inadequate provisions' sub-theme, evidence from 1 study showed that people felt dissatisfied with treatment services if they were unable to deliver what people expected them to. Confidence in this sub-theme was judged to be very low. In the 'flexibility and convenience' sub-theme, evidence from 3 studies showed the people were more likely to engage in services that suited their schedule and were flexible around their other commitments and needs. Complicated registration processes and prescriptive programmes decreased engagement with treatment services. Confidence in this sub-theme was judged to be low. In the 'format of therapy – range of formats' sub-theme, evidence from 1 study showed that people thought that offering a hybrid approach to treatment (for example, in person treatment supplemented with digital therapies) would combine the best characteristics of each format while decreasing the disadvantages. Confidence in this sub-theme was judged to be low. In the 'format of therapy – advantages of group therapy' sub-theme, evidence from 5 studies showed that group therapy had several benefits for people experiencing harmful gambling. They could share their experiences in an accepting environment, increase their recovery skills and gain practical advice. Confidence in this sub-theme was judged to be moderate. In the' format of therapy – role of online options' sub-theme, evidence from 3 studies showed that people appreciated the increased flexibility and access to specific therapies afforded by online formats. However, it was also seen to decrease engagement with the content of therapy as people did not form the same personal attachments as when attending in-person treatment. Confidence in this sub-theme was judged to be very low.

Practitioners and peer supporters:

Two sub-themes were identified. In the 'communication and feedback' sub-theme, evidence from 1 study showed that communication between therapists and people experiencing harmful gambling should be a 2-way process. Communication should be personalised towards the individual to be more meaningful to both participants. Confidence in this sub-theme was judged to be low. In the 'training and values of practitioners' sub-theme, evidence from 6 studies showed that people were less likely to engage in treatments and services that were perceived to be disrespectful or minimising issues faced by people experiencing harmful gambling. Confidence in this sub-theme was judged to be low.

Organisation of services:

Five sub-themes were identified. In the 'crisis intervention' sub-theme, evidence from 1 study showed that people often require urgent help by the time they present for harmful gambling treatment. Therefore, services should include a crisis intervention element. Confidence in this sub-theme was judged to be low. In the 'consistency and care continuity' sub-theme, evidence from 1 study showed that continuity of treatment is important to ensure progress is maintained. Confidence in this sub-theme was judged to be very low. In the 'improving integration' sub-theme, evidence from 1 study showed that gambling treatment services should be integrated into wider healthcare and social care pathways to increase the opportunity for early interventions for gambling-related harms. Confidence in this sub-theme was judged to be very low. In the 'physical attributes' sub-theme, evidence from 1 study showed that the location and appearance of treatment services was important in increasing trust and confidence in the quality of services and treatments offered. This also extended to the service staff, who should not appear too clinical. Confidence in this sub-theme was judged to be low. In the 'treatment of co-morbidities and social issues' sub-theme, evidence from 3 studies showed that harmful gambling treatment services should be holistic in their approach, ensuring they have the facilities to address co-morbid health and social care issues that often present alongside harmful gambling. Confidence in this sub-theme was judged to be high.

No evidence was identified for the anticipated potential theme of funding of services.

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 this was a qualitative review.

The committee's discussion and interpretation of the evidence

The outcomes that matter most

To address the issue of works well and what could be improved in gambling treatment services 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.

- Acceptability – for example, people's experiences of using treatment services and suggestions for ways of improving various aspects of the way it is delivered.
- Content – for example, people's views about the relevance and appropriateness of treatment services provided or about the nature of the treatment being offered, including whether service planning and design involved people with lived experience.

- Delivery – for example, data about the delivery of treatment including for example, treatment quality, language and communication, stigma and discrimination, role of outreach, consistency and care continuity.
- Diversity – for example, data about people's experience of services being set up to meet the needs of different genders, ethnicities, cultures and languages.
- Practitioners and peer supporters – for example, data about people's perspectives of practitioners and peer supporters including communication, issues around fear, and apprehensions and trust, skills, training and values of practitioners and peer supporters.
- Significant others (also known as affected others) – for example, people's experience of the involvement of significant others in the treatment process
- Funding of services – for example, people's views about the funding of gambling treatment, for example whether funded by the gambling industry either directly or indirectly.
- Organisation of services – for example, perceptions about what works well and what could be improved may be influenced by the configuration and organisation of services.

These themes were chosen as they were expected to be the key aspects that influence opinion and preferences about the way in which treatment for gambling that harms should be made available and delivered to people experiencing gambling that harms, their families and affected others.

Evidence was identified for all these themes except acceptability and funding of services. Additional themes identified from the evidence were peer support.

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 use of convenience sampling within other experimental studies, lack of justification on data collection techniques, and poorly described data analysis methods. Examples of adequacy concerns were when only 1 study contributed to a theme, or when there was a lack of first order quotes to support themes. Studies were also downgraded due to relevance concerns (for example, when themes only used findings on specific treatment formats or services) and coherence of themes (for example, when themes included both positive and negative findings).

An anticipated theme set out in the protocol but not reported by any studies was that of funding of services.

Benefits and harms

The committee reviewed the broad range of themes and sub-themes available from this evidence review. They discussed whether to consider all the evidence or whether to prioritise themes from non-industry funded and unclear funding 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 (delivery of services, practitioners and peer supporters, and organisation of services) 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 whole body of evidence 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, because, for example their adequacy

would be improved. The committee also noted that many of the themes identified, even if low confidence, resonated with their knowledge of the benefits and drawbacks of different ways of delivering gambling treatment services and so they agreed to consider all the evidence.

The committee discussed that the themes provided some useful information on best practice when delivering treatments for gambling that harms and so used the evidence to make recommendations to cover the 'general principles for treatment'.

Based on their knowledge and experience, and with input from a NICE social care advisor, the committee set out an over-arching principle that care of people experiencing gambling-related harms would need a multidisciplinary approach with input not just from healthcare professionals but from social care practitioners, those working in the criminal justice system and others working in the voluntary sector.

Evidence from sub-theme 1.6.1 Affected others (moderate confidence) showed that people appreciated being able to meet for treatment and support both on their own but also with the support of a friend or member of their family (if both agreed to this) and so the committee advised that as an option.

The next principles included discussing and agreeing treatment goals. This was based on the evidence from sub-theme 3.1.3 Personalised goals (low confidence). This showed that people wanted to set their own gambling treatment goals which may be abstinence or harm reduction, but that people may also have other goals such as improving their relationships (which could be a joint goal with their partner), improving their mental health or improving their financial situation. The committee discussed that although people think it is possible to aim just for harm reduction in their experience it was preferable if people aimed for abstinence and so they used this as one example of a treatment goal in the recommendation.

Several sub-themes such as 1.1.1 Nature of therapy (high confidence), 1.2.1, 2.1.2 and 3.2.2 Flexibility and convenience (moderate confidence, very low confidence and low confidence respectively), 1.7.1 Improving availability (moderate confidence) 3.2.3 Format of therapy – range of formats (low confidence), and 3.2.5 Format of therapy – role of online options (very low confidence) provided evidence that people prefer to have a choice of methods of delivery for treatments. This relates both to the way the therapy is delivered (for example, online or in-person sessions), flexibility so that they can fit it around their lives and other commitments, and the geographical location for in-person therapy. This reinforced the recommendations the committee had made on improving access which suggested that offering people a treatment format that was preferred by them improved access and engagement. The committee agreed that evidence about time required to participate in treatment (low confidence) from evidence review I also supported this recommendation.

The committee noted that there was evidence that people being treated for gambling that harms felt that there was stigma in being associated with people with other addictions such as drug and alcohol dependence, and that they did not wish to be 'lumped together' or treated in the same location as people with other dependencies. This was based on evidence from theme 3.4.4 Physical attributes (low confidence). The committee therefore recommended that gambling treatment services should not be co-located with other such services, but agreed this recommendation was specifically to improve acceptability and access to services, and so it was put in the section of the guideline on access.

This preference to be treated separately also extended to the treatments themselves, with people experiencing gambling-related harm wanting treatment that was aimed specifically at gambling and that had been proven to be effective for gambling that harms, rather than simply adapted from treatment for other addictions. This evidence was from theme 1.1.2 Relevance and appropriateness of treatments offered (high confidence). The committee discussed that certain settings such as the criminal justice system are more likely to only

provide general addiction treatment programmes (rather than those aimed at treating gambling that harms) and highlighted this in their recommendation.

Several sub-themes such as 1.1.1 Nature of therapy (high confidence) and 3.2.5 Format of therapy – role of online options (very low confidence) highlighted the desire for a choice of methods for delivering services and the fact that online appointments may be easier to attend. However, sub-themes 2.1.3 and 3.2.5 Format of therapy (both very low confidence) provided evidence that virtual appointments with therapists were preferred by some people but engagement was less likely as there was less of a personal connection and no opportunity to develop a therapeutic relationship. The committee recommended that a variety of treatment methods should be available to people experiencing gambling-related harm, but that people should also be informed about the advantages and disadvantages of different formats. Stakeholders at consultation commented that people who cannot access services online or digitally may also be disadvantaged but the committee agreed that the option of in-person consultation was always provided so lack of digital access should not disadvantage people.

As there was some evidence relating to treatment for people with comorbidities the committee discussed the relationship between gambling-related harms and comorbidities and the order in which different problems should be addressed. For example, the committee knew based on their experience that some people with severe alcohol or substance dependencies would not be able to engage with treatment for their gambling-related harms until they had been supported to address their other addictions. However, other people needed treatment for comorbidities alongside their treatment for gambling-related harms, and in others an improvement in their gambling-related harms would lead to an improve their distress, anxiety or other similar comorbidities.

The evidence about treatment for people with comorbidities came from sub-theme 1.7.2 Improving integration (low confidence) and sub-theme 3.4.5 Treatment of comorbidities and social issues (high confidence). This showed that people preferred to have treatment for their comorbidities at the same time as their gambling that harms and that they did not want to have multiple clashing appointments, and this included appointments for other aspects of their gambling-related harms such as financial or employment support. The committee discussed that this could be achieved by providing treatment for common comorbidities (for example, mental health and substance dependencies) within the gambling treatment service, or by ensuring good coordination by establishing links between services involved in the treatment of co-morbidities.

There was evidence that people wanted to be treated by trained and competent staff from sub-theme 1.4.2 Training and values of practitioners (moderate confidence). The committee agreed with this evidence and specified that this extended to practitioners providing peer support or group treatment options, rather than only those professionals involved in individual pharmacological or psychological treatment options. The committee discussed that there was currently no formal accreditation for staff delivering gambling treatment services. However, they were aware that a GP competency framework had been developed and work was underway by the organisation Addiction Professionals (a voluntary registration body for practitioners working in the addictions sector) and by the Department of Health and Social Care to develop competency frameworks and that in the future this may provide guidance on a recognised standard of practice for professionals providing gambling interventions.

In addition to the competency of staff, there were a number of themes which provided information on the preferred attributes of staff delivering gambling treatment. There was evidence from sub-themes 1.4.2, 2.2.1 and 3.3.2 Training and values of practitioners (moderate, very low and low confidence respectively) that people wanted to be treated by therapists who were understanding, supportive, helpful, sincere and empathetic, and with whom they could build a therapeutic relationship. People did not want a therapist who minimized their concerns or made them feel stigmatized. People also wanted a therapist who

encouraged communication and ownership, and this was based on the evidence from sub-themes 2.1.1 and 3.3.1 Communication and feedback (very low and low confidence respectively) and theme 3.1.2 Supports empowerment (moderate confidence). Finally, people expressed a preference for continuity of treatment as this was helpful for their recovery and this evidence was in sub-theme 3.4.2 Consistency and care continuity (very low confidence).

There was evidence from 2 sub-themes that people experiencing gambling that harms greatly value peer support. Sub-theme 1.4.1 Fear, apprehension and trust (low confidence) provided evidence that people found it useful to talk to people in the same situation, and sub-theme 1.5.1 Lived experience and safe spaces (high confidence) provided evidence that people found peer support invaluable for sharing stories, discussing their recovery, and for encouraging them to continue with treatment. The committee agreed that, in their experience, peer support was a valuable part of treatment and so they included recommendations to offer it. However, they were aware that sharing sensitive information in a group setting can be daunting to some people, and recommended that these benefits of peer support be explained to people experiencing gambling-related harms when discussing treatment options.

In addition to the recommendations on principles of treatment and peer support the committee used evidence from this review to make recommendations in other sections of the guideline.

There was evidence from a study of female gamblers in sub-theme 1.3.1 Service needs for different genders (low confidence) that some women preferred to attend female-only treatment groups as they felt out-numbered if treated in groups with more men. The committee agreed with this evidence, and further noted that his preference may extend beyond women, and that other diverse groups may prefer to be treated with people from similar backgrounds or experiences (for example, veterans). Therefore, the committee recommended that reasonable adjustments should be made by treatment services so that people feel more comfortable in group settings such as offering women-only groups and to reduce the stigma they may experience. The committee also used themes from evidence review I to expand this recommendation to cover culturally sensitive services that adequately support the needs of the local population and improve access. These recommendations are in the section of the guideline on improving access to treatment. Stakeholders at consultation commented on the need to adapt services to meet the needs of people from different ethnic groups, but the committee agreed the existing recommendations already did this and so made no further changes to the recommendations.

In addition to treatment for gambling that harms there was also evidence that people valued advice and support on other topics such as self-exclusion (either using blocking software for online gambling or physical self-exclusion from land-based gambling venues), finances (including methods to block payments to gambling venues or to limit access to money), social issues such as housing, and employment issues. This evidence came from 2 sub-themes: 1.5.2 Practical advice (low confidence) and 3.4.5 Treatment of comorbidities and social issues (high confidence). The committee agreed that these recommendations based on these themes fitted better into the section of the guideline on ‘Initial support for people experiencing harm from their own or another’s gambling rather than in the section on treatment principles.

There was also evidence that provided additional confirmation of themes from evidence review C regarding information and support for people experiencing gambling-related harms. For example, sub-theme 3.1.6 Understanding addiction and treatment (high confidence) suggested that people thought therapies were more effective when they understood what led to the development of gambling addiction, and this supported the recommendations about explaining the nature of addiction. Similarly, the committee had already made recommendations on providing information on treatment availability, and this was backed up

by the evidence from sub-theme 3.4.1 Crisis intervention (low confidence) which indicated that people want to have urgent help available.

Some of the evidence identified in this review related to access to services and the committee were aware that this topic was covered by separate evidence reviews but agreed that the evidence should be used to supplement the more specific access evidence. Sub-theme 1.7.3 Referrals from gambling services (low confidence), sub-theme 2.3.2 Partnership between services (very low confidence), sub-theme 3.3.2 Training and values of practitioners (low confidence) and sub-theme 3.4.3 Improving integration (very low confidence) all provided evidence that involvement of a wide range of services, including social care, benefits systems, children's services, gambling providers, voluntary sector, education, GPs and financial services may lead to earlier referral and earlier interventions.

Other themes provided suggestions from people about things that would encourage access and engagement: sub-themes 1.2.1, 2.1.2 and 3.2.2 Flexibility and convenience (moderate confidence very low confidence and low confidence respectively) suggested that providing treatment that was easy to access and theme 1.7.4 Wait times (high confidence) suggested that access and engagement would be improved if people did not have long waiting times for services.

Some of the included studies reported views and preferences from affected others of people experiencing gambling that harms. However, there were very few themes that related to interventions or support for affected others, and most of the evidence related to how affected others could be involved in treatment for those experiencing gambling that harms. One sub-theme identified was 1.6.1 Support with relationships (moderate confidence) that showed that it may be useful for affected others to receive support by themselves as well as with the person, and that it may be useful for affected others to be helped to engage in non-judgemental and calm communication. As these views related to families and affected others the committee placed these recommendations in the section of the guideline on interventions for affected others, where there had been a lack of quantitative evidence.

Finally, there was some evidence relating to relapse and the committee made recommendations relating to this in the section of the guideline on relapse prevention. Sub-theme 3.1.5 Relapse planning and prevention (moderate confidence) provided evidence that people recognise that relapse can be a taboo subject, and may lead to feelings of stigma and shame, but that by discussing it and planning how to reduce the risk, this may help people experiencing gambling that harms.

There were some themes the committee did not use to make recommendations: sub-theme 3.1.1 Cue exposure therapy (low confidence) related to a specific intervention, and the committee agreed that to recommend specific interventions they would need evidence of effectiveness. Theme 3.2 4 Format of group therapy – advantages of group therapy (moderate confidence) related to the advantages of group therapy. Similarly, the committee agreed they were unable to recommend a specific format of delivery based on qualitative evidence, and instead used the effectiveness and cost-effectiveness evidence identified in review F on psychological therapies to inform their recommendations on group sessions. Finally, theme 3.2 1 Inadequate provision (very low confidence) related to the perceived inadequacies of a specific telephone helpline. The committee agreed that this theme did not have a broader application, so they did not use it to make recommendations.

The committee noted that there was very little evidence about how gambling treatment services could be best delivered to people from diverse groups, such as those who were neurodiverse, or who were from different races or genders, and so they made a research recommendation, which is described in appendix K. Stakeholders at consultation also identified that older people may also require adjustments to treatment and so the research recommendation was amended to include this group.

Cost effectiveness and resource use

No economic evidence was identified for this review. The committee acknowledged that there is currently large variation in practice across gambling treatment services and expressed the view that providing services within the framework set by these recommendations will reinforce good practice. They acknowledged that recommendations may lead to a need for increased resources in terms of buildings, facilities and staff. More health professionals' time will be needed to provide information to people who experience gambling that harms, to discuss with them their treatment options and treatment goals, and also to provide advice and support to them and their family, friends and affected others. The committee also considered the additional resources involved in providing gambling treatments in separate locations from other addiction services, as well as separately for distinct groups of people (taking into account, for example, gender, vocation and cultural issues), but expressed the view that related recommendations are likely to improve access to services for people who experience gambling that harms, which currently is very low. Training of health professionals involved in the care of people who experience gambling-related harms will also require additional resources but is essential to ensure appropriate and high-quality care. 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 took into account the guideline evidence on the cost-effectiveness of the recommended interventions, which considered the interventions' mode of delivery. Overall, the recommendations made are expected to improve access, care, treatment 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 finding: Forsstrom 2017, Guilcher 2016, Nilsson 2021, Wood 2007, Woodall 2021
- No industry funding: Kourgiantakis 2018, Piquette-Tomei 2008, Riley 2018, Syvertsen 2020, Tremblay 2017, Wieczorek 2018
- Unclear funding source: Dunn 2012, Flores-Pajot 2021, Heiskanen 2017, Lee 2008, Marionneau 2021, Penfold 2021, Pickering 2019a, Pickering 2019b, Piquette 2013, Rodda 2019, Shandley 2008, Smith 2016

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.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.5.1 to 1.5.11 and a research recommendation on services for diverse groups. Other evidence supporting these recommendations can be found in evidence review I on access.

References – included studies

Qualitative

Dunn 2012

Dunn, Kirsten; Delfabbro, Paul; Harvey, Peter (2012) A preliminary, qualitative exploration of the influences associated with drop-out from cognitive-behavioural therapy for problem gambling: an Australian perspective. Journal of gambling studies 28(2): 253-72

Flores-Pajot 2021

Flores-Pajot, Marie-Claire, Atif, Sara, Dufour, Magali et al. (2021) Gambling Self-Control Strategies: A Qualitative Analysis. International journal of environmental research and public health 18(2)

Forsstrom 2017

Forsstrom, David, Jansson-Frojmark, Markus, Hesser, Hugo et al. (2017) Experiences of Playscan: Interviews with users of a responsible gambling tool. Internet interventions 8: 53-62

Guilcher 2016

Guilcher, Sara J T, Hamilton-Wright, Sarah, Skinner, Wayne et al. (2016) “Talk with me”: perspectives on services for men with problem gambling and housing instability. BMC health services research 16(a): 340

Heiskanen 2017

Heiskanen, Maria (2017) Financial recovery from problem gambling: Problem gamblers’ experiences of social assistance and other financial support. Journal of Gambling Issues 35: 24-48

Kourgiantakis 2018

Kourgiantakis, Toula, Saint-Jacques, Marie-Christine, Tremblay, Joel et al. (2018) Facilitators and barriers to family involvement in problem gambling treatment. International Journal of Mental Health and Addiction 16(2): 291-312

Lee 2008

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Appendices

Appendix A Review protocols

Review protocol for review question: What works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, 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	Experiences of gambling treatment services (qualitative review)
2.	Review question	What works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, 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 what works well in gambling treatment services for people participating in harmful gambling and affected others • To establish what could be improved in treatment services
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 gambling treatment services, including treatments for individuals, family approaches and relapse prevention.
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 the identification, assessment and management 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.
7.	Phenomenon of interest	The committee wish to locate qualitative evidence about what works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them. 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: • Acceptability – data may relate to people's experiences of using treatment services and may suggest ways of improving various aspects of the way it is delivered.

ID	Field	Content
		• Content – there may be data on people's views about the relevance and appropriateness of treatment services provided or about the nature of the treatment being offered, for example whether service planning and design involved people with lived experience. • Delivery – data may relate to the delivery of treatment including for example, treatment quality, language and communication, stigma and discrimination, role of outreach, consistency and care continuity. • Diversity – data may relate to people's experience of services being set up to meet the needs of different genders, ethnicities, cultures and languages. • Practitioners and peer supporters – data may relate to people's perspectives of practitioners and peer supporters including communication, issues around fear, and apprehensions and trust, skills, training and values of practitioners and peer supporters. • Significant others – data may relate to people's experience of the involvement of significant others in the treatment process • Funding of services– data may relate to people's views on the funding of gambling treatment, for example whether funded by the gambling industry either directly or indirectly. • Organisation of services – perceptions about what works well and what could be improved may be influenced by the configuration and organisation of services.
8.	Comparator/Reference standard/Confounding factors	Not applicable as this is a qualitative review.
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.

ID	Field	Content
		Exclusion: • Articles published before 2000 • Population-level gambling disorder interventions • 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 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 anticipated 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 6 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 NHS-commissioned healthcare is provided for people who participate in harmful gambling and affected others.
12.	Primary outcomes (critical outcomes)	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

ID	Field	Content
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 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	Risk of bias of individual qualitative studies will be assessed using the CASP (Critical Skills Appraisal Programme) qualitative checklist, and systematic reviews of qualitative studies will be assessed using the CASP Systematic Review checklist. See Appendix H in Developing NICE guidelines: the manual for further details. 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

ID	Field	Content			
		• No industry funding • Unclear funding source As this is a qualitative review subgroup 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.			
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	February 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		☑	☑

ID	Field	Content		
		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 Gambling@nice.org.uk 5c. Organisational affiliation of the review National Institute for Health and Care Excellence (NICE)		
25.	Review team members	NICE technical 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		

ID	Field	Content	
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.	
32.	Keywords	Harmful gambling; views and experiences; lived experience; treatment; family approaches; relapse prevention; qualitative	
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 works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, 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.
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	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.
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.

#	Searches
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.
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.

#	Searches
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: Medline and Medline In-Process

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.

#	Searches
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/
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.

#	Searches
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
92	31 and 90
93	91 or 92

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
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.

#	Searches
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: 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/

#	Searches
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/
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.

#	Searches
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: 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.
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.

#	Searches
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: Health Management Information Consortium (HMIC)

Date of last search: 04/04/2023

#	Searches
1	GAMBLING/
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/

#	Searches
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.
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: Social Policy and Practice

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.

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

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

#	Searches
#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
#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

#	Searches
#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: 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: 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: 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: 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)

#	Searches
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 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: 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 Sciences Citation Index

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

Other sources

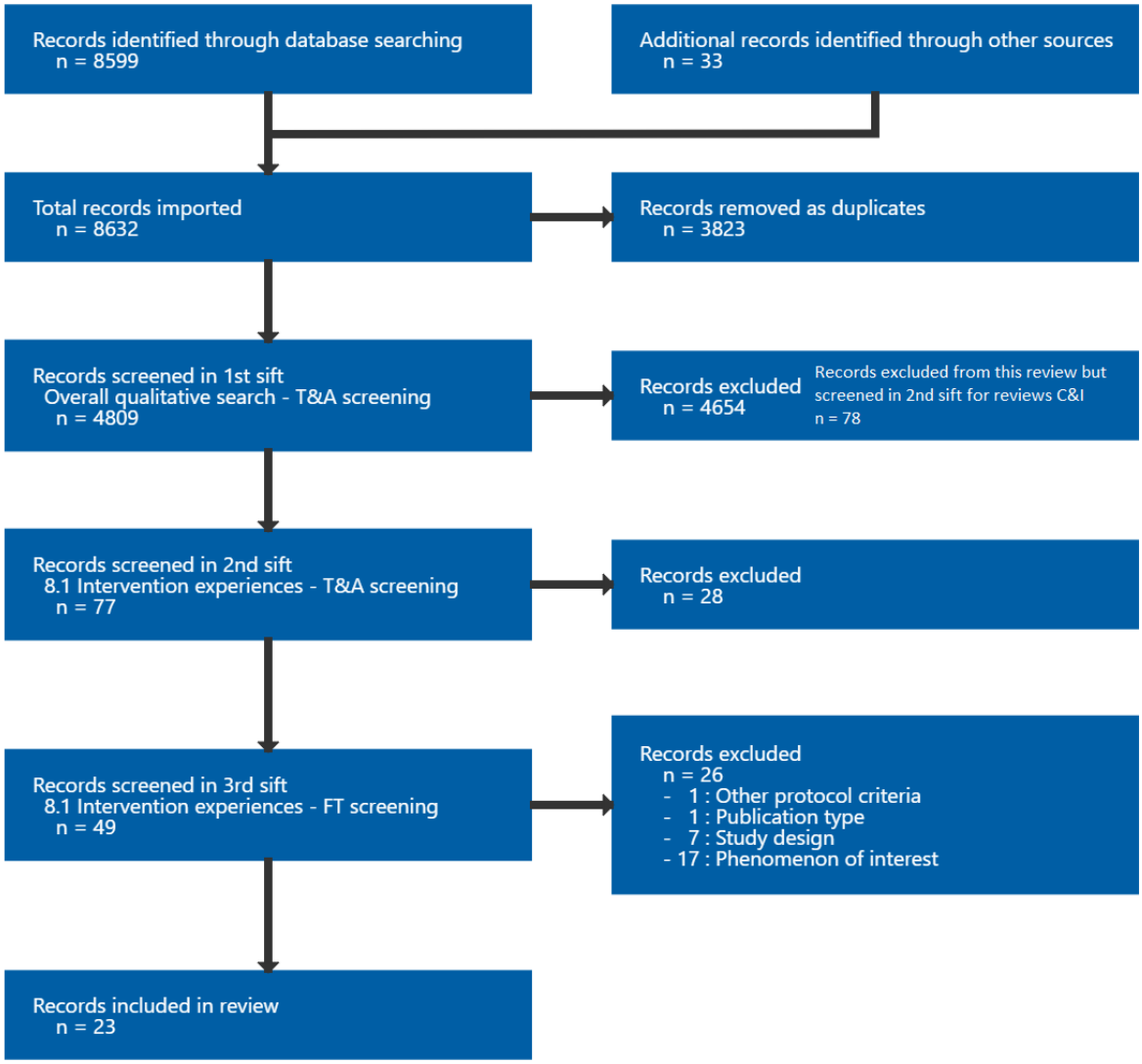
All websites listed in the protocol were searched and browsed.

Date of last search: 11/04/2023

Appendix C Qualitative evidence study selection

Study selection for: What works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, 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 works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, 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

Dunn, 2012

Bibliographic Reference	Dunn, Kirsten; Delfabbro, Paul; Harvey, Peter; A preliminary, qualitative exploration of the influences associated with drop-out from cognitive-behavioural therapy for problem gambling: an Australian perspective.; Journal of gambling studies; 2012; vol. 28 (no. 2); 253-72

Study Characteristics

Study type	General qualitative inquiry (within mixed methods)
Country/ies where study was carried out	Australia
Setting and aim	**Setting** In the community, State-wide Gambling Therapy Service, which provides a CBT-based treatment (including cue and in vivo exposure) for people experiencing harmful gambling. **Aim** To explore views and experiences relating to treatment cessation in people experiencing harmful gambling.
Data collection and analysis	**Data collection** Semi-structured interviews. 40-80 minute telephone interviews starting with a semi-structured approach, using broad questions to guide responses while allowing flexibility between participants. Key areas of discussion included factors

	surrounding the development and identification of their harmful gambling, the impact of their gambling, help-seeking behaviour and preferences (including therapy goals), and factors that may have impacted their ability to complete treatment. More direct prompts were included in the interview guide if needed. Data was analysed as it was collected, with emerging themes incorporated into the guide for subsequent interviews. Interviews were conducted by first author, who made extensive notes as close to verbatim as possible. Interviews were not audio-recorded. The final part of the interview was a structured questionnaire using Likert-scale responses, designed to explore participants' readiness to change when they commenced the therapy programme. **Analysis** Thematic analysis. Data from interviews were collated into a central database according to question number. The first author and research associate independently coded the data into recurring themes and items of interest. These were compared for consistency between the 2 researchers, including discussing and merging initial codes before finalising themes. Findings and themes were compared between people who withdrew early from therapy and those who completed their course.
Recruitment strategy	Purposive sampling from the treatment database of State-wide Gambling Therapy Service. Two groups were approached for recruitment. 1 group consisted of people who had withdrawn early from therapy (defined as attending at least 1 session but no more than 2). The other group consisted of people who had completed all the treatment programme (8-12 sessions) and had been discharged from the service.
Study dates	Not reported.
Sources of funding	Unclear funding source (funding not reported).
Inclusion criteria	Participants had to: • Be aged 18 years or over • Be registered for treatment with State-wide Gambling Therapy Services Note: Although not listed as an inclusion criteria, participants had to agree to short-term cash-restriction (particularly during early sessions) as part of their exposure therapy.
Exclusion criteria	Not reported.

Sample size	N=10 people who received CBT for harmful gambling • Early withdrawal group: n=5 • Therapy completion group: n=5
Participant characteristics	Age in years [Mean (SD)]: 47.7 (SD not reported) Sex: Not reported. Gambling symptom severity scale and score: Not reported.
Results	**Author's themes** • Recognition of problem gambling and help-seeking • Mastery over gambling urge • Gambling-related cognitions • Participant perceptions of therapy • Homework compliance and relapse • Treatment goals **Study findings** *Recognition of problem gambling and help-seeking* The majority of participants had been gambling for a long period of time, over which their harmful gambling had slowly developed, before a point of crisis prompted the realisation that they were no longer in control of their gambling behaviour and they needed to seek help. Their experiences suggest that they had been unable or unwilling to recognise warning signs up until this point. Consistent with this, only 1 participant reported actively seeking information on harmful gambling and which services might be available to them. The remaining respondents were referred to treatment services by a professional (for example, social worker or hospital staff) during this crisis point, or had an affected other seek out information on their behalf. Some people had experience of a variety of counselling therapies, and these participants reported the cue exposure technique used in this study to be more focussed and useful when compared to the general therapies.

	After accepting they needed help for their harmful gambling, the majority of participants felt emotions such as shame and self-hatred, causing them to hide their help-seeking from their family and friends. "I was sacked from my job for stealing money. I had a nervous breakdown, ending up in hospital…" (page 263) *Mastery over gambling urge* Participants reported that the cue exposure therapy used in this study allowed them to be more aware of their urges and therefore better equipped to handle them, independent of how much time they had spent in therapy. People who did not complete their therapy course still were confident in their identification as non-gamblers, although tended to have less confidence in their ability to remain abstinent when compared to treatment completers. This might be due to early perceptions of control, leading people to believe that they need to complete the therapy course. "I now understand what the urge is and how to control it. I can manage it now." (page 264) "Now I can sit and see the others, what they are doing. I see who they are. Other people must have looked at me that way." (page 266) *Gambling-related cognitions* Participants reported irrational beliefs about their gambling outcomes (for example, the probability that they would win when gambling or gambling to earn their losses back), but this did not correspond to people who did not complete their course of therapy. After therapy, most people were better informed on how gambling machines operate and were better able to estimate their probability of winning. "I did have a favourite machine and thought I was lucky on this one." (page 266) *Participant perceptions of therapy* All participants noted that they were able to establish good relationships with their therapists, and that their experience of cue exposure therapy had met or exceeded their expectations (for example, the number and duration of sessions, waiting times or confidentiality aspect of treatment). "…it [cue exposure] gave me a better understanding of how it all works." (page 267)

	Homework compliance and relapse All treatment-completing participants noted that the homework assigned during therapy was difficult and time consuming, although none failed to complete their tasks. This view was supported by people who withdrew early from therapy, although some of these participants did not complete their additional assignments. This might cause early withdrawal, as 1 participant reported that not completing their homework felt like a failure and letting a therapist down. "I just felt like, after all the effort they had put in, I didn't want to let them, or myself, down." (page 267) *Treatment goals* Participants were encouraged to set their own goals regarding abstinence versus controlled gambling. This did not differ between treatment completers and people who withdrew from therapy. Of the people whose goal was complete abstinence, not everyone achieved this but all reported a better level of control over their gambling urges and some noted their goals had changed throughout their treatment. "My goal for therapy was either a massive reduction in my gambling or, hopefully, a total cessation of the activity. I have slowed down, but I'm still gambling which I don't like." (page 268)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Lack of information on researcher impact, lack of information on rigour of data analysis beyond independent reviewing.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Flores-Pajot, 2021

Bibliographic Reference	Flores-Pajot, Marie-Claire; Atif, Sara; Dufour, Magali; Brunelle, Natacha; Currie, Shawn R; Hodgins, David C; Nadeau, Louise; Young, Matthew M; Gambling Self-Control Strategies: A Qualitative Analysis.; International journal of environmental research and public health; 2021; vol. 18 (no. 2)

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting and aim	**Setting** In the community **Aim** To explore views and experiences of self-control strategies employed by people experiencing harmful gambling (including which ones, when, and why they are used).
Data collection and analysis	**Data collection** Focus groups and semi-structured interviews. 9 x approximately 90 minutes focus groups overseen by 2 researchers. 5 x 45-minute individual interviews with 1 researcher. Interview guide consisted of 20 open-ended questions (including 4 introductory questions) which covered various gambling control strategies and how substance use may affect these methods. This guide was designed and validated after consultation with Lower-Risk Gambling Guidelines Scientific Working Group. The guide was piloted in a focus group and was subsequently refined. The data from this focus group was included in the final synthesis. **Analysis** Thematic analysis. Focus groups and interviews were audio recorded and transcribed by a professional. Data analysis was completed alongside data collection, until thematic saturation was reached. Themes were identified and grouped during

	initial reading of transcripts, and a coding grid was developed. Two researchers coded a transcript together and then independently. Any discrepancies were discussed and themes modified as appropriate. Both inductive and deductive analyses were used by researchers.
Recruitment strategy	Purposive sampling. Participants who completed a national online survey and met the inclusion criteria were contacted via email with information on the study. Invitations to focus groups (or individual interviews if availability was limited) were then sent. Recruitment was designed to be diverse in terms of sex, age, socio-economic status and gambling activities.
Study dates	April - June 2019
Sources of funding	Unclear funding source (Grant to the Canadian Centre on Substance Use and Addiction from La Fondation Mise Sur Toi)
Inclusion criteria	Participants had to: • Have participated in national Canadian online survey on gambling and harmful gambling Have reported gambling in the previous 12 months • Reported using a self-control strategy “at least sometimes” • Live in Montreal, Calgary or Toronto
Exclusion criteria	• People playing ≤1 gambling session per month • People only playing lotteries
Sample size	N=56 people reporting gambling in previous 12 months
Participant characteristics	Age in years [Mean (SD)]: 51.9 (14.9) Sex (n): M=27, F=29 Gambling symptom severity scale and score [Mean (SD)]: PGSI, 2.9 (5.0) • Non-problem (%): 54 • Low risk (%): 23 • Moderate risk/problem (%): 23
Results	**Author’s themes**

	• Witnessing someone experience gambling harms **Study findings** *Witnessing someone experience gambling harms* Participants reported that seeing other people experiencing harmful gambling might cause them to gamble less. "It's when that person that is getting addictive is starting to ask you to borrow money to play more, so now you're getting turned off, you don't want to gamble anymore, you don't want to go out with that person anymore" (page 9)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Low value for current question as focuses on self-control strategies rather than how services can be improved.)*
Overall risk of bias and relevance	Relevance	Relevant *(Sample includes non-problem gamblers [as measured using Problem Gambling Severity Index].)*

Forsstrom, 2017

Bibliographic Reference	Forsstrom, David; Jansson-Frojmark, Markus; Hesser, Hugo; Carlbring, Per; Experiences of Playscan: Interviews with users of a responsible gambling tool.; Internet interventions; 2017; vol. 8; 53-62

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	Sweden
Setting and aim	**Setting** Using a responsible gambling tool in the community, provided through Svenska Spel's gambling site. It aims to help at-risk gamblers reduce both time and money spent on gambling through completion of a risk assessment and providing detailed information on gambling behaviour to facilitate change. **Aim** To explore Playscan users' experiences and views of the behaviour tracking tool.
Data collection and analysis	**Data collection** Semi-structured interviews. The interview guide consisted of 13 open-ended questions revolving around participants views of Playscan, how they joined the programme and their satisfaction with the tool. The interview guide was piloted with 3 telephone interviews, which resulted in minor changes being made (no further details reported). Data from these interviews were not included in the final synthesis. **Analysis** Thematic analysis. Interviews were audio-recorded and transcribed verbatim by interviewer and first author, before a 6-step analysis was carried out by the first author. The analysis consisted of reading and re-reading transcripts, coding data, identifying themes, reviewing themes, and expanding these themes with example quotes. Sub-themes were further classified according to the number of discrepancies between experiences: • Rare: 2-3 participants shared this experience • General: 19-20 participants shared this experience • Typical: 10-18 participants shared this experience • Variant: 4-9 participants shared this experience • Rare: 2-3 participants shared this experience

Recruitment strategy	Purposive sampling. Information on the study was compiled by researchers, and emailed out by Svenska Spel to registered Playscan users in Stockholm. Interested individuals could sign up through a website which was separate from the Svenska Spel gambling site and maintained by researchers. Selected participants were then contacted via telephone to arrange interviews, before being sent PGSI questionnaire and questions on gambling habits. Emails were sent in 2 batches, as initial wave did not manage to recruit enough individuals from yellow and red categories. The first batch targeted 200 people, the next targeted 1473.
Study dates	Not reported.
Sources of funding	Any industry funding (grant from Svenska Spel's Research Council) Note: Svenska Spel is the state-organized gambling provider in Sweden.
Inclusion criteria	Participants had to: • Be registered Playscan users • Have gambled during previous month • Live in Stockholm area
Exclusion criteria	Not reported.
Sample size	N=20 people registered with Playscan (a responsible gambling tool) • Green participants: n=7 • Yellow participants: n=6 • Red participants: n=7 The risk assessment utilizes information from a self-test component and gambling data. This results in a colour grading like the traffic light system: green is low risk gambling behaviour, yellow is medium risk gambling behaviour and red is high risk gambling behaviour.
Participant characteristics	Age in years [Mean (SD)]: 42.15 (12.70) • Green participants: 40.57 (10.23) • Yellow participants: 42.17 (17.10) • Red participants: 43.71 (12.53)

	Sex (n): M=19, F=1 • Green participants: 7:0 • Yellow participants: 5:1 • Red participants: 7:0 Gambling symptom severity scale and score [Mean (SD)]: PGSI, 2.65 (3.36) • Green participants: 1.71 (2.36) • Yellow participants: 2.00 (2.10) • Red participants: 4.14 (4.74)
Results	**Author's themes** • Participants' views on their lack of repeated use • The perceived tone of the information issued by Playscan • The users' views and experiences of the reliability of the risk assessment • Suggestions regarding improving the tool **Study findings** *Participants' views on their lack of repeated use* Participants reported not receiving adequate feedback on their gambling behaviour. Because they continued to receive promotional emails from the gambling the company, they assumed that feedback would be emailed. When this did not happen, some participants assumed they were no longer a part of the study. Some other people reported thinking that they did not need to use the tool. "…Yes, I'd actually forgotten I'd been involved in that when I received the email from Svenska Spel…" (page 57) *The perceived tone of the information issued by Playscan* Some participants describe the tone of information from Playscan to be neutral, candid and boring, although this perception did not influence engagement with the tool. A minority of participants did not agree with their received risk rating and reported that the correspondence tone was harsh and accusatory. This perception negatively affected their engagement

	with the tool. Conversely, a minority of participants reported a positive experience with correspondence. The information was easy to read and well-written which made the content more accessible and encouraged engagement with the tool. “It was a little. It was a little. It depends on your mood. It felt accusatory, maybe harsh. But only a bit” (page 58) *The users' views and experiences of the reliability of the risk assessment* Some participants reflected that assessments were fair and reliable. They identified the self-test as the primary part of the assessment and reported that the questions were repetitive and suggested that they should change periodically. However, participants did not seem to fully understand how the risk assessment worked. A few participants did not agree with the assessment results, and found the high rating insulting. “…It is pretty blunt in someway. You receive a rough estimate, but it is someone else's opinion” (page 59) *Suggestions regarding improving the tool* Respondents wanted to receive more feedback (either via email and/or text message) regarding their gambling habits and their risk assessment. Pop-up reminders of Playscan when using the gambling website was also suggested. Feedback should be tailored to a user’s gambling behaviour and patterns. “…So feedback, send an email, we see you're playing a little bit more. Over the limit there… Then you've still been seen” (page 59)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Gambling industry involvement in recruitment and with intervention, monetary incentive for joining, recall bias in data collection, data saturation not mentioned, lack of information on researcher bias.)*
Overall risk of bias and relevance	Relevance	Relevant *(Restricted to views on application.)*

Guilcher, 2016

Bibliographic Reference	Guilcher, Sara J T; Hamilton-Wright, Sarah; Skinner, Wayne; Woodhall-Melnik, Julia; Ferentzy, Peter; Wendaferew, Aklilu; Hwang, Stephen W; Matheson, Flora I; "Talk with me": perspectives on services for men with problem gambling and housing instability.; BMC health services research; 2016; vol. 16 (no. a); 340

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting and aim	**Setting** In the community, urban non-profit organisation providing services for men with housing instability. **Aim** To explore the health and social care experiences of men with a history of housing instability and harmful gambling
Data collection and analysis	**Data collection** Semi-structured interviews. 30–90-minute interviews consisting of open-ended questions revolving around participants' history of harmful gambling, gambling behaviour, stigma surrounding housing instability and addiction, and help-seeking behaviour, as well as access to services and inter-connectivity of social and healthcare services. Interviews were conducted by people with lived experiences of mental illness, addiction, and housing instability. Peer-interviewers received interview guide and questionnaire training prior to conducting interviews. The interview guide was piloted with 5 participants initially, resulting in changes to the order of questions and addition of questions on use of services. **Analysis**

	Grounded theory. Data analysis carried out simultaneously with data collection. Open coding was initially used with 7 interviews, covering a range of time points in data collection, peer-interviewer, and gambling behaviour. Each of these 7 transcripts were coded independently by 2 researchers, with subsequent discussion to develop and finalise main themes and sub-themes. These were also confirmed with peer-interviewers. These codes were applied to all transcripts (including the ones that had previously be subject to open coding). If additional codes were identified, these were incorporated into the initial code list and previously analysed transcripts were checked for consistency. Data saturation of themes included in the interview guide was determined by 3 researchers.
Recruitment strategy	Purposive sampling. Men attending the study centre or Drug and Alchohol Recovery Enrichment programme were screened for a history of harmful gambling using NODS tool. Participants were then randomly listed and contacted sequentially.
Study dates	October 2013 - February 2014
Sources of funding	Any industry funding (funded by Ontario Problem Gambling Research Centre and the Ministry of Health and Long-Term Care)
Inclusion criteria	Participants had to: • Be male • Have a history of housing instability • Have a history of at-risk, problem or pathological gambling as defined by NODS or NODS-CLiP
Exclusion criteria	Not reported.
Sample size	N=30 men with a history of housing instability as well as at-risk, problem, or pathological gambling as defined by NODS or NODS-CLiP
Participant characteristics	Age in years [Mean (SD)]: 48 (SD not reported). Sex (n): Not reported. Gambling symptom severity scale and score [Mean (SD)]: Not reported, PGSI score in previous 12 months (n): • Problem gambling: 23 • Moderate problem gambling: 4

	• Low-level/no problem gambling: 3
Results	**Author's themes** • Empathy, compassion and sincerity • Respectful communication • Empowerment and autonomy • Tailored and holistic life plans • Recommendation for services **Study findings** *Empathy, compassion and sincerity* Respondents identified positive therapeutic relationships as being critical to a successful recovery. Some participants had had previous negative experiences with health and social care providers, which impacted their faith in treatment services and future help-seeking. This was exacerbated by feelings of embarrassment and weakness when divulging their gambling behaviour, as well as the fear of social stigma and judgement. Interviewees reported a difference between the virtues reported by treatment services and the reality that they experienced. Due to these concerns and vulnerabilities, participants concluded that treatment services should practice empathy, compassion, and sincerity. "Like I said with gambling or drinking, whatever, but just speaking to a regular doctor, I thought this is not their specialty. I felt somewhat embarrassed because I looked at it like…a sign of weakness, and kind of like not mentally stable, and I was worried about coming across that way. I didn't want to feel that way. I especially more recently being in an environment of shelters, I seen people with mental health problems, I didn't want to be like them. I didn't want to be associated like as being someone like that." (page 6) "So, it's…have more compassion for people that drink and do drugs and gamble. Try to help them, and get more programs out there for people with addictions and gambling. Like get more stabilized housing for them. Get more counsellors for them, you know." (page 6) *Respectful communication* The majority of respondents wanted to feel valued and respected during their interactions with treatment services and noted that they were very conscious of how treatment service professionals interacted with them. Communication should not be

	presumptive, suspicious or judgemental but should make people feel as though healthcare professionals genuinely care for their wellbeing. Respectful communication increased engagement with treatment services. Conversely, disrespectful communication decreased engagement and could antagonise clients. Participants often lacked support from family and friends, which could mean that they particularly value services that demonstrate active listening. "… [If] I think they're talking to me not with me, they're talking at me, not with me, I'll stop communication right away. I'll say, look it, you're talking at me, talk to me, talk with me, but don't talk at me, don't talk down to me." (page 7) "'This [service agency] is in the middle of [name of park]. It's the biggest crack haven in the entire city, okay. So, let me get this straight. We're smart, we're going to put a rehab right in the middle of crack land. Are you kidding me. What do you think the success rate is there? It's horrible. You can't even go to the store and get a pack of cigarettes without some dealer in your face. Right, this is a problem. This needs to change." (page 8) *Empowerment and autonomy* Respondents identified their personal empowerment and ability to take control of their situation as important factors in their recovery. Gambling led to a loss of this autonomy, with participants reporting several different measures to try and regain control. Some people self-imposed parameters to limit access to funds or gambling venues while others tried reducing gambling behaviour incrementally. Some people did not want to access treatment services due to previous poor experiences (for example, being told what to do and feeling disempowered). Additionally, people felt a sense of pride in not having to access services and be able to self-recover. There was tension between being able to support participants correctly while respecting their send to self-manage, take control and acquire skills needed for the future. This was especially apparent when talking about financial support for people experiencing harmful gambling. "No. Because they [service providers] tell you what to do. I used to go every day. Now once every week, maybe three, four, five times a month. Cut down, but big money. So, was no good. You have to be strong willed. You have to have a strong will power." (page 5) *Tailored and holistic life plans* Participants reported needing to have holistic treatment plans that were tailored to their specific goals. Treatment and recovery should encompass physical and mental health, education, employment, and housing in order to prevent a downward spiral of a person's circumstances.. This is especially important in the homeless population as many people experience mental and physical comorbidities alongside their harmful gambling.

	"Getting more personal, one-on-one with the clients. You know, they're very detached nowadays, and I guess it's a sense of jadedness knowing that…we know what you're doing with your money, but we're not going to, you won't tell, we won't tell, and no harm, no foul whereas they need to be more one-on-one, what do you need…What do you need, do you need a program, school, that kind of thing. Being able to know a person's personal file. Like my OW [Ontario Works provider] knows me very well. Knows exactly what I need and what I can't get because of it. That kind of thing… They need to be more one-on-one with the people." (page 7) *Recommendation for services* Participants had several recommendations to improve future services: 1. Increasing awareness of harmful gambling treatment services; 2. Allow all services to be delivered in a central, accessible environment; 3. Treating mental health with a mixture of pharmaceutical and psychological interventions; 4. Timely access to prevention and recovery services; and 5. Using peer support to teach future life skills. "It's one simple thing. Have a mega treatment centre with counsellors and social workers. Instead of saying, okay I'm a social worker. Okay, I'm going to send you to this counsellor. You go to this counsellor, this counsellor goes, okay, I'm going to send you to this detox. This detox says, I'm going to send you to this treatment centre. This treatment centre goes, okay I'm going to send you back to [service agency] so that they can get you housing. Why not have it all under one building and save tax payers a hell of a lot of money, and your OHIP [Ontario Health Insurance Plan] card a hell of a lot of money…" (page 8) "I think the big fault with our health system is listen I know I have a drug problem, and you can go to meetings and you can go to rehabs, and they're all great, they're still not telling me why… So, at the end of the day, the crack's not the problem, the gambling's not the problem, that's the solution to us. That's our solution, right. So, we have to figure out what's causing the problem in the first place. We're not doing that…" (page 9)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns
Overall risk of bias and relevance	Relevance	Highly relevant

Heiskanen, 2017

Bibliographic Reference	Heiskanen, Maria; Financial recovery from problem gambling: Problem gamblers' experiences of social assistance and other financial support.; Journal of Gambling Issues; 2017; vol. 35; 24-48

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Finland
Setting and aim	**Setting** Within gambling treatment services, treatment clinics or support groups for harmful gambling, A-clinic Foundation clinics, and GA. **Aim** To explore the views and experiences of people experiencing harmful gambling with financial support, particularly financial social assistance from public services.
Data collection and analysis	**Data collection** Semi-structured interviews. 50-150-minute face-to-face interviews consisting of open-ended questions revolving around problem gambling, the process of help-seeking and quitting, and treatment for harmful gambling. **Analysis** Thematic content analysis. Interviews were recorded and transcribed before being uploaded into a digital qualitative programme (Atlas.ti). Transcripts were read before codes were identified around financial aspects of treatment for harmful gambling, experiences of financial survival after harmful gambling and availability of financial social services. 27 codes were

	re-organised into 6 wider themes and 4 final themes. All coding was done by the first author. Finally, these themes were visually organised into socio-economic status of respondents contributing to the theme and level of financial troubles.
Recruitment strategy	Purposive sampling. Recruited through an advertisement calling for 'gamblers who have experienced gambling-related harms in their lives and who saw their gambling excessive', distributed to treatment clinics or support groups for harmful gambling, A-clinic Foundation clinics, and GA. People who were interested contacted treatment service staff or GA facilitators.
Study dates	2011 - 2012
Sources of funding	Unclear funding source (funded by Finnish Foundation for Alcohol Studies)
Inclusion criteria	Participants had to: • Be receiving or previously received treatment for harmful gambling
Exclusion criteria	• People <18 years old.
Sample size	N=17 people receiving or previously received treatment for harmful gambling, and history of financial difficulties due to gambling
Participant characteristics	Age in years [Mean (SD)]: Not reported, age categories (n): • 20-39: 8 • 40-59: 6 • 60-70: 3 Sex (n): M=5, F=12 Gambling symptom severity scale and score: Not reported.
Results	**Author's themes** • Financial support as part of problem gambling treatment • Outside the realm of financial social assistance **Study findings**

	Financial support as part of problem gambling treatment Respondents were being frustrated at the poor understanding that services had towards to the financial consequences of harmful gambling. People reported being told to simply quit gambling, and experienced a lack of financial support even when their primary issue. It also impacted the most beneficial format of treatment, as some people were unable to speak about their financial woes if support groups had banned it as a topic. Some participants found the mutual support aspect of Gambler's Anonymous to be especially helpful for financial issues, as it provided practical advice and emotional support. "[I told her] we have a divorce coming and our son will be born soon. I have 100 000 [marks] worth of debt, I have nothing but these clothes on my back, so my life is kind of in your hands. Please, help me somehow, goddammit. The girl sits and listens and says that, I can book a new meeting for you for next week, if you want to talk." (page 31) "'you get practical help from there [GA] as well, they can advise what to do and, you get some courage to contact different places [authorities and creditors]." (page 32) *Outside the realm of financial social assistance* People experiencing harmful gambling may need external support when facing financial difficulties, which may come in the form of social welfare. There was a mixture of respondents who had and had not applied for financial social assistance. People reported pride and the need to treat harmful gambling on their own as reasons why they did not apply for social welfare. Additionally, many people are already employed and managing their income otherwise so may not be eligible for financial assistance, despite them feeling as though their financial troubles are overwhelming. "Q: How about then, have you, at some point received, for example, social assistance, or something like that? A: No, I can't get it, my income is so high, no…. Q: So gambling has not, not in any point, taken you…? A: No, of course the social services won't help me if I gamble my money. I don't think such a place exists in this world." (page 33)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Analysis performed by 1 person; no description of how relationship between researcher and participants may impact; no ethical approval sought; no direct information on harmful gambling treatment services.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Data related to non-UK financial social services.)*

Kourgiantakis, 2018

Bibliographic Reference	Kourgiantakis, Toula; Saint-Jacques, Marie-Christine; Tremblay, Joel; Facilitators and barriers to family involvement in problem gambling treatment.; International Journal of Mental Health and Addiction; 2018; vol. 16 (no. 2); 291-312

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting and aim	**Setting** Within addiction/mental health treatment services, an urban addictions and mental health hospital. **Aim** To explore the views and experiences of people experiencing harmful gambling and their affected others on family involvement in harmful gambling treatment.
Data collection and analysis	**Data collection** Semi-structured interviews. Individual interviews conducted by the first author, focussing around 4 main categories: impact of problem gambling on people experiencing harmful gambling, affected others and family functions; experiences on

	treatments and services received; changes in the behaviour of people experiencing harmful gambling and affected others, and family functioning; and experiences of how affected others were included in the treatment programme. **Analysis** Grounded theory. Interviews were audio recorded and transcribed verbatim before being uploaded and organised in a digital qualitative programme (NVivo). Data was then coded using inductive and deductive methods, starting with provisional broad categories based on interview questions. The first author then openly coded these initial categories to further define themes and definitions. A second researcher independently coded 2 random transcripts (inter-rater reliability 83-97% for all codes), and any discrepancies were discussed. Conceptual categories were developed from these themes and a matrix developed to identify patterns and themes across and within individual dyads. Regular peer debriefing sessions were held between the first author and 2 other researchers during the last stage of analysis.
Recruitment strategy	Purposive sampling. All participants consented to the study prior to starting treatment for harmful treatment and were followed-up for interviews after 12-weeks (standard time taken to complete the main part of treatment programme).
Study dates	Not reported.
Sources of funding	No industry funding (no funding received)
Inclusion criteria	Participants had to: • Be receiving treatment at participating addiction and mental health hospital in Toronto • Have both person experiencing harmful gambling and their affected others agreeing to participate • Have moderate-severe gambling behaviour as measured by PGSI (score ≥3, person experiencing harmful gambling only)
Exclusion criteria	Not reported.
Sample size	N=22 (11 dyads) people experiencing harmful gambling and their affected others • People experiencing harmful gambling: n=11 • Affected others: n=11
Participant characteristics	Age in years [Mean (SD)]: 49 (14.35) • People experiencing harmful gambling: 50 (14.20)

	• Affected others: 48 (15.09) Sex (n): • People experiencing harmful gambling: M=5, F=6 • Affected others: M=3, F=8 Gambling symptom severity scale and score [Mean (SD)]: • People experiencing harmful gambling: Not reported beyond inclusion criteria stating PGSI score equal to or above 3. • Affected others: Not applicable.
Results	**Author's themes** • Facilitators to family involvement: Communication • Facilitators to family involvement: Support • Facilitators to family involvement: Coping skills • Barriers to family involvement: Isolation **Study findings** *Facilitators to family involvement: Communication* Some participants reported that learning new communication skills (for example, active listening, remain calm and focusing on positive changes) also encouraged family involvement by increasing the frequency and quality of their communication. Additionally, communication was more open and honest, which increased support – people experiencing harmful gambling were more truthful about gambling urges and relapses, and family members were more accepting and supporting in these situations. "When we started here we both realised how to communicate more and better so we can talk through everything now instead of arguing, even about financial issues" (page 300)

Facilitators to family involvement: Support

Respondents reported on the important of support, especially when encouraging family involvement in treatment for harmful gambling. Some people noted that non-judgemental support of a family member increased goal attainment and treatment attendance. Professional support was also helpful to help identify gambling triggers, develop strategies to cope with urges, regulate emotions, and develop communication skills that allowed them to respond more appropriately to affected others. Family members also echoed that professional support was important during treatment, as it allowed them to talk freely about issues that they not feel comfortable talking about with friends and family. Support could mean emotional support, education about harmful gambling, and communication strategies.

“She was always thinking that she alone could change me. She didn’t realize that I have to be the person who is willing to change… But now I know you depend on the other person for any change because you alone are not going to do anything” (page 301)

Facilitators to family involvement: Coping skills

Participants reported benefits of coping skills for their family involvement and identifying new ways of dealing with negative thoughts and emotions. People experiencing harmful gambling also mentioned being better able to identify triggers and cope with gambling urges using the tools learnt in therapy sessions. Both people experiencing harmful gambling and family members reported learning self-care coping strategies which allowed them to better regulate their emotional responses, increase communication and reduce conflict.

“The tools and skills that I’ve learned in the group sessions have provided me some better understanding on being able identify my urges and being mindful of those and, and number two, strategize on ways to deal with them” (page 301)

Barriers to family involvement: Isolation

Some respondents reported that isolation was a barrier to involving their family in treatment for harmful gambling (for example, when families were estranged). A proportion of family members did not engage with people experiencing harmful gambling due to the emotional burden interactions could elicit. Some people noted that isolation was due to feeling shame about harmful gambling, possibly due to lack of understanding about the disorder.

“I resented coming here [treatment centre]. Nothing against anybody here. I don’t want to be associated with this because it’s embarrassing and it’s shameful to me” (page 303)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(No discussion on how interview guide was developed or piloted, first author conducted interviews. No mention whether they were involved in treatment too.)*
Overall risk of bias and relevance	Relevance	Relevant *(Limited to gambler-affected other dyads receiving treatment at same time.)*

Lee, 2008

Bibliographic Reference	Lee, Bonnie K; Rovers, Martin; 'Bringing torn lives together again': Effects of the first Congruence Couple Therapy training application to clients in pathological gambling.; International Gambling Studies; 2008; vol. 8 (no. 1); 113-129

Study Characteristics

Study type	General qualitative inquiry (with in mixed methods study)
Country/ies where study was carried out	Canada
Setting and aim	**Setting** Within gambling treatment intervention study, investigating the effectiveness of 12-session CCT programme for people experiencing harmful gambling and their affected others. **Aim** To explore views and experiences of Congruence Couple Therapy, from the perspective of people experiencing harmful gambling, their affected significant other, and counsellors delivering the therapy.

Data collection and analysis	**Data collection** Free-text questionnaires and focus groups. Couples participating in CCT programme were asked 4 open-ended questions about their experience of the service at the end of the study period. Questions covered what they found most beneficial about the therapy, how they would describe their experience and any additional comments. Approximately 1-hour long focus groups, each with 4-5 participants, were conducted with CCT therapists. Questions covered their experiences of the CCT training, application of the therapy, participation in the study, and personal and professional growth. **Analysis** Thematic content analysis. Free-text questions were analysed qualitatively using key words and thematic categories. No details given about analysis of focus group data.
Recruitment strategy	Convenience sampling. After attending a 4-day CCT workshop, 19 CCT trainee therapists each recruited 24 couples currently undergoing CCT at their respective clinics.
Study dates	Not reported.
Sources of funding	Unclear funding source (funded by Ontario Problem Gambling Research Centre)
Inclusion criteria	Participating couples had to: • Intend on continuing in their relationships after treatment • Have 1 member experiencing pathological gambling as defined by DSM-IV criteria
Exclusion criteria	• Presence of intimate partner violence in relationship

Sample size	N=69 counsellors, people experiencing harmful gambling and their affected others participants in CCT intervention study
	
	• CCT counsellors: n=21
	• Gambler-affected other dyads:
	  ○ People experiencing harmful gambling: n=24
	  ○ Affected others: n=24

Participant characteristics	Age in years [Mean (SD)]:

	• CCT counsellors: Not reported. • People experiencing harmful gambling: Not reported beyond '76% above 40 years old'. • Affected others: Not reported. Sex (n): • CCT counsellors: Not reported. • People experiencing harmful gambling: M=18, F=6 • Affected others: Not reported. Gambling symptom severity scale and score [Mean (SD)]: • CCT counsellors: Not applicable. • People experiencing harmful gambling: G-SAS, 15.87 (10.20)* ○ Scale 0-48, lower is better. • Affected others: Not applicable. *Data only available for 16 participants
Results	**Author's themes** • Counsellor's attributes: Impact on gambler • Counsellor's attributes: Impact on spouse • CCT structure and process: Impact on gambler • CCT structure and process: Impact on spouse • Couple communication • Counsellors' assessment of CCT: CCT structure • Counsellors' assessment of CCT: CCT process **Study findings** *Counsellor's attributes: Impact on gambler* People experiencing harmful gambling reported that counsellors were patient, understanding, non-judgemental and neutral.

	No first-order quotes provided for this theme. *Counsellor's attributes: Impact on spouse* Spouses of people experiencing harmful gambling reported that counsellors were perceptive, respectful, compassionate, and providing good analysis. No quotes provided for this theme *CCT structure and process: Impact on gambler* People experiencing harmful gambling reported that the intervention allowed them to set achievable goals as a couple, as well as being honest, helpful and free of charge. No first-order quotes provided for this theme. *CCT structure and process: Impact on spouse* Spouses of people experiencing harmful gambling reported that the intervention allowed them to communicate throughout, revisit their goals, as well as being open and calming. No first-order quotes provided for this theme. *Couple communication* Counsellors reported that the intervention allowed couples to work on their communication, working towards open language and congruent communication. "... and she's even recognizing where she'll say something and as soon as it's out of her mouth she'll say —wait a minute, I need to rephrase that" (page 11) *Counsellors' assessment of CCT: CCT structure*

	Counsellors reported that the intervention was structured but provided a degree of flexibility around their own clinical judgement and experience. "It's focused and it's ... specific. You can go and use different tools and you don't have to use all the tools and interventions in the model because you can pick and choose what might be most appropriate. But it is very focused and on track." (page 12) *Counsellors' assessment of CCT: CCT process* Counsellors reported that the intervention did not just focus on gambling behaviour and allowed them to relate this back to interpersonal relationships. "it's allowed people to go a little deeper and look at what's going on in their relationship patterns ... that correlate with their gambling" (page 12)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Poor description of data collection and analysis. Lack of information on ethical consideration. Discussion of qualitative results is brief.)*
Overall risk of bias and relevance	Relevance	Relevant *(Qualitative component within parent experimental study.)*

Marionneau, 2021

Bibliographic Reference	Marionneau, V.; Jarvinen-Tassopoulos, J.; Treatment and help services for gambling during COVID-19: Experiences of gamblers and their concerned significant others; NAD Nordic Studies on Alcohol and Drugs; 2021

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Finland
Setting and aim	**Setting** Within gambling treatment services, independent online questionnaires conducted by University of Helsinki, SOSPED Foundation and Finnish Association for Substance Abuse Prevention. **Aim** To explore the experiences and views of help-seeking and treatment for harmful gambling during the COVID-19 pandemic, from the perspective of people experiencing harmful gambling and their affected others.
Data collection and analysis	**Data collection** Free-text questions. 3 separate online questionnaires, including free-text questions, were devised and results pooled for the final sample. Questions centred around perceptions of harmful gambling treatment services. **Analysis** Thematic content analysis. The responses were read and re-read before initial codes were developed and themes were refined.
Recruitment strategy	Questionnaires were distributed using a variety of online methods (including social media, online communities and forums, the websites of relevant treatment and help-seeking services, and newsletters. Direct invitations were also sent to clients of relevant treatment and help-seeking services. 2 of the 3 questionnaires were also distributed via telephone helplines.
Study dates	April - June 2020
Sources of funding	Unclear funding source (grant from Academy of Finland and Finnish Ministry of Social Affairs and Health) Note: Ministry of Social Affairs and Health issue funds under section 52 of the ‘Lotteries Act’.
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.

Sample size	N=847 people experiencing harmful gambling and, or affected others • People experiencing harmful gambling: n=688 • Affected others: n=97 • Both: n=62
Participant characteristics	Age in years [Mean (SD)]: Not reported, age categories (n)*: • 15-24: 69 • 25-34: 88 • 35-49: 205 • 50-64: 143 • 65-74: 64 • Not reported: 270 Sex (n)*: M=282, F=278, unknown=278 Gambling symptom severity scale and score: • People experiencing harmful gambling: Not reported. • Affected others: Not applicable. • Both: Not reported *Reported as per study but adds up to 839.
Results	**Author's themes** • Changed needs for treatment or help services during the COVID-19 lockdown • Impacts of service closures and the transfer of services online • Suggestions for improving existing help services during and after COVID-19 **Study findings** *Changed needs for treatment or help services during the COVID-19 lockdown*

	Total gambling consumption decreased during COVID-19 lockdown, although online gambling levels were maintained and even increased in some instances. This was followed by decreased need for harmful gambling help services during spring 2020, for both people experiencing harmful gambling and affected others. Electronic gaming machine closures were seen as a good thing, particularly for people experiencing harmful gambling prior to COVID-19. Future goals included services acting to maintain the further the positive effect of gambling venue closures, as well as manage the potential shift to online gambling. "It would be good to have widely available distance support right not. Now many have almost a mandatory opportunity to wean off gambling, and correctly aimed support might be crucial to also not gamble in the future." (page 15) *Impacts of service closures and the transfer of services online* People who had their regular harmful gambling services discontinued during lockdown, and their affected others, were concerned over how the cessation of treatment and support would affect them. Some reported experiencing increased harms and noted that support was weak during this period. Other people did not have their treatment and support services stopped, but they were moved online. Not all participants felt as though this was a good change, although they did note that virtual delivery allowed more consistent support by expanding available formats (for example, WhatsApp or email). "My support group has become a video conference. It's a bit different than meeting face-to-face, but it is slowly starting to take form. I'm grateful that we can meet at distance and [the group has] not been obliged to close." (page 16) *Suggestions for improving existing help services during and after COVID-19* Participants suggested both COVID-specific and long-term changes for harmful gambling services: additional online tools (for example, regular support messaging); increase the accessibility and visibility of services (for example, increasing their social media presence); keeping low-threshold services that were developed during the pandemic (for example, online interventions, online peer support); professionals to be more proactive in discussing harmful gambling; integrating treatment for harmful gambling in health and social care agenda in order to identify and start treatment earlier; psychological support for harmful gambling; and regular contact with either treatment professionals, peer support groups or support person contacts, and debt management professionals. However, some respondents noted that they were happy with current harmful gambling services. "'Integration of gambling addiction support in occupational healthcare" (page 16)

	"[What would be needed is] that after this lockdown different cities would have more peer support groups, and that gambling problems in general would be discussed more and more openly, and more support services would be available. For example, one-on-one chats with a recovered problem gambler would in my situation be more than necessary and a great thing if these could be organised. I wish for more resources in the treatment of gambling problems in all of Finland (and that all those who are willing would be accommodated in peer-support groups and other kind of help in this sector)." (page 17)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(No inclusion criteria and gambling involvement not reported, lack of information on data analysis.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Experiences and views of specific time and event [COVID-19].)*

Nilsson, 2021

Bibliographic Reference	Nilsson, A.; Simonsson, O.; Hellner, C. (2021) Reasons for dropping out of internet-based problem gambling treatment, and the process of recovery – a qualitative assessment. Current Psychology

Study Characteristics

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

	Within gambling treatment intervention, 1-2 years after completion of an experimental study investigating the effectiveness of an internet-based gambling treatment. **Aim** To explore the experiences and views of harmful gambling treatment and reasons for drop-out, from the perspective of people experiencing harmful gambling and their affected significant other.
Data collection and analysis	**Data collection** Semi-structured interviews. 10-25-minute semi-structured telephone interviews. Interview guide was developed by 2 of the authors, although not all questions were asked to all participants (for example, some were aims specifically at affected others) and questions revolved around experiences of the content and online delivery of treatment, participating in treatment as a couple, reasons for dropping out of the study, support for people experiencing harmful gambling and whether participants had tried any other treatments since leaving the programme. **Analysis** Thematic analysis. Interviews were audio recorded and transcribed by the first author. Some parts of the interviews were not transcribed (for example, small talk not related to a posed questions). 2 authors independently coded 3 transcripts to create initial codes, and then a 4th was coded together to create a common code template. This template was applied to the remaining transcripts by the first author, before coalescing codes into possible themes and sub-themes, separated by people participating in harmful gambling and affected others. Throughout this stage, researchers met regularly to discuss their interpretation. Data from people participating in harmful gambling and affected others were then re-grouped and organised according to what research question they mainly addressed before final themes were defined.
Recruitment strategy	Purposive sampling. Participants recruited from people who had dropped out of experimental study for an online CBT therapy were followed-up with information about the study. Interested participants were then contacted to schedule interviews.
Study dates	January - May 2019
Sources of funding	Any industry funding (funded by Karolinska Institute and Svenska Spel's Independent Research Council) Note: Svenska Spel is the state-organized gambling provider in Sweden
Inclusion criteria	Participants had to:

	• Have participated in RCT on involving affected others in internet-based CBT programme for harmful gambling, and subsequently dropped-out of treatment. Inclusion criteria for RCT dyads was:
	  ○ 1 member of the dyad currently experiencing gambling problems as defined by PGSI criteria
	  ○ The other member was a friend, sibling, child or partner of the person experiencing harmful gambling
	  ○ Know each other for ≥3 months
	  ○ Be ≥18 years old
	  ○ Live in Sweden
	  ○ Be able to read and converse in Swedish
	  ○ No psychiatric co-morbidities that require additional treatment

Exclusion criteria	Not reported.
Sample size	N=16 people experiencing harmful gambling and their affected others who participated in internet-based harmful gambling intervention study • People experiencing harmful gambling: n=8 • Affected others: n=8
Participant characteristics	Age in years [Mean (SD)]: Not reported, age range: • People experiencing harmful gambling: 23-58 • Affected others: 30-63 Sex (n): • People experiencing harmful gambling: M=6, F=2 • Affected others: M=2, F=6 Gambling symptom severity scale and score [Mean (SD)]: • People experiencing harmful gambling: PGSI, 19.93 (5.57) ○ Scale 0-27, lower is better • Affected others: Not applicable.

Results	**Author's themes** • Content and format of treatment • The key of openness and support **Study findings** *Content and format of treatment* Some respondents noted several benefits of online treatment formats, including decreasing physical and psychological barriers to initiating treatment. People noted that it could be seen as the first step, when accessing face-to-face treatment formats was too scary. However, it was noted that the reduced barriers to accessing services also could lead to less engagement and adherence to treatment. Other participants were less confident in the efficacy of online treatment compared to face-to-face treatments. Not many participants reported a preference for specific treatment components (for example, cognitive restructuring, exposure therapy or communication training). "I think that, for the part of my boyfriend, he probably couldn't have taken a step as big as actually talking to someone in flesh and blood. So, it was kind of, at least for him, a smaller step to take [enrolling in the RCT] than to seek ordinary care." (page 6) "That it could be this simple and easy! I was very shameful, and to not go out and say…because I wasn't ready to seek any other treatment at that point. It helped me a lot to gain insight and that I got some support. It was a relief, otherwise I don't know what would have happened." (page 6) *The key of openness and support* Both people experiencing harmful gambling and affected others highlighted the important of openness within recovery, as is encourages honesty with oneself and affected others. In turn, this can lead to an increased understanding of a person's gambling behaviour and it's consequences. People experiencing harmful gambling mentioned that support is needed from a variety of sources, including friends, families, treatment professionals and peers. Peer support was identified as being particularly important during recovery, as it provided examples of people who had been through the same experiences and circumstances.

	"You need someone with some experience of what can happen and so on. You probably don't need that much support from someone who's never gambled. But (you need support from) someone who's had a rough time, and who got back up again, and who's fought, and who knows that gambling is a dead end." (page 7)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Large proportion of dropouts not contactable, telephone interviews.)*
Overall risk of bias and relevance	Relevance	Relevant *(Qualitative component within parent experimental study.)*

Penfold, 2021

Bibliographic Reference	Penfold, Katy L; Ogden, Jane; Exploring the experience of Gamblers Anonymous meetings during COVID-19: a qualitative study.; Current psychology (New Brunswick, N.J.); 2021; 1-14

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting and aim	**Setting** In the community, Gambler's Anonymous support groups **Aim**

	To explores the views and experiences of people attending Gambler's Anonymous meetings throughout the COVID-19 pandemic.
Data collection and analysis	**Data collection** Semi-structured interviews. 30–80-minute telephone or video interviews using open-ended questions revolving around participants' experiences with Gambler's Anonymous, experience with online meetings, and how they differ. **Analysis** Thematic analysis. Interviews were audio recorded and transcribed verbatim. Transcripts were analysed in 6-stage process: familiarisation with data, identification of initial themes and emerging themes, developing themes, and refining and describing final themes.
Recruitment strategy	Purposive sampling. Gambler's Anonymous listed on the Gambler's Anonymous website throughout the UK were contacted with details about the study and invited to take part.
Study dates	Not reported but during COVID-19 pandemic.
Sources of funding	Unclear funding source (funding not reported)
Inclusion criteria	Participants had to: • Be aged 18 years or older • Be a current active member of Gambler's Anonymous UK • Have experience of Gambler's Anonymous UK meetings during COVID-19 lockdown • Be able to speak and understand English
Exclusion criteria	Not reported.
Sample size	N=21 active members of Gambler's Anonymous UK
Participant characteristics	Age in years: Not reported. Sex (n): M=18, F=3 Gambling symptom severity scale and score: Not reported.
Results	**Author's themes**

- Practicalities of GA in lockdown: Opportunity
- Practicalities of GA in lockdown: Novelty and variety
- Practicalities of GA in lockdown: Zoom fatigue
- The importance of relationships within GA: Social comparison
- The importance of relationships within GA: Solidarity
- The importance of relationships within GA: Disconnection
- Therapeutic elements of the meetings: Contract making and maintaining
- Therapeutic elements of the meetings: Dropout rates and refusal to engage
- Therapeutic elements of the meetings: Reduced investment

Study findings

Practicalities of GA in lockdown: Opportunity

Participants reported several benefits to attending online meetings, with the most common being no geographical barriers to attendance. Transitioning to online meeting gave people much more choice about what type of meetings to attend (for example, 12-step meetings), where they were located (for example, nationally or internationally), and how many meetings to attend.

"...the only reason I've changed this time is because I've gone onto the steps meeting on Zoom. If I'm honest, and that's what the GA programme is all about, and that's the message I'm hearing on the Zoom meeting is…get on the Steps meetings. Get on the steps." (page 5)

Practicalities of GA in lockdown: Novelty and variety

Another reported benefit of online meetings was novelty and variety. Reduced geographical barriers meant that meetings could involve people from across the world, which was more enjoyable for some participants. It was postulated that this sense of novelty could encourage new people to attend meetings, increasing the amount of experience and support in the groups.

"… I can't just get on a plane and go "right, I'm off to GA in LA today". So, that's opened new doors and it all helps to recovery because you get that many different perspectives if you speak to people from similar situations but with their own story and it's all useful." (page 6)

Practicalities of GA in lockdown: Zoom fatigue

Participants reported experiencing Zoom fatigue due to the increased amount of time spent in front of the screen during lockdown. This fatigue led to people feeling apathetic and demotivated during their online group meetings, despite the reduced physical barriers that a virtual format allows. However, this was not enough of a reason to not attend, with respondents noting that online meetings were better than nothing.

"it's easier to actually attend because you don't have to go anywhere but at the same time, if you've been sat at a desk or a makeshift desk and on Zoom meetings all day and you're a bit frazzled then I can understand why at 8 o'clock at night the last thing you really want to be doing is getting on another Zoom meeting." (page 6)

The importance of relationships within GA: Social comparison

Participants used social comparison during the meetings, listening to other people's negative experiences can remind people of how far they have come, reinforcing their desire to continue treatment and attending meetings. Social comparison can also have a positive impact, allow people to find inspiration in recovery stories. Meetings also provide a sense of community and support, which is paramount to recovery.

"What I like about GA is when the new members turn up and you hear their horror stories, and then that makes it really kind-of raw and brings back the memories … that's what it was that always worked for me. Hearing – I don't want to be there – and it reminds me if I take my eye off the ball that's exactly where I'm going to be." (page 6)

The importance of relationships within GA: Solidarity

Solidarity within peer support groups allow the creation and strengthening of social support networks, with participants describing the meeting as a team with common goals. This, together with lower levels of judgement, can forge strong social relationships. However, moving meetings online has impacted this team either directly (for example, physically not being in the same room) or indirectly (for example, because not all people chose to attend the virtual meetings). Trust in people who had decided not to attend online was severely impacted, with people still attending feeling as though they should no longer be included in this community.

"As a team on a Sunday evening we all have each other's backs, and we all understand what's required of the meeting, everybody just has the ability to listen without having a self-opinionated point because everybody just wants everybody to stop gambling." (page 7)

	The importance of relationships within GA: Disconnection People reported that online meetings were not able to foster the same emotional connections experienced with face-to-face meetings. Although they were not able to explain why this was, it could be due to a lack of physical presence or poorly conveyed non-verbal communication. This disconnect negatively affected how satisfied people were with meetings. "…there is a lack of, sort-of, humanity is not the right word for it, but the fact that you're sat looking at a screen or listening to other people rather than sitting in a room with other people…there's something that's a bit…dehumanizing about that." (page 8) *Therapeutic elements of the meetings: Contract making and maintaining* Participants reported using meeting attendance as a behavioural contract strategy, with the goal being abstinence from gambling and the reward being social affirmation. People reported that continued meeting attendance was the key to continued recovery. When these meetings were force to stop at the beginning of COVID-19, attendees were worried that it would affect their recovery. Online meetings help to allay this fear in the people who decided to attend, although not everyone made the change. This causes people to be fearful of relapse in their friends who did not attend online meetings, as they were no longer completing their behavioural contract. "…when suddenly all the meetings shut in March, I was quite worried about what are we going to do? How are we going to get our medicine? Fortunately, you know, after a week…a couple of weeks, these Zoom meetings started popping up and then it sort-of took off. So, that was a big relief for me because, you know, going 3, 6 months without a meeting could be very dangerous…" (page 8) *Therapeutic elements of the meetings: Dropout rates and refusal to engage* Moving meetings online results in a large initial drop in attendance, with some people not engaging with the new format. This was true even with well-established members. "I would say that there is…erm…75% of the members that go on Wednesday I've never seen online – 3 quarters. And that's since March." (page 9) *Therapeutic elements of the meetings: Reduced investment*

	Participants reflected that they were more likely to become distracted in online meetings, which negatively impacted how engaged they were. The lines between life areas blurred, meaning people did not devote a particular allotted time slot to meetings (for example, joining meetings when completing chores). People are less likely to walk out of face-to-face meetings, but it is easier to turn off a camera. "…it's definitely easier to tap out of it because if you don't like what you see you can just close the screen on your computer, can't you. Whereas the physical meeting, it's a real life-changing moment for people, to come through those doors and sit down and say out loud I've got a problem" (page 9)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Lack of information on data collection and analysis methods, lack of information on researcher impact.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Experiences and views of specific time and event [COVID-19].)*

Pickering, 2019a

Bibliographic Reference	Pickering, D.; Spoelma, M.J.; Dawczyk, A.; Gainsbury, S.M.; Blaszczynski, A.; What does it mean to recover from a gambling disorder? Perspectives of gambling help service users; Addiction Research and Theory; 2019

Study Characteristics

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

Setting and aim	**Setting** Within the community and gambling treatment services, self-exclusion programme (from ClubsNSW [a representative body for not-for-profit social venues containing gambling machines and services]) and gambling counselling services. **Aim** To explore how people experiencing harmful gambling conceptualize and define recovery.
Data collection and analysis	**Data collection** Semi-structured interviews. Face-to-face (n=25), telephone (n=6) and virtual (n=1) semi-structured interviews lasting an average of 44-minutes. Questions revolved around how participants defined recovery in their own words, how if impacts different areas of their life, the role of abstinence in recovery, and barriers and facilitators to recovering from harmful gambling. Additional field notes were taken by the researcher to aid analysis. **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, including use of the field notes taken during interviews. The same 2 authors independently applied these descriptive codes to the remaining data, before discussing and rearranging the codes into themes and sub-themes which were continuously cross-referenced with the original data to ensure that no meaning was lost or mis-interpreted. Lastly, a theme maps was devised and representative quotes selected.
Recruitment strategy	Purposive sampling. 20 participants were recruited from a multi-venue self-exclusion programme who had previously consented to be contacted for future research opportunities. A further 12 participants were recruited from a gambling counselling service by service centre staff.
Study dates	April 2016 - June 2017
Sources of funding	Unclear funding source (funded by ClubsNSW (New South Wales), University of Sydney postgraduate research funding, and Australian Research Council Discovery Early Career Research Award)
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=32 people in a self-exclusion programme and gambling counselling services.

Participant characteristics	Age in years [Mean (SD)]: 43.59(11.51) Sex (n): M=20, F=12 Gambling symptom severity scale and score [Mean (SD)]: Not reported, PGSI categories (n [%]): • Non-problem gamblers: 2 (6.3) • Moderate risk gamblers: 2 (6.3) • Problem gamblers: 28 (87.4)
Results	**Author's themes** • Insight • Sense of agency - Personal empowerment • Managing gambling urges **Study findings** *Insight* Participants highlighted a deeper understanding of their harmful gambling as an important aspect of their recovery journey, with the initial step being admitting the existence of an issue. This insight needs to extend past the individual, into the impact on affected others and a wider environment. This self-reflection should continue throughout a person's recovery journey consistently comparing one's current self to their previous selves. Insight also should be directed towards triggers, identifying whether they are emotional (for example, depression anxiety, stress, frustration, issues at work) or environmental (for example, walking past an electronic gaming machine in daily life). By identifying their triggers, participants were able to avoid high-risk situations and therefore manage their urges. All interviewees mentioned relapse as a fear. While some noted that the spectre of long-term abstinence negatively impacted their motivation to recover, others reflected that acceptance of this possibility as a normal part of the recovery process strengthened their commitment to treatment. Counselling also allowed people to identify erroneous gambling cognitions (for example, believing certain gambling formats are more likely to have large wins, remembering wins rather than losses, and favouring short-term thoughts) and correct these mistaken beliefs.

	"'You'll have your weak days and strong days, but what you have to remember about your weak days is you'll come through it. And even if you do lapse, it's hard to come to terms with, but don't lose faith." (page 16) · "I had some misconceived ideas… when I actually went through the course, [I] realized the way I was thinking about it, was totally the wrong way to go about [it]… we [counselor and participant] addressed some issues and certain things that I was accepting as basic truths. It really sort of just dispelled it, it was like a web that I was trapped in." (page 17) *Sense of agency - Personal empowerment* The majority of people framed themselves as active participants in their gambling behaviour and treatment process, with a need to take responsibility for harmful gambling. This led to empowerment and greater self-assurance, particularly when making positive changes. Increased self-efficacy also encouraged people to engage in self-help activities and active information seeking, allowing more informed decisions in their recovery. "Actually owning it… you can't really blame anyone else… for what I am doing myself. I am the one putting money through these machines… So, not being in denial, that yes, I do have a problem and, you know, I am seeking the help." (page 17) "So that was where educating myself and learning… gave me knowledge, and the ability to empower myself… this allows me to think about things in a different way and acquire the tools to overcome this." (page 18) *Managing gambling urges* The majority of interviewees reported the need to overcome gambling urges throughout recovery (either after coming into contact with a trigger or unprompted) but had differing goals on dealing with cravings. Some people wanted to eradicate them completely, while others thought that this was unrealistic and wished to concentrate on managing urges. Counselling was identified as an important tool to develop these proactive management strategies, but it was noted that there is a difficulty with transferring techniques from a clinical to a real-world environment. Meditation, exercise, support groups, and shifting attention to different tasks were also identified as helpful strategies. "The urges are still going to be there no matter what and it's just I'm conscious of it and managing it." (page 20)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Lack of information on how interview guide was developed, focuses on recovery as a concept rather than service improvements.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Pickering, 2019b

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, self-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	Unclear funding source (funded by ClubsNSW (New South Wales), University of Sydney postgraduate research funding, and Australian Research Council Discovery Early Career Research Award)
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=20 people 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, 90% classified as experiencing harmful gambling in previous 12 months*

	*No details given on how this was measured
Results	**Author's themes** • Registration • Self-registration • Additional help • Revocation and renewal **Study findings** *Registration* Some interviewees reported that the sign-up procedure were too complex and time-consuming. There was agreement that people should be able to self-exclude from multiple venues, and that the maximum limit applied (35 different venues) was still too low. Additional suggestions were the ability to self-exclude across different geographical areas and longer exclusion periods. People had different experiences of gambling venue staff during the self-exclusion registration. Some felt disrespected will others felt as though staff were professional and empathetic. Therefore, staff training in this area was encouraged. People who self-excluded with a counsellor reported counsellors were helpful in recommending certain programmes, providing pertinent information, and assisting with the registration paperwork. "Have a person with compassion, who doesn't treat you like an imbecile and lecture you, somebody who is trained to deal with people with addiction problems. They need to educate staff to know how to handle it. It's just about respecting that person." (page 8) *Self-registration* The majority of respondents believed that online self-exclusion registration that could be completed by the person wishing to self-exclude would be more convenient, efficient, and confidential. It would also increase their sense of self-efficacy. However, there were a number of noted disadvantages to online self-registration: people not being technologically literate to accurately complete the registration; people not being aware of the legal complexities of the process; impulsive exclusions leading to poorer commitment to the intervention; people excluding for other people without consent; and missed opportunities for counselling.

	"A lot of people may not be technically savvy enough to do that, and for me there was a lot of technicalities and legalities that I didn't necessarily understand." (page 8) *Additional help* Two other interventions were identified as being effective in conjunction with self-exclusion: face-to-face counselling and 24-hour remote support services (either telephone or internet). This is because self-exclusion was not seen as effective to treat the underlying psychological problems that accompany harmful gambling. As a way of providing immediate psychological help to people experiencing harmful gambling, counselling services located within gambling venues were suggested. "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* There were mixed opinions on early withdrawal from the self-exclusion programme. Some participants felt as though it should not be allowed as self-exclusions are legal contracts that should be binding, and having the ability to withdrawal at any time decreases the engagement with the intervention. However, other participants believe that withdrawal should remain at the discretion of the self-excluder and should not need the agreement of a counsellor. A majority of interviewees suggested that there should be some type of notification before the current agreement ends, including instructions on how to renew the self-exclusion contract. Other suggestions were that renewal should be the default option that people need to expressly opt out of to end their self-exclusion, there should be a mandatory in-person counselling session prior to end of every self-exclusion period (even if people decide to renew), and a brief probationary period of supervised motoring from gambling venues after self-exclusion for gambling. "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 *(Evidence restricted to self-exclusion programmes for land-based gambling.)*

Piquette, 2013

Bibliographic Reference	Piquette, Noella; Norman, Erika; An all-female problem-gambling counseling treatment: Perceptions of effectiveness.; Journal of Groups in Addiction & Recovery; 2013; vol. 8 (no. 1); 51-75

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting and aim	**Setting** Within addiction treatment services, a provincially run urban health agency with a mandate to serve people with addictions (drugs, alcohol, or gambling). Services include assessment, treatment, referrals, and counselling. **Aim** To explore the views and experiences of women experiencing harmful gambling with a gender-specific group counselling programme.
Data collection and analysis	**Data collection**

	Semi-structured interviews and focus groups. Semi-structured telephone interviews focused on women's views of their women-only group therapy sessions, specifically what they considered to be beneficial and effective about the format. Face-to-face focus groups involved research, the group facilitator/counsellor and study participants. Discussions revolved around initial themes identified from the interviews, whether participants agreed with them, and if they wished to clarify or comment further. **Analysis** Grounded theory. Semi-structured interviews and focus group were audio recorded and transcribed. Transcripts were then subjected to open coding, axial coding, and constant comparison to generate initial themes., guided by notes made by the researcher during interviews. Themes were coded by exploring common words from the interview, common quotes arranged, and themes were developed further. Semi-structured interviews were analysed before the focus group, with themes and connections discussed at the subsequent focus group.
Recruitment strategy	Purposive sampling. Participants were recruited from a 12-week female-only harmful gambling group therapy held at the study centre. After learning about the study, women were asked to contact group facilitator/counsellor if they wanted to participate.
Study dates	Not reported.
Sources of funding	Unclear funding source (funding not reported)
Inclusion criteria	Participants had to: • Be enrolled in women-only group therapy programme at the study centre
Exclusion criteria	Not reported.
Sample size	N=5 women attending single-sex group therapy for harmful gambling • Semi-structured interviews and focus group: n=4 • Focus group only: n=1
Participant characteristics	Age in years [Mean (SD)]: Not reported, age range 30-50. Sex (n): M=0, F=5.

	Gambling symptom severity scale and score [Mean (SD)]: Not reported. beyond participants all being 'unhappy' with their gambling.
Results	**Author's themes** • Relationships: What works? • Learning: Why does this work? • Facilitation: Process of how to make it work **Study findings** *Relationships: What works?* Participants reported that the positive relationships developed during women-only group sessions helped them to feel comfortable and safe in sharing their experiences. This safe feeling was attributed to shared experiences, common ground, and increased trust. The counsellor was also credited in helping to foster this accepting environment. Group sessions also helped them to accept support from others. "I feel it is a definite need in the community, whether it be our community or someone else's community, [with] the all-female group, you just feel more comfortable. You do not have to put on any airs, there are no impressions, and there is no dominance, if you will. So yeah, I think it is very beneficial." (page 61) *Learning: Why does this work?* Participants appreciated learning about relapse prevention skills, which allowed them to develop plans to avoid triggering situations or overcome these triggers. Another area of learning people were interested in was psychoeducation and the development of addiction. Listening to other women's experiences helped them to reflect on individual circumstances and gambling behaviours and reflect on their addiction. "Went through all of the various types of gamblers that there are. Um, I know for myself I could see myself in every one of the steps, into how you go from being a non- or social gambler into [being a] problem or compulsive gambler. Gosh, I can see myself. I can see this progression, learning how you become addicted to the actual gambling, because for myself, I never thought of it as an addiction. I thought, 'I am a smoker or addicted to smoking.' That I understand" (page 63) "She (the counselor) . . . took us through the exercise on how to bring yourself back down and to . . . ask what can I do for myself right now? And basically sit down and take a couple of deep breaths and go through the exercises, strictly mental

	exercises and envisioning things and how you can bring yourself down, to get as far down on the negative side as you can. And it works." (page 63) *Facilitation: Process of how to make it work* Participants noted that the group counsellor is paramount to the success of the group sessions. They help to create a safe environment, introduce learning techniques and skills, and facilitate group conversations. Ideally, they should probe people's views, be supportive, encourage collaboration, and be an active participant. While people were willing to participate in a mixed-gender group, they stressed that the group leader would have to make sure male voices did not overpower female voices. "[The facilitator] is fabulous with getting people to open up. She has got just a tremendous, tremendous way about her. She seems to have the ability. She is soft spoken and what have you, and she does not judge. She is involved herself in that, after we have our break, we all have to with a couple of words describe how we are feeling . . . after we have gone through it, then she also gives us what she is feeling at that point. So she totally participates with us, so she is not just being a teacher, she is an active participant with us. I am really sad that the group only goes for 12 weeks. You know, I would definitely like to see it go longer." (page 65)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Lack of information on data collection and analysis methods, lack of information on researcher impact, brief description of ethical considerations.)*
Overall risk of bias and relevance	Relevance	Relevant *(Very small sample but focusing on under-represented group.)*

Piquette-Tomei, 2008

Bibliographic Reference	Piquette-Tomei, Noella; Norman, Erika; Dwyer, Sonya Corbin; McCaslin, Evelyn; Group therapy for women problem gamblers: A space of their own.; Journal of Gambling Issues; 2008; vol. 22; 275-296

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Canada
Setting and aim	**Setting** Within addiction treatment services, a provincially run urban health agency with a mandate to serve people with addictions (drugs, alcohol, or gambling). Services include assessment, treatment, referrals, and counselling. **Aim** To explore the views and experiences of women experiencing harmful gambling with a gender-specific group counselling programme.
Data collection and analysis	**Data collection** Semi-structured interviews and focus groups. 3 x approximately 1-hour semi-structured interviews carried out per participant (at the beginning of the study, at 3-months, and at 6-months [end of the study]). Questions focused on what made women decide to attend a single-gender group therapy, what they considered to be beneficial and effective about the format, and what improvements could be made. Focus groups involved a researcher, the group facilitator/counsellor and study participants. Discussions revolved around initial themes identified from the interviews, whether participants agreed with them, and if they wished to clarify or comment further. **Analysis** Grounded theory. Semi-structured interviews and focus group were audio recorded and transcribed. Transcripts were then subjected to open coding, axial coding, and constant comparison to generate initial themes., guided by notes made by the researcher during interviews. Themes were coded by exploring common words from the interview, common quotes arranged and themes were developed further. Semi-structured interviews were analysed before the focus group, with themes and connections discussed at the subsequent focus group.

Recruitment strategy	Purposive sampling. Participants were recruited from a female-only harmful gambling group therapy held at the study centre.
Study dates	Not reported.
Sources of funding	No industry funding (funded by Alberta Gaming Research Institute)
Inclusion criteria	Participants had to: • Be enrolled in women-only group therapy programme at the study centre
Exclusion criteria	Not reported.
Sample size	N=14 women attending single-sex group therapy for harmful gambling
Participant characteristics	Age in years [Mean (SD)]: 46.5 (SD not reported). Sex (n): M=0, F=14. Gambling symptom severity scale and score [Mean (SD)]: Not reported beyond inclusion criteria of SOGS score equal to or above 5.
Results	**Author's themes** • Accessibility and nourishment • A safe space that provides acceptance • All women of various ages • Therapy format **Study findings** *Accessibility and nourishment* Participants reported that they wanted to part of a group that was flexible and understanding around their busy lives and multiple responsibilities (for example, groups in the evenings allowed women to attend after work). While some people wanted specific a start time and duration for sessions, others wanted a more flexible format to allow for longer

conversations if needed. Most respondents noted that refreshments were helpful to help create a comfortable environment conducive to sharing stories.

“Having coffee and cookies makes me feel that we are relaxed and can talk about things. Sometimes I don't want any but others enjoy it and they can fuss around the table, getting their food and talking about how their week went. … when there is food is feels like we belong together.” (page 281)

A safe space that provides acceptance

All respondents felt that the most important facilitator of group counselling sessions was creating a safe space to discuss very personal issues and share their stories. This should be both physically (for example, a closed room for provide confidentiality from non-participants) and emotionally. It was important for women to feel accepted in the group environment, and sharing experiences helped them to accept themselves (for example, normalising relapse), start to understand their gambling behaviour, and learn techniques to prevent relapse. Most women highlighted acceptance as the main reason they attended group sessions, as well as the group facilitator’s ability to facilitate a safe space.

“Well one thing that is a definite benefit is that somebody else is there; other people there have failed. When I failed before, I spiralled into a severe depression … it gives me permission to be human and make a mistake without thinking I have to die for it. So it helps to hear other women say, "I screwed up once and went and gambled so huge." It is normalizing that you are not the only one who is struggling with addiction and has been able to come back.” (page282)

“When I go to group … I realize there are other people that have just as large problem[s] as I did and that is helpful to me because I realize that I am not alone. There are other people out there that have it just as bad as I do and that is effective to me.” (page 282)

All women of various ages

All interviewees reported that they felt most comfortable in all-female environment and would prefer gender-specific groups compared to mixed-gender groups. They felt more confident to talk about their problems (gambling and non-gambling), and believed that they might be experiencing different issues compared to male gamblers. Having a variety of ages in the group was also noted as a benefit to this group, allowing people to see harmful gambling affects older and younger people alike.

“I would not be able to say what I wanted to say [with men in the group] … that is why I go to the all-women group — it helps.” (page 284)

	"With just the women's group it is more intimate — there is nothing really that cannot be said. With the men it is more reserved. The honesty is there about the gambling but there is more than that in this group." (page 285) *Therapy format* Women reported several negative experiences that they had experienced in alternative therapy settings and were keen that more people should have access to an all-woman harmful gambling counselling group. A few made suggestions for improvements to the format, including guest speaks, psychoeducational presentations, watching videos followed by a discussion, and topic nights. Journaling was also noted as a beneficial addition to counselling sessions, as it helped to reinforce what they learned with their group. "I think it would be helpful. Once there was a man who spoke about AA. It was so powerful to learn about another addiction. It is so powerful for people to tell their stories." (page 285) "It has been good because you ask some very poignant questions and they make me think about things that I have not really thought about or reflected on in depth. It is weekly homework that forces one to document feelings, behaviours, and accountability." (page 286) "'We need more counsellors. I wish they [the government] would spend more of their money on getting more counsellors because this is not going to stop on its own. I do not know how they expect to work with all of the gambling addictions with the few counsellors that we have." (page 287)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Lack of information on data collection and researcher impact, no discussion of limitations.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Riley, 2018

Bibliographic Reference	Riley, Ben J; Orlowski, Simone; Smith, David; Baigent, Michael; Battersby, Malcolm; Lawn, Sharon; Understanding the business versus care paradox in gambling venues: a qualitative study of the perspectives from gamblers, venue staff and counsellors.; Harm reduction journal; 2018; vol. 15 (no. 1); 49

Study Characteristics

Study type	Phenomenological
Country/ies where study was carried out	Australia
Setting and aim	**Setting** In the community. **Aim** To explore the views and experiences of help-seeking, identification and response measures to harmful gambling within gambling venues from the perspective of people experiencing harmful gambling, people involved in treatment of harmful gambling and venue staff.
Data collection and analysis	**Data collection** Semi-structured interviews and focus groups. 4 x focus groups conducted with 1. People experiencing harmful gambling in active treatment, 2. People working in land-based gambling venues, 3. Consumer advocates with a history of harmful gambling, and 4. Counsellors from harmful gambling treatment services. 1 researcher ran the discussion and anther recorded the answers along with detailed observational notes (including behavioural cues). Semi-structured interviews were then conducted with 2 additional groups: Aboriginal and/or Torres Strait Islander individuals impacted by harmful gambling and people experiencing harmful gambling attending harmful gambling counselling.

	Questions for focus groups and semi-structured interviews were targeted depending on which participants were being interviewed. Questions centred around experiences with general help seeking for harmful gambling, help seeking resources in gambling venues, and interactions between people experiencing harmful gambling and gambling venue staff. Data from focus groups was analysed before conducting any subsequent focus groups, with emerging themes used refine and expand the focus group interview guide. Additionally, debriefing sessions between 2 researchers involved in focus groups were held after each one and notes from these sessions were included in the analysis. Groups for interviews were also chosen based on themes identified from focus group data analysis, to be able to explore these emerging themes in greater detail. **Analysis** Interpretative phenomenological analysis. Focus groups were audio-recorded and transcribed, along with the observational notes taken by 2nd researcher and recorded post-session debriefing notes. Transcripts were checked for accuracy by 2 researchers. Coding took place using qualitative software. Initially, 2 researchers independently familiarised themselves with the focus group data (both records and transcribed), identifying emerging themes. These were them compared between the 2 researchers, further refining themes which were then applied to the semi-structure interview data. After thematic coding, all transcripts were phenomenologically coded and phenomenological clusters developed. Observational and debriefing notes were included in the analysis at this stage. Finally, themes were interpreted within context of the study.
Recruitment strategy	Mixed purposive sampling (maximum variation sampling, expert, and homogenous). • People experiencing harmful gambling in active treatment: Maximum variation sampling. People meeting the inclusion criteria and currently attending 2 local gambling treatment services were contacted by staff at the respective centre and invited to participate in the study. • People working in land-based gambling venues: Expert sampling. Invited to participate by a member of Australian Hotels Association in order to recruit professionals in gambling venues that had experience with assisting potential harmful gamblers (usually venue managers). • Consumer advocates with a history of harmful gambling: Expert sampling. Recruited from local consumer advocate group in order to ensure a good knowledge of local gaming rooms policies and procedures. • Counsellors from harmful gambling treatment services: Maximum variation sampling. Invited to participate by managers of 6 different gambling treatment services. • Aboriginal and/or Torres Strait Islander individuals impacted by harmful gambling: Maximum variation and homogenous sampling. People meeting inclusion criteria and attending 2 local gambling treatment services invited to participate by counsellors.

	• People experiencing harmful gambling attending harmful gambling counselling: Maximum variation and homogenous sampling. People meeting inclusion criteria and attending 2 local gambling treatment services invited to participate by counsellors.
Study dates	Not reported.
Sources of funding	No industry funding (grant from Department for Communities and Social Inclusion (DCSI459) to the Flinders Centre for Gambling Research, Gambling Advisory Committee, and Office of Problem Gambling)

Inclusion criteria	Focus groups
	
	Participants had to:
	
	• Belong to 1 of the following groups:
	  ○ People experiencing harmful gambling in active treatment
	  ○ People working in land-based gambling venues
	  ○ Consumer advocates who have a history of harmful gambling
	  ○ Counsellors from harmful gambling treatment services
	
	Semi-structured interviews
	
	Participants had to:
	
	• Be either:
	  ○ Aboriginal and/or Torres Strait Islander individuals impacted by harmful gambling
	  ○ People experiencing harmful gambling attending counselling

Exclusion criteria	Not reported.
Sample size	N=41 people experiencing harmful gambling, gambling venue staff and practitioners in gambling treatment service • People experiencing harmful gambling: n=17 • Gambling venue staff: n=10 • Advocated with lived experience of harmful gambling: n=7 • Harmful gambling counsellors: n=7

Participant characteristics	Age in years [Mean (SD)]: Not reported, age categories (n):
	
	• People experiencing harmful gambling:
	  ○ 18-29: 0
	  ○ 30-39: 5
	  ○ 40-49: 5
	  ○ 50-59: 3
	  ○ Over 60: 2
	• Gambling venue staff:
	  ○ 18-29: 1
	  ○ 30-39: 5
	  ○ 40-49: 1
	  ○ 50-59: 3
	  ○ Over 60: 0
	• Advocates with lived experience of harmful gambling:
	  ○ 18-29: 0
	  ○ 30-39: 0
	  ○ 40-49: 4
	  ○ 50-59: 3
	  ○ Over 60: 0
	• Harmful gambling counsellors:
	  ○ 18-29: 0
	  ○ 30-39: 4
	  ○ 40-49: 2
	  ○ 50-59: 1
	  ○ Over 60: 0
	
	Sex (n):
	
	• People experiencing harmful gambling: M=6, F=11
	• Gambling venue staff: Not reported.
	• Advocates with lived experience of harmful gambling: M=4, F=3
	• Harmful gambling counsellors: Not reported.
	
	Gambling symptom severity scale and score [Mean (SD)]: Not reported, length of time experiencing harmful gambling (n):

	• People experiencing harmful gambling:
	  ○ Under 12 months: 1
	  ○ 1-2 years: 2
	  ○ 2-5 years: 4
	  ○ 5-7 years: 3
	  ○ 7-10 years: 3
	  ○ Over 10 years: 4
	• Gambling venue staff: Not applicable.
	• Advocates with lived experience of harmful gambling: Not reported.
	• Harmful gambling counsellors: Not applicable.

Results	**Author's themes** • Personal connection • Relapse: a hidden and common experience **Study findings** *Personal connection* This theme describes the important of rapport between people experiencing harmful gambling and gambling venue staff and harmful gambling treatment professionals. This connection affected both the venue staff's willingness and ability to initial contact with people who might be experiencing harmful gambling and made people more likely to respond positively to these interactions. These relationships normally formed over time. A close working relationship between gambling venue patrons and harmful gambling treatment professionals was key for effective referrals, provide support for early intervention teams at gambling venues, and allow opportunities for feedback about successful treatment. Lack of personal connection was reported in culturally diverse populations, although these same populations seemed unwilling to access services even if there was a good rapport. "I wouldn't be here today if it wasn't for one of the people in the venues. She didn't approach me outright. She just kept an eye on me, and she'd come around, just quickly, say, 'Oh how are you today?' and slowly I got to know her, and with the problems I had I started to confide in her, and on my own bat, I rung up the help, and that's how the staff, I couldn't thank her enough, because it changed my life. But like I said, the venue people, they try, but all depends how you click with them, I think" (page 7)

	Relapse: a hidden and common experience Interviewees reported making the decision to stop gambling before they tried to access formal treatment services. However, they were not able to on their own, leading to feelings of failure, which caused them to be less likely to access formal treatment services. If they had accessed services before their relapse, they were also less inclined to access treatment services afterwards. Shame is a prevalent emotion surrounding relapsing, meaning it is often not talked about. "Well, you've got to face the person that you've sat with for quite a bit of time and discussed it with and you know in your own head that everything you've said is right, you know, and no, it's not comfortable. It doesn't feel comfortable coming back and saying, 'Hey, I played the pokies again. I failed' you know?" (page 11)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(No information on researcher impact, study is focused on help-seeking so limited views about treatment.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Rodda, 2019

Bibliographic Reference	Rodda, S N; Merkouris, S; Lavis, T; Smith, D; Lubman, D I; Austin, D; Harvey, P; Battersby, M; Dowling, N A; The therapist experience of internet delivered CBT for problem gambling: Service integration considerations.; Internet interventions; 2019; vol. 18; 100264

Study Characteristics

Study type	General qualitative inquiry

Country/ies where study was carried out	Australia
Setting and aim	**Setting** Within gambling treatment intervention study, a RCT designed to evaluate the effectiveness of iCBT programme with and without guidance provided by therapists within harmful gambling treatment services. **Aim** To explore the views and experiences of therapists regarding the feasibility and acceptability of iCBT integration into harmful gambling services.
Data collection and analysis	**Data collection** Semi-structured interviews. Approximately 45-minute (range 26-86 minutes) telephone semi-structured interviews held after the completion of the study. Key areas covered in the interview guide were acceptability of the programme, experiences providing treatment and how feasible it would be to integrate the programme into existing services. **Analysis** Thematic content analysis. Interviews were audio-recorded and transcribed. Analysis carried out using qualitative computer software. After reading and re-reading transcripts, initial codes were identified and collated into emerging themes. These themes were then discussed with the first author.
Recruitment strategy	Purposive sampling from RCT. Therapists who delivered the guided portion of the iCBT were invited to participate.
Study dates	August 2015 - August 2016
Sources of funding	Unclear funding source (funded by Victorian Responsible Gambling Foundation)
Inclusion criteria	Participants had to be: • Therapists participating in RCT investigating the effectiveness of internet-delivered CBT for the treatment of harmful gambling.

Exclusion criteria	Not reported.
Sample size	N=7 harmful gambling therapists participating in iCBT harmful gambling intervention study.
Participant characteristics	Age in years: Not reported. Sex (n): M=2, F=5 Gambling symptom severity scale and score: Not applicable.
Results	**Author's themes** • Participant suitability and screening • Participant information and management • Email communication • Ongoing service integration **Study findings** *Participant suitability and screening* Therapists reported that some people were more suitable for the intervention than others. People more suited included those with fluency in English and a higher education level. Participants also needed to have technical competence and good internet access in order to engage with the virtual format. Counsellors reflected that this online format was more likely to engage people who were socially isolated, which could be beneficial (allowing people experiencing harmful gambling to connect more) and detrimental (allowing people experiencing harmful gambling to remain disconnected). Therapists also highlighted that the programme might not be suitable for people experiencing severe gambling-related harms (as this would impact their ability to work methodically through an online programme without strong professional support), those with co-morbid mental health problems, and those with legal issues. The people most suited to the programme are those who show motivation and commitment, and this should be screened for at recruitment to ensure people were aware of the commitment involved in entering the programme. It would also allow the content of the intervention to be tailored towards an individual. Professionals noted that engagement would fluctuate throughout the period, and that this flexible access could be an advantage to the programme, and counsellors mentioned several methods they used to try and keep participants motivated (for example, consistent communication, support, and encouragement).

	“Somebody with a reasonably high level of motivation to want to make the change because even though there are aspects of the programme that encourage motivation, I think the person has got to come at it with that. I'm not necessarily sure how much, going through the program, would increase the level of motivation to change.” (page 4) *Participant information and management* The intervention had a self-evaluation form at the end of each module which the majority of people did not complete, meaning therapists assumed that these modules were not being taken. Professionals requested other information being provided to them, including number of log-ins, page views, activities attempted and modules completed (minus the self-evaluation form). It was felt that this would help in assisting people to complete the intervention, form a basis for a therapeutic relationship between counsellors and people experiencing harmful gambling, and address a perceived lack of engagement. Information should be easy to access and collated in 1 system (compared to the 4 systems used during the study). Counsellors wished to use their own email as well as receive alerts for new participants and participant activity. “From my perspective, there's not enough integration between what the participant has actually been doing within the program and what information you have, other than if they tell you so in their email exchange.” (page 5) *Email communication* Counsellors were asked to provide weekly emails, using a template that included general advice, encouragement, acknowledgement, answers to any questions and reassurance of support. However, therapists reported that these were impersonal and appeared to be computer generated. The scheduled nature of the emails was also noted to be restrictive as professionals were not always able to respond in a timely manner. Shorter, conversational emails were felt to be better when trying to develop a therapeutic relationship. Therapists reflected that they felt the emails were invasive to some people, with participants frequently not responding to emails which in turn left therapists feeling unappreciated. Therapists did receive some positive feedback from participants, who noted the background support, reduced social isolation and appreciation of communication. “The rejection was terrible. I just thought I'd get a bit back. I'm in the field, because I clearly crave the human interaction, so I wasn't getting my own addiction fed very well.” (page 5) *Ongoing service integration* The majority of therapists were optimistic about how the intervention could be integrated into their services (for example, offering email, telephone, and video sessions) but they would need more information on how effective the programme

	would be for their clients before offering it. They reflected that they would need more specific advice on when and how it was delivered. Examples of when it should be offered included people in the early stages of help-seeking, people experiencing less severe gambling-related harms, or post-treatment if people lived a long distance from treatment centres. Counsellor's were frustrated when participants didn't engage with the programme, as it appeared to reduce their role to an administrator rather than therapist. This frustration was felt more so in counsellor's with a long period of time in the field. Some counsellors suggested a hybrid approach might increase engagement in the intervention, where the online format was supported by face-to-face sessions. Overall, the majority of therapists would participate in the programme again, and found the training and supervision of the trial to be acceptable. "I think it just needs to be a part of what a service can offer a participant and I think if it is offered to a participant that has an existing relationship with a service then it's probably more likely to be taken up rather than if somebody stumbles over a website." (page 6) "I think the program's quite useful, but I think it actually needs to be in tandem with something else. So, if it was part of a counselling setting, so you're actually giving them a bit of control themselves, that they can go and do this and we can keep talking about it in counselling, so the counsellor knew what was actually happening, then that would actually be quite useful. I don't know whether it's a stand-alone, because they have to be pretty highly motivated to continue doing it, and clearly, I didn't have many of them." (page 6)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Minor concerns *(Participants volunteered to participate in initial study, unlikely saturation reached, lack of information on data analysis.)*
Overall risk of bias and relevance	Relevance	Relevant *(Qualitative component within parent experimental study, restricted to views on internet therapy.)*

Shandley, 2008

Bibliographic Reference	Shandley, Kerrie; Moore, Susan; Evaluation of Gambler's Helpline: A consumer perspective.; International Gambling Studies; 2008; vol. 8 (no. 3); 315-330

Study Characteristics

Study type	General qualitative inquiry (within mixed methods study)
Country/ies where study was carried out	Australia
Setting and aim	**Setting** Within gambling treatment services, a Gambler's Helpline which provides a telephone first-point of access for people affected by harmful gambling. It also provides a referral service for face-to-face counselling. **Aim** To explore views and experiences of people accessing Gambler's Helpline.
Data collection and analysis	**Data collection** Semi-structured interviews. Conducted via telephone after contact with the helpline, with structured questions about reasons for accessing the service and prior help-seeking behaviour as well as open-ended questions were also asked regarding satisfaction with the helpline, experiences with counsellors and what assistance they received. **Analysis** Thematic analysis. No further details reported.
Recruitment strategy	Convenience sampling. People calling into the Gambler's Helpline were asked by helpline counsellors to participate in an immediate post-call questionnaire-based telephone interview. Counsellors recruited suitable participants (based on the exclusion criteria and counsellor's own discretion) by reading a script at the end of each call. If callers were interested, they were directly transferred to a researcher at the completion of the call.

	Note: Participants were also invited to complete a 1-month follow-up interview. However, questions in this follow-up interview did not include any themes relevant to this review question and therefore data has not been extracted.
Study dates	Not reported.
Sources of funding	Unclear funding source (funding not reported)
Inclusion criteria	Participants had to: • Call into the Gambler's Helpline
Exclusion criteria	Not reported.
Sample size	N=90 people calling into Gambler's Helpline • Gambler: n=64 • Non-gambler: n=26
Participant characteristics	Age in years: Not reported. Sex (n): M=33, F=57 Gambling symptom severity scale and score: • Gamblers: Not reported. • Non-gambler: Not applicable.
Results	**Author's themes** • Satisfaction with the service **Study findings** *Satisfaction with the service*

	The majority of participants were satisfied with the service. They reported feeling understood by their counsellor, therapists were professional with a good knowledge of harmful gambling and understanding of the circumstances people were calling about, and counsellors were impartial in their advice. People were more likely to feel understood if they received support, compassion, and empathy from counsellors. Callers reported that counsellors were helpful if they provided appropriate referrals and appropriate strategies to manage current issues. Some participants were not satisfied with the service, either having unrealistic expectations about what the service could provide or being given ineffective strategies and techniques to manage their current issues. “Wanting someone to make the contacts for me because feeling overburdened and am going into hospital next week.” (page 323) “Preparing me in advance for possible things that might happen and how to handle them. Felt like (the counsellor) knew where I was coming from.” (page 323)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Poor description of data collection and analysis. Lack of information on ethical consideration. Discussion of qualitative results is brief. Unsure whether qualitative component was explored fully.)*
Overall risk of bias and relevance	Relevance	Relevant *(Participants included non-gamblers.)*

Smith, 2016

Bibliographic Reference	Smith, David; Pols, Rene; Lavis, Tiffany; Battersby, Malcolm; Harvey, Peter; Experiences and Perceptions of Problem Gamblers on Cognitive and Exposure Therapies When Taking Part in a Randomised Controlled Trial: A Qualitative Study.; Journal of gambling studies; 2016; vol. 32 (no. 4); 1243-1260

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	Australia
Setting and aim	**Setting** Within gambling treatment intervention study, a RCT evaluating the effectiveness of gambling-specific exposure therapy compared to gambling-specific cognitive therapy in electronic gaming machine harmful gamblers. Participants received average of 12 x 60-minute weekly individual therapy sessions . **Aim** To explore views and treatment experiences of exposure therapy compared to cognitive therapy in people experiencing harmful gambling.
Data collection and analysis	**Data collection** Semi-structured interviews. Approximately 1-hour interviews beginning with general question of 'Tell me about your experiences with your gambling treatment?'. Further open-ended questions were then used to explore views on barriers and/or facilitators to gambling treatment and how they might be improved. **Analysis** Thematic analysis. Interviews were audio recorded and transcribed verbatim (including behavioural notes) within 2-5 days post-interview. Transcripts were analysed in 6-stage process: checking transcripts for accuracy, independent coding by 2 researchers according to therapy specific and non-therapy specific experiences, identification of sub-themes, and developing and refining of the themes within the context of the wider RCT. A 3rd researcher cross-checked all coding for consistency and objectivity.
Recruitment strategy	Purposive sampling. Suitable participants suggested by therapists from parent RCT after the end of intervention period, and then contacted by first author with information about the study.
Study dates	April - November 2012
Sources of funding	Unclear funding source (funding not reported)

Inclusion criteria	Participants had to: • Have taken part in the main RCT investigating differences in effectiveness of cognitive therapy versus exposure therapy in the treatment of harmful gambling.
Exclusion criteria	Not reported.
Sample size	N=8 people participating in harmful gambling intervention study
Participant characteristics	Age in years [Mean (SD)]: Not reported, age range 29-65. Sex (n): M=4, F=4 Gambling symptom severity scale and score: Not reported.
Results	**Author's themes** • Participants' overall evaluation of the therapy • 'Questioning your desire': Relational interpretation of CT and E **Study findings** *Participants' overall evaluation of the therapy* All participants receiving cognitive therapies and exposure therapies rated the experience as positive overall, although there was a difference in how positive. Outcomes included improved social functioning and decreased financial stress. Others reported that these therapies empowered them, allowing them to develop control over their gambling behaviour and better deal with stressful situations. One participant reflected that the interventions worked for them but that they were unable to complete the trial because of the time investment needed. Others did not complete the treatment because the abstinence goal of the therapy did not meet their personal goal of moderation. "…such a revelation of yes, I'm sitting here with this money in the bucket but I do not have the feelings I used to have when I used to be there and absolutely feel that rush and that, I want to play, I want to, you know. So that was good. It was a good feeling to sit there and feel that you are in control." (page 1249)

	'Questioning your desire': Relational interpretation of CT and ET Most participants showed signs of an urge-continuum interplay between psychobiological states and perceptions of control. Utilising cognitive strategies and rational thoughts helped people to overcome erroneous cognitive beliefs encouraging people to gamble. One respondent felt that the simple nature of exposure therapy meant it was a quick, effective intervention. Another participant found the homework helpful, as it gave them better insight into their gambling behaviour. “Well recognising they’re gambling thoughts and understanding that the machines are not going to win and actually questioning your desire to go in there, you know, in your head - that was good.” (page 1254)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Participants were from parent RCT and suggested by therapists; lack of information on data collection.)*
Overall risk of bias and relevance	Relevance	Relevant *(Qualitative component within parent experimental study.)*

Syvertsen, 2020

Bibliographic Reference	Syvertsen, A.; Erevik, E. K.; Mentzoni, R. A.; Pallesen, S.; Gambling Addiction Norway - experiences among members of a Norwegian self-help group for problem gambling; INTERNATIONAL GAMBLING STUDIES; 2020; vol. 20 (no. 2); 246-261

Study Characteristics

Study type	Phenomenological

Country/ies where study was carried out	Norway
Setting and aim	**Setting** Within gambling treatment services, self-help groups for people experiencing harmful gambling. **Aim** To explore the views and experiences of people attending Gambling Addiction Norway self-help groups.
Data collection and analysis	**Data collection** Semi-structured interviews. Prior to the main interview, a diagnostic interview using DSM-5 was conducted. 9 x 40-minute (range 22-60 minutes) semi-structured interviews using an interview guide developed by 2 researchers. Open-ended questions explored participants' understanding of self-help groups practices and their experiences being part of the group. **Analysis** Thematic analysis. Interviews were audio-recorded and transcribed verbatim before being uploaded into a qualitative software programme (NVivo). Analysis was conducted by the first author, with a second researcher providing a credibility check of identified themes and supporting data. Transcripts were analysed in 6-stage process: familiarisation with the data; generation of initial codes; searching for themes; reviewing themes; refining and defining themes. Quantifiers (for example, a few = 1–2 participants, many = 5–6 participants) were added to the data to indicate how salient experiences were among participants.
Recruitment strategy	Purposive sampling. People who have experienced (either currently or historically) harmful gambling attending self-help groups listed on Gambling Addiction Norway website. These groups were emailed with a brief introduction to the study, and a request to help recruitment. This information was passed on to people participating in the self-help meetings, and people who were interested shared their phone numbers with group facilitators. Researchers then contacted these potential participants by phone to give more detailed information on the study, and interviews scheduled.
Study dates	Autumn 2017
Sources of funding	No industry funding (funded by Norwegian Competence Center for Gaming and Gambling Research) Note: Statement included that authors reported that they had no potential conflict of interests.

Inclusion criteria	Participants had to:
	
	• Be experiencing or have a history of Gambling Disorder, as defined by DSM-5 criteria
	  o Current Gambling Disorder: ≥4 criteria within the last 12-month period.
	  o Life-time Gambling Disorder: ≥4 criteria within the any 12-month period.
	• Be attending Gambling Addiction Norway self-help group

Exclusion criteria	• Affected others of people experiencing harmful gambling
Sample size	N=9 people attending self-help groups for harmful gambling • Currently experiencing harmful gambling: n=4 • History of harmful gambling: n=5
Participant characteristics	Age in years [Mean (SD)]: Not reported, age range 29-52 Sex (n): M=8, F=1 Gambling symptom severity scale and score: Not reported.
Results	**Author's themes** • Shared narratives and understanding • Keeping it relevant to problem gambling • Complete sharing • Finding solutions **Study findings** *Shared narratives and understanding* Participants valued shared narratives, goals and understanding during group meetings, as it allowed them to feel understood and validated. People experiencing harmful gambling felt that there were certain things only other gamblers can understand (for example, the challenges of stopping gambling, and financial and economic concerns). Group settings gave

people the freedom to share as much as they wanted, and when they wanted, as well as giving them a sense of community. Respondents noted that another rewards aspect of group meetings was feeling as though their experiences and advice was helping others in similar situations. Lastly, people were appreciative of the social aspect group sessions, which helped them to feel understood and decrease social isolation experienced by many.

“It’s very reassuring to be able to talk to others, there’s nobody judging, there’s nobody deterring, [they’re] supportive and shaking hands and they’re smiling and pleasant, and there’s also laughter involved in those meetings, there’s no depressed atmosphere. It’s a very

good atmosphere in that way as well” (page 252)

Keeping it relevant to problem gambling

Participants reported that self-help groups should remain focused on harmful gambling, although there were a variety of opinions about how this could be achieved. It also requires flexibility within discussion structure. Sometimes conversations may have to be more structured (for example, by introducing pre-defined topics) while other time conversations may have to be less so which may facilitate sharing on experiences.

“Then it becomes a more relaxed atmosphere and yeah. [I] think it makes people share more than they otherwise would, not that one should dry out people for good stories but I believe it’s good for them to let out what they have on their chest and articulate the feelings” (page 253)

Complete sharing

Participants reflected that comprehensive personal stories were shared, with negative consequences of gambling forming a major topic area for people. These included trust issues, financial worries, employment problems and mental health issues. People reported being affected by hearing these stories from other people in similar situations, reflecting on their own behaviour and consequences. It was also helpful to hear of peer progress and setbacks in treatment. Listening to affected others’ stories was particularly poignant to people experiencing harmful gambling.

"I went there without wanting to quit. I went there with an attitude that I would just go there, as an obligation, and listen to people talk and then I would just leave again and go back to gambling. I didn’t, I, there were some people there with some powerful stories. There was this one story, one very powerful story, and it made me come to terms with myself” (page 254)

	Finding solutions Participants reported that group support gave them access to practical advice and help on gambling-related harms. This could include debt management strategies, how to get help from social services or financial advisors, self-exclusion and how to initiate therapy. Guest speakers were also invited along to meetings periodically, to educate people on topics such as government legislation or types of therapy offered. "[. . .] and then new ones are arriving who are often receiving another form of treatment and . . . but then we give them tips and advice on, well, how to blacklist oneself from creditors, how to exclude oneself from Norsk Tipping, help with, with getting somebody else to manage the finances of the gambling addict, so parents or sibling, or a partner or NAV [the Norwegian public welfare agency] or whatever. We have a complete shopping list with that kind of acute help" (page 255)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Recruited from self-help groups limits those with negative experiences, 1/3 participants only attended up to 3 sessions, no mention of independent coding.)*
Overall risk of bias and relevance	Relevance	Relevant *(Evidence restricted to experiences with 1 self-help group only.)*

Tremblay, 2017

Bibliographic Reference	Tremblay, Joel; Dufour, Magali; Bertrand, Karine; Blanchette-Martin, Nadine; Ferland, Francine; Savard, Annie-Claude; Saint-Jacques, Marianne; Cote, Melissa; The Experience of Couples in the Process of Treatment of Pathological Gambling: Couple vs. Individual Therapy.; Frontiers in psychology; 2017; vol. 8; 2344

Study Characteristics

Study type	Phenomenological

Country/ies where study was carried out	Canada
Setting and aim	**Setting** Within gambling treatment intervention study, a parent non-randomised controlled trial evaluating the effectiveness of integrated couple treatment compared with usual care for people experiencing harmful gambling and their affected others. **Aim** To explore the views and experiences with individual therapy compared to couple therapy in people experiencing harmful gambling and their affected partners, participating in a RCT.
Data collection and analysis	**Data collection** Semi-structured interviews. Approximately 20 minutes (range 10 -55 minutes) interview conducted individually with people experiencing harmful gambling and affected others. Key areas explored were experiences of therapy (including perceived effectiveness) and what could be improved. Interview guide content was similar for both groups of participants, although minor changes were made to make questions more applicable to participants. **Analysis** Descriptive phenomenological analysis. Interviews were audio-recorded and transcribed by 3 researchers. Initial themes were coded after reading a random sample of transcripts, which were developed into a coding table created by multiple researchers. 2 research assistants applied this to the remainder of the interviews. In order to ensure consistency, 6 interviews were independently classified, with any discrepancies resolved through discussion.
Recruitment strategy	Convenience sampling. Participants were recruited during 9 months follow-up evaluation from study baseline.
Study dates	June 2012 - July 2014
Sources of funding	No industry funding (grants from Fonds québécois de recherche: Société et culture).
Inclusion criteria	Participant couples had to: • Be part of larger experimental study into the effectiveness of Integrated Couple Therapy for harmful gambling when compared to individual therapy

	• Be aged ≥18 years old • Be living together for ≥6 months • Have 1 of the couple diagnosed as a pathological gambler as assessed by WHM-CIDI* • Sought help from participating addiction treatment centres *World Health Organization World Mental Health Composite International Diagnostic Interview
Exclusion criteria	• Participants with alcohol and/or drug abuse problems as assessed using the DEBA-Alcohol and Drugs tool.
Sample size	N=42 people experiencing harmful gambling and their affected others participating in harmful gambling intervention study • People experiencing harmful gambling: n=21 • Affected others: n=21
Participant characteristics	Age in years: Not reported. Sex (n): • People experiencing harmful gambling: M=18, F=3 • Affected others: M=2, F=19 Gambling symptom severity scale and score: Not reported.
Results	**Author's themes** • Format and structure **Study findings** *Format and structure* Both couples receiving individual and joint therapy interventions were happy with the service. A few people received both formats and reflected that a combination would work better (for example, start with individual sessions and move onto couple sessions) as this would allow people experiencing harmful gambling to be more open about their gambling

	behaviour without their partner present. It also allowed partners to consume the educational materials about the psychology of harmful gambling, before discussing it in couple sessions. “Begin in individual, work on some things, then after, do some couple therapy. I’d suggest that to lots of people. If I had begun in couple, things would have seized right up. It wouldn’t have helped me. If you can, do individual for a while like I did, then after jump into couple therapy. Cause then, you’ve worked on problems, you’ve understood some things that you wouldn’t have understood [in couple treatment]. Individual helped me to get some of the bad things out, to understand stuff. Then you go to couple treatment and you can go farther.” (page 8)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Moderate concerns *(Recruited from parent RCT with participants aware of assignment, lack of discussion and expansion of findings.)*
Overall risk of bias and relevance	Relevance	Partially relevant *(Qualitative component within parent experimental study, very specific to couples therapy and how that affects relationships.)*

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** Within alcohol or drug treatment services. **Aim** To explore the support and treatment needs of people experiencing both harmful gambling and alcohol/drug misuse, both from the perspective of people undergoing treatment and healthcare professionals providing treatment.
Data collection and analysis	**Data collection** Semi-structured interviews. 25–30-minute interviews using 3 interview guides developed for the targeted populations using literature reviews. • People experiencing harmful gambling: Key areas covered were experiences of help-seeking, availability of treatment, satisfaction with harmful gambling treatment, social perceptions of people experiencing harmful gambling, and co-morbidities. • Healthcare professionals working in outpatient clinics: Key areas covered were reasons for help-seeking within the healthcare sector, experience of current harmful gambling treatment services, and perceptions of people experiencing harmful gambling. • Social workers: Key areas covered were reasons for help-seeking within the social service sector, experience of social welfare services for harmful gambling, social perceptions of people experiencing harmful gambling, and co-morbidities. **Analysis** Thematic analysis. Interviews were audio-recorded and transcribed. Each transcript was analysed by 2 researchers. Initial codes were developed using a sample of 3 interviews, which were collated into a code matrix. Emerging themes in subsequent interviews were added to this framework. Any themes that were only representative of certain participating groups were included but highlighted as not being transferable.

Recruitment strategy	Purposive sampling. People experiencing harmful gambling recruited by healthcare professionals in outpatient clinics for substance use disorder during therapy sessions, who then relayed their interest to the study researchers. They were also recruited at Gamblers Anonymous meetings, when information on the study was disseminated and interested participants made direct contact with study researchers. Professionals and therapists were recruited by researchers at their place of work, either using information from websites or relevant directories.
Study dates	January - June 2015
Sources of funding	No industry funding (Fund of Solving of Gambling Problems grant from the Ministry of Health) Note: Statement included that authors reported that they had no potential conflict of interests.
Inclusion criteria	For people experiencing harmful gambling Participants had to: • Be diagnosed with gambling disorder and substance use disorder as defined by ICD-10 and confirmed by psychiatrist For healthcare professionals Participants had to: • Be experienced in the treatment of patients with gambling disorder (as defined above) • Be employed as general practitioners, psychiatrists, and therapists in substance use disorder outpatient clinics, or as social workers from social welfare centres
Exclusion criteria	Not reported.
Sample size	N=90 people experiencing harmful gambling and co-morbid substance use disorder, and health- and social care professionals involved in treatment of harmful gambling • People experiencing harmful gambling: n=30 • General practitioners: n=15 • Psychiatrists: n=15 • Therapists: n=15

	• Social workers: n=15
Participant characteristics	Age in years [Mean (SD)]: • People experiencing harmful gambling and co-morbid substance use disorder: 38.3 (SD not reported) • Health- and social care professionals: 42.9 (SD not reported) Sex (n): • People experiencing harmful gambling and co-morbid substance use disorder: M=27, F=3 • Health- and social care professionals: M=42, F=18 Gambling symptom severity scale and score: • People experiencing harmful gambling and co-morbid substance use disorder: Not reported. • Health- and social care professionals: Not applicable.
Results	**Author's themes** • Factors determining choice of facility: Availability and access • Factors determining choice of facility: Living arrangements in facilities and quality of treatment • Barriers appearing during the treatment process: Individual barriers • Barriers appearing during the treatment process: Structural barriers • Facilitators appearing during the treatment process: Individual facilitators **Study findings** *Factors determining choice of facility: Availability and access* People experiencing harmful gambling reported that practical considerations often determine their choice of treatment facility. These issues included distance from home, availability of individual or group counselling, flexibility of opening times, and cost of sessions.

	"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) *Factors determining choice of facility: Living arrangements in facilities and quality of treatment* Treatment professionals (particularly general practitioners and counsellors) thought that people might choose private sector facilities over public sector facilities because the living arrangements were of higher quality, they had better availability of counsellors, and there was a perception of better confidentiality and discretion. "Some patients think that in private facilities they will be treated better than in the public sector. They claim that if they pay for treatment they must offer something special, a better standard." (page 204) *Barriers appearing during the treatment process: Individual barriers* People experiencing harmful gambling and professionals involved in the treatment of harmful gambling noted several individual barriers for accessing treatment services (for example, shame of their harmful gambling or stigma associated with mental health treatment), which culminated in a reluctance to talk to others about personal issues, emotions, and experiences. Treatment professionals also highlighted denial as an internal barrier, when people believed they were not dependent and able to recover without formal treatment, which resulted in a decreased motivation to start treatment. People experiencing harmful gambling also noted that they felt marginalised and misunderstood when they were forced to join therapies and group support designed for people with dependence on alcohol and other substances. "I am ashamed of my dependence, I never talk about it, and don't draw attention to it. I think that if you can't manage your own life, you're a little bit worse than others and, as such, sick. Some people have this "valid" conviction that if someone is sick, they are a little bit worse than others and I do not want to be treated as someone worse, I want to be normal and treated as a normal person." (page 205) *Barriers appearing during the treatment process: Structural barriers* People experiencing harmful gambling and professionals involved in the treatment of harmful gambling noted several structural barriers for accessing treatment services. The most frequently identified barrier was the lack of outpatient treatment services available for people experiencing harmful gambling. If they are available, they are very rarely tailored towards harmful gambling but are designed for people experiencing alcohol and other substance misuse disorders. People experiencing harmful gambling are often a minority in these services, and group sessions and educational materials are primarily dedicated towards alcohol and drug dependency, so these services can feel inadequate and poorly representative

of harmful gambling. Treatment for harmful gambling was not always free, which was another barrier for accessing services if people's insurance did not have cover treatment.

People experiencing harmful gambling noted that group sessions were often overcrowded, meaning that they did not have enough time to talk through their issues and exercise practical skills. Sessions times could be inflexible around people's everyday commitments (for example, outpatient clinics not being open on weekends), preventing engagement in group therapy. There were long waiting lists for an initial meeting with a therapist meant that people could change their mind about seeking treatment in the interim.

Other barriers included people working at treatment services. Some people experiencing harmful gambling and therapists believed that professionals did not have the specialist knowledge and relevant experience to effectively deliver treatment for harmful gambling. Some treatment service staff were not trusting of clients, meaning people have to explain every absence from therapy.

General practitioners respondents reflected that they did not always identify harmful gambling as it is not a visible disease and they did not screen for the problem or routinely ask patient's about it. It is hard to diagnose during a quick primary care visit, and many general practitioners felt that they did not have knowledge about the disorder or treatment services. Psychiatrists reported that people were not aware of the referral pathways for harmful gambling, and that they could self-refer into the psychiatric outpatient clinics. Social workers mentioned that people experiencing harmful gambling were unaware of the breadth of their services outside of providing financial support. This is a viscous circle in that people are unaware that social welfare centres can help, so levels of people experiencing harmful gambling are low in these settings, so the problem is not recognised on questionnaire or application forms and social workers cannot refer them to appropriate services.

"There are different facilities which offer therapy for alcohol dependency or for dependency on other psychoactive substances, including opioids, stimulants, new psychoactive substances, and so on. There is a lack of treatment services addressed directly to people with gambling disorder. Sometimes it is a very modest service and consists of individual meetings conducted in outpatient clinics. With regard to inpatient treatment services, this is a typical situation for alcohol dependent persons." (page 205)

"'The educational materials are incorrect. I think the materials should be changed and adapted for patients with a gambling disorder, because they only address alcohol dependency and it could be a problem." (page 206)

Facilitators appearing during the treatment process: Individual facilitators

	People experiencing harmful gambling noted several internal facilitators the treatment offered (for example, exploring emotions or identifying how to fix personal problems), by providing insight into their disorder and mechanisms for preventing relapses. These techniques also helped them dealing with everyday issues outside of their harmful gambling. Other individual facilitators were confidentiality and discretion. “It started fairly quickly, as I got a referral here to the outpatient clinic. The lady [receptionist] told me that I should come in the next three to four days.” (page 204) “When I returned to gambling, it was much easier for me to come out after that experience [with treatment].” (page 207) “The most important thing [was] the initial contact with patients, in that they came to us and something persuaded them to stay here, and the fact that the visit did not discourage them. Initial contact, both face to face and by phone, is very important.” (page 208)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	No or very minor concerns *(Multiple people involved in data analysis but no mention of independent coding.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Wood, 2007

Bibliographic Reference	Wood Richard T, A.; Griffiths Mark, D.; Online guidance, advice, and support for problem gamblers and concerned relatives and friends: an evaluation of the GamAid pilot service; British Journal of Guidance and Counselling; 2007; vol. 35 (no. 4); 373-389

Study Characteristics

Study type	General qualitative inquiry (within mixed methods study)
Country/ies where study was carried out	UK
Setting and aim	**Setting** Within gambling treatment services, online advisory, guidance and signposting service (GamAid). **Aim** To evaluate a GamAid pilot service against its stated aims and objectives, as well as review user's views and experiences of the service.
Data collection and analysis	**Data collection** Free-text questionnaires. Online questionnaire online survey automatically appeared after service users logged off following communication. Questions explored people experiences and views of the service. No further details reported. **Analysis** Thematic content analysis. No further details reported.
Recruitment strategy	Convenience sampling. Online questionnaire automatically offered to people immediately after they have been in contact with an online advisor.
Study dates	Not reported.
Sources of funding	Any industry funding (funded by Responsibility in Gambling Trust)
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=33 experiencing harmful gambling and affected others attending GamAid treatment service
Participant characteristics	Age in years [Mean (SD)]*: 36 (11)

	Sex (n)*: M=36, F=33, unknown=11. Gambling symptom severity scale and score: Not reported. *From the larger sample of people filling out online questionnaire (n=80)
Results	**Author's themes** • Qualitative feedback on GamAid from the online survey - good • Qualitative feedback on GamAid from the online survey – bad **Study findings** *Qualitative feedback on GamAid from the online survey – good* Participants reported that GamAid advisors were available when they needed to talk, and that they were understanding, supportive and helpful. Respondents also noted that the format was easy and convenient to use, and it was an advantage to see counsellors via the webcam while talking. Other benefits to GamAid were the provision of useful web links by counsellors, and the fact the service was confidential. "The best thing was that it was available when I needed to talk to someone. It helped me over the urge to go out and gamble today" (page 382) *Qualitative feedback on GamAid from the online survey – bad* Respondents reported that face-to-face support is limited to certain geographical areas, there was a lack of remote support options (for example, via telephone) and that the exact role of the service was not clear to people. "It's a shame they don't have a clinic in my area and that they don't have more people on the phones to help" (page 382)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Lack of information on participants, inclusion criteria, data collection or ethical considerations. Data analysis poorly described.)*
Overall risk of bias and relevance	Relevance	Relevant *(Evidence restricted to experiences of this 1 online help-seeking service.)*

Woodall, 2021

Bibliographic Reference	Woodall, J; Freeman, C; Emerging lessons from the commissioning and delivery of a gambling treatment service.; Public health; 2021; vol. 196; 69-73

Study Characteristics

Study type	General qualitative inquiry
Country/ies where study was carried out	UK
Setting and aim	**Setting** Within gambling treatment services. **Aim** To explore the views and experiences of designing, commissioning, and delivery of a new metropolitan gambling treatment service.
Data collection and analysis	**Data collection**

	Semi-structured interviews and free-text questionnaires. 1 hour face-to-face or telephone semi-structured interviews. 1 participant opted to provide written responses to questions included in interview guide due to restrictions enforced by COVID-19 pandemic. **Data analysis** Framework analysis. Central matrix was developed using themes and sub-themes. Finalised framework was agreed by all members of the research team.
Recruitment strategy	Critical case sampling. Experts identified by key personnel in treatment for harmful gambling services, and included professionals from local NHS mental health trust, local authority, commissioning organisation and a service user representative.
Study dates	February - March 2020
Sources of funding	Any industry funding (funded by GambleAware)
Inclusion criteria	Not reported.
Exclusion criteria	Not reported.
Sample size	N=9 professionals working in a gambling treatment service
Participant characteristics	Age in years: Not reported. Sex: Not reported. Gambling symptom severity scale and score: Not reported.
Results	**Author's themes** • What worked well: Working in partnership • What worked well: Central location • Challenge: Commissioning clarity **Study findings** *What worked well: Working in partnership*

	Having a variety of partners involved in a harmful gambling service is key to it's success (for example, third sector, local authorities, community outreach, and public health). There were some initial problems with commissioners not being clear what was expected for certain partners, but ultimately this approach led to better communication and problem-solving. A common aim of supporting people experiencing harmful gambling and their affected others was key to overcome the differences in language, culture, practice, and ways of working. "It was a very useful meeting in terms of clearing the air...It was good because it was the first time all key players were round a table and were communicating directly. So people were able to expose their own basic assumptions and be exposed to other people's basic assumptions, seeing where there was commonality, and seeing where there was ground to close before moving forward." (page 5) *What worked well: Central location* Harmful gambling treatment services located in a city centre increase accessibility due to established public transport and plenty of parking. Co-location with multipurpose government facility was a benefit as it can help to decrease stigma attached with accessing mental health services, raise awareness of gambling related harms with other government departments and organisations, and be a symbol of partnership in treatment harmful gambling. "There are some real advantages...The fact that people aren't coming into a hospital, into a mental health unit, they're coming into the same place where people are talking about their housing benefit or registering the birth of their son. It's a multipurpose council building and I think there is less stigma associated with it than walking into somewhere that says 'here's the gambling clinic'." (page 6) *Challenge: Commissioning clarity* Commissioning of harmful ambling treatment services was challenging because of ambiguities in referral pathway, eligibility criteria, estates, and accommodation. In the future, commissioning should include a balance between light-touch commissioning approach with formal contracts and a clear vision. This additional clarity will also decrease potential harms for people experiencing harmful gambling who might otherwise be placed in an inappropriate part of the pathway. "No one has to come to any conclusion how you would specify who a complex client is." (page 6)

Critical appraisal

Section	Question	Answer
Overall risk of bias and relevance	Overall risk of bias	Serious concerns *(Lack of information on data collection, data analysis and whether researcher was involved in service implementation.)*
Overall risk of bias and relevance	Relevance	Highly relevant

Appendix E Forest plots

Forest plots for review question: What works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, 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-CERQual tables for review question: What works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

K1 Improving gambling treatment services (from studies receiving no industry funding)

Table 5: Evidence profile for theme K1.1 Content of therapy

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 K1.1.1 Nature of therapy						
3 studies • Piquette-Tomei 2008 (General qualitative inquiry, semi-structured interviews and focus groups) • Syvertsen 2020 (Phenomenological, semi-structured interviews) • Wieczorek 2018 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling appreciated services that include a range of therapies and methods of delivery. Increasing exposure to guest speakers and introductions to other forms of therapies increased the amount of skills that they were able to develop throughout treatment and allowed them to explore other forms of therapy while still receiving treatment. Offering a range of therapies also allowed people to choose the best treatment for them. However, gambling should remain the focus of these additional therapies. *'I think it would be helpful. Once there was a man who spoke about AA. It was so powerful to learn about another addiction. It is so powerful for*	Minor concerns (Minor 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

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	people to tell their stories.' (Piquette-Tomei 2008, p285)					
Sub-theme K1.1.2 Relevance and appropriateness of treatment offered						
1 study • Wieczorek 2018 (General qualitative inquiry, semi-structured interviews)	People were more likely to engage in services that offered gambling specific treatments, as opposed to treatments for addictions more broadly. People experiencing harmful gambling often felt lonely, marginalised, and misunderstood if they had to participate in treatment that was designed for people with substance misuse disorders or psychiatric disorders, as therapies were not tailored towards their needs. *'The educational materials are incorrect. I think the materials should be changed and adapted for patients with a gambling disorder, because they only address alcohol dependency and it could be a problem.' (Wieczorek 2018, p206)*	No or very minor concerns	No or very minor concerns	No or very minor concerns	Minor concerns (Findings only derived from 1 study with rich data reinforced with first-order quotes)	HIGH

Table 6: Evidence profile for theme K1.2 Delivery

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 K1.2.1 Flexibility and convenience						
2 studies • Piquette-Tomei 2008 (General qualitative inquiry, semi-structured	People experiencing harmful gambling were more likely to engage with services that were flexible around their daily lives and commitments. Considerations included times	Minor concerns (Minor concerns about methodological limitations as per	No or very minor concerns	No or very minor concerns	Moderate concerns (Findings only derived from 2	MODERATE

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) • Wieczorek 2018 (General qualitative inquiry, semi-structured interviews)	services were available, range of services and how easy it was to travel to service locations. *'I got a referral to a facility near my home. I would ride on my bike for about 15 minutes, which was quite close.' (Wieczorek 2018, p204)*	CASP qualitative checklist)			studies with limited data)	

Table 7: Evidence profile for theme K1.3 Diversity

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 K1.3.1 Service needs for different genders						
1 study • Piquette-Tomei 2008 (General qualitative inquiry, semi-structured interviews and focus groups)	Women felt more comfortable in single-gender group therapy sessions, compared to mixed group sessions. This setting allowed participants to share their experiences freely without feeling judged by male participants. *'I would not be able to say what I wanted to say [with men in the group] … that is why I go to the all-women group — it helps.' (Piquette-Tomei 2008, p284)*	Minor concerns (Minor concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	Serious concerns (Findings were from a non-UK setting and study was specifically exploring single-gender therapy groups)	Moderate concerns (Findings only derived from 1 study with moderately rich data)	LOW

Table 8: Evidence profile for theme K1.4 Practitioners and peer supporters

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 K1.4.1 Issues around fear, apprehensions, and trust						

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 • Kourgiantakis 2018 (General qualitative inquiry, semi-structured interviews) • Piquette-Tomei 2008 (General qualitative inquiry, semi-structured interviews and focus groups)	People experiencing harmful gambling were more likely to share their experiences when they felt comfortable in their therapeutic environment. This allowed them to impartially identify triggers and develop methods of coping with urges. *'Well one thing that is a definite benefit is that somebody else is there; other people there have failed. When I failed before, I spiralled into a severe depression … it gives me permission to be human and make a mistake without thinking I have to die for it. So it helps to hear other women say, "I screwed up once and went and gambled so huge." It is normalizing that you are not the only one who is struggling with addiction and has been able to come back.' (Piquette-Tomei 2008, p282)*	Minor concerns (Minor concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	Minor concerns (Findings were derived from studies exploring individual forms of therapy)	Serious concerns (Findings only derived from 1 study with limited data and first-order quotes)	LOW
Sub-theme K1.4.2 Training and values of practitioners						
2 studies • Piquette-Tomei 2008 (General qualitative inquiry, semi-structured interviews and focus groups) • Wieczorek 2018 (General qualitative inquiry, semi-structured interviews)	The attitudes of therapists were important in fostering good working relationships with people experiencing harmful gambling. This begins with initial contact and carries through the treatment process. People taking part in group therapies reported that the facilitator was paramount in creating an accepting environment, allowing people to share their experiences in a safe space. Conversely, if people felt	Minor concerns (Minor concerns about methodological limitations as per CASP qualitative checklist)	Minor concerns (Findings were about advantages and disadvantages of theme)	No or very minor concerns	Moderate concerns (Findings derived from 2 studies without 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
	that therapists did not have the required knowledge regarding treatment of harmful gambling or that their trust was not reciprocated, this could hinder treatment progress. *'The most important thing [was] the initial contact with patients, in that they came to us and something persuaded them to stay here, and the fact that the visit did not discourage them. Initial contact, both face to face and by phone, is very important.' (Wieczorek 2018, p208)*					

Table 9: Evidence profile for theme K1.5 Peer support

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 K1.5.1 Lived experiences and safe spaces						
3 studies • Piquette-Tomei 2008 (General qualitative inquiry, semi-structured interviews and focus groups) • Riley 2018 (Phenomenological, semi-structured interviews and focus groups) • Syvertsen 2020 (Phenomenological,	Peer support was invaluable to people experiencing harmful gambling as it allowed them to share their stories in an accepting environment. This extended beyond their experiences with harmful gambling, to their current personal challenges and social opportunities. This format of therapy allowed people to discuss aspects of recovery that can be shameful and stigmatising, such as relapse. Additionally, hearing stories from other attendees helped people experiencing harmful gambling to	Minor concerns (Minor 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 but with rich data supported by first-order quotes)	HIGH

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
semi-structured interviews)	reinforce their own commitment to treatment. *'It's very reassuring to be able to talk to others, there's nobody judging, there's nobody deterring, [they're] supportive and shaking hands and they're smiling and pleasant, and there's also laughter involved in those meetings, there's no depressed atmosphere. It's a very good atmosphere in that way as well' (Syvertsen 2020, p252)*					
Sub-theme K1.5.2 Practical advice						
1 study • Syvertsen 2020 (Phenomenological, semi-structured interviews)	People experiencing harmful gambling found the practical advice offered from peers and peer support groups to be very helpful (including financial matters, enlisting help from social services or financial advisors, self-exclusion from gambling sites, and help-seeking). This could be from peers themselves or from guest speakers within meetings. *'[. . .] and then new ones are arriving who are often receiving another form of treatment and . . . but then we give them tips and advice on, well, how to blacklist oneself from creditors, how to exclude oneself from Norsk Tipping, help with, with getting somebody else to manage the finances of the gambling addict, so parents or sibling, or a partner or NAV [the Norwegian*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Moderate concerns (Findings only derived from 1 study with limited data reinforced with first-order quotes)	LOW

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	public welfare agency] or whatever. We have a complete shopping list with that kind of acute help' (Syvertsen 2020, p255)					

Table 10: Evidence profile for theme K1.6 Affected others

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 K1.6.1 Support with relationships						
2 studies • Kourgiantakis 2018 (General qualitative inquiry, semi-structured interviews) • Tremblay 2017 (Phenomenological, semi-structured interviews)	Both people experiencing harmful gambling and their affected others appreciated treatments that taught techniques for non-judgemental and calm communication between couples. However, some people experiencing harmful gambling who were estranged from their families felt that this would not be beneficial as it would increase the stress on affected others. A combination approach was suggested as being optimal, so people could talk individually about topics that might emotionally hurt their partner, before coming together to discuss joint issues and joint coping techniques. *No quotes reported to support this theme.*	Minor concerns (Minor concerns about methodological limitations as per CASP qualitative checklist)	Minor concerns (Findings were about advantages and disadvantages of theme)	Moderate concerns (Findings were derived from studies exploring affected others who are romantic partners and 1 study was in the context of larger experimental study)	Minor concerns (Findings only derived from 2 studies but with rich data reinforced with first-order quotes)	MODERATE

Table 11: Evidence profile for theme K1.7 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 K1.7.1 Improving availability						
2 studies • Piquette-Tomei 2008 (General qualitative inquiry, semi-structured interviews) • Wieczorek 2018 (General qualitative inquiry, semi-structured interviews)	Availability of treatment options was limited, which decreased trust in public treatment services. For example, fewer numbers of group therapy sessions meant that available groups are overcrowded, leading people to feel as though their experiences were not being heard. *'We need more counsellors. I wish they [the government] would spend more of their money on getting more counsellors because this is not going to stop on its own. I do not know how they expect to work with all of the gambling addictions with the few counsellors that we have.' (Piquette-Tomei 2008, p287)*	Minor concerns (Minor concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Moderate concerns (Findings derived from 2 studies without rich data)	MODERATE
Sub-theme K1.7.2 Improving integration						
1 study • Wieczorek 2018 (General qualitative inquiry, semi-structured interviews)	Integration of services was beneficial for people experiencing harmful gambling. This was noted during the assessment period, when people can have appointments with different professionals involved in the referral process at 1 time. It was also true during treatment, when consultations with different professionals could be scheduled for the same period. *No relevant first-order quotes reported to support this theme.*	No or very minor concerns	No or very minor concerns	No or very minor concerns	Serious concerns (Findings only derived from 1 study with limited 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
Sub-theme K1.7.3 Referrals from gambling services						
1 study • Riley 2018 (Phenomenological, semi-structured interviews and focus groups)	When gambling venues are involved in referring people to treatment services, a close working relationship allowed better feedback to be provided. This could help to increase the number of referrals, as well as provide an opportunity to discuss what works well and what could be improved in services. *No relevant first-order quotes reported 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 only derived from 1 study with limited data)	LOW
Sub-theme K1.7.4 Wait times						
1 study • Wieczorek 2018 (General qualitative inquiry, semi-structured interviews)	Shorter waiting times increased the amount of people progressing with treatment after the initial referral and access. Longer waiting times meant that decisions of what treatment to participate in, or even whether to engage at all with services, could change. *'It started fairly quickly, as I got a referral here to the outpatient clinic. The lady [receptionist] told me that I should come in the next three to four days.' (Wieczorek 2018, p204)*	No or very minor concerns	No or very minor concerns	No or very minor concerns	Moderate concerns (Findings only derived from 1 study with limited data reinforced with first-order quotes)	HIGH

K2 Improving gambling treatment services (from studies receiving any industry funding)

Table 12: Evidence profile for theme K2.1 Delivery

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 K2.1.1 Communication and feedback						
1 study • Forsstrom 2017 (General qualitative inquiry, semi-structured interviews)	Regular communication from treatment services was important to people experiencing harmful gambling. When using a digital application, this served as a reminder of their initial treatment goals and feedback throughout their rehabilitation journey. This communication should be fair and impartial, and delivered in a way that is acceptable to the individual receiving it. *'…So feedback, send an email, we see you're playing a little bit more. Over the limit there… Then you've still been seen' (Forsstrom 2017, p 59)*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	Moderate concerns (Findings were restricted to views about a specific application)	Moderate concerns (Findings only derived from 1 study but with rich data)	VERY LOW
Sub-theme K2.1.2 Flexibility and convenience						
2 studies • Wood 2007 (General qualitative inquiry [within mixed methods study], free-text questionnaires) • Woodall 2021 (General qualitative inquiry, semi-structured interviews and free-text questionnaires)	Harmful gambling treatment services should be convenient to use. Examples included geographically convenient services for face-to-face services, or temporally convenient services for digital services. *'The best thing was that it was available when I needed to talk to someone. It helped me over the urge to go out and gamble today' (Wood 2007, p11)*	Serious concerns (Serious concerns about methodological limitations as per CASP qualitative checklist)	Minor concerns (Findings were about advantages and disadvantages of theme)	Moderate concerns (Findings derived from studies exploring individual services)	Moderate concerns (Findings derived from 2 studies 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
Sub-theme K2.1.3 Format of therapy						
2 studies • Nilsson 2021 (General qualitative inquiry [within mixed methods study], semi-structured interviews) • Wood 2007 (General qualitative inquiry [within mixed methods study], free-text questionnaires)	The format in which therapy was delivered was an important factor in treatment engagement for people experiencing harmful gambling. Internet-based therapies lowered mental barriers to participating in therapy, which some people found helpful when sharing their experiences. Seeing therapists during virtual appointments (for example, using web-cameras) was preferable when this was the format offered. However, some people found that this virtual form of therapy meant that there were also fewer barriers to stopping treatment, as they did not have the personal connections to keep attending. *'I think that, for the part of my boyfriend, he probably couldn't have taken a step as big as actually talking to someone in flesh and blood. So, it was kind of, at least for him, a smaller step to take [enrolling in the RCT] than to seek ordinary care.' (Nilsson 2021, p6)*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	Minor concerns (Findings were about advantages and disadvantages of theme)	Moderate concerns (Findings were derived from studies exploring individual services [1 within the context of an RCT])	Moderate concerns (Findings derived from 2 studies without rich data)	VERY LOW

Table 13: Evidence profile for theme K2.2 Practitioners and peer supporters

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 K2.2.1 Training and values of practitioners						

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 • Nilsson 2021 (General qualitative inquiry [within mixed methods study], semi-structured interviews) • Wood 2007 (General qualitative inquiry [within mixed methods study], free-text questionnaires)	Practitioners delivering treatments for harmful gambling should be understanding, supportive and helpful to people experiencing harmful gambling. *No relevant first-order quotes reported to support this theme.*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	Minor concerns (Findings were about advantages and disadvantages of theme)	Moderate concerns (Findings were derived from studies exploring individual services [1 within the context of an RCT])	Moderate concerns (Findings derived from 2 studies without rich data and no quotations to support this theme)	VERY LOW

Table 14: Evidence profile for theme K2.3 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 K2.3.1 Clear service descriptions						
2 studies • Wood 2007 (General qualitative inquiry [within mixed methods study], free-text questionnaires) • Woodall 2021 (General qualitative inquiry, semi-structured interviews and free-text questionnaires)	Both people experiencing harmful gambling and people involved in commissioning harmful gambling treatment feel that services should be explicit about what stage of the treatment pathway they cover, and what services people can expect from them. *'No one has to come to any conclusion how you would specify who a complex client is.' (Woodall 2021, p6)*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	Moderate concerns (Findings derived from studies exploring individual services)	Moderate concerns (Findings derived from 2 studies without rich data)	LOW
Sub-theme K2.3.2 Partnership between services						
1 study	There should be good partnership between different components of a	Serious concerns	No or very minor concerns	No or very minor concerns	Serious concerns	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
• Woodall 2021 (General qualitative inquiry, semi-structured interviews and free-text questionnaires)	harmful gambling treatment pathway. This should cover voluntary sectors, education and implementation in the community, and commissioners. *No relevant first-order quotes reported to support this theme.*	(Serious concerns about methodological limitations as per CASP qualitative checklist)			(Findings derived from 2 studies without rich data)	

K3 Improving gambling treatment services (from studies receiving funding from an unclear funding source)

Table 15: Evidence profile for theme K3.1 Content of therapy

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 K3.1.1 Cue exposure						
1 study • Dunn 2012 (General qualitative inquiry [within mixed methods study], semi-structured interviews)	People experiencing harmful gambling found that cue exposure was a more focused and useful approach when compared to other, more general, therapies they had experienced. However, in some people, it might also increase early perceptions of gambling control which might then lead to increased drop-out rates from treatment. *'…it [cue exposure] gave me a better understanding of how it all works.' (Dunn 2012, p276)*	Minor concerns (Minor concerns about methodological limitations as per CASP qualitative checklist)	Minor concerns (Findings were about advantages and disadvantages of theme)	Moderate concerns (Findings were derived from a small sample group)	Moderate concerns (Findings only derived from 1 study with moderately rich data)	LOW
Sub-theme K3.1.2 Supporting empowerment						
2 studies	People experiencing harmful gambling were more likely to engage in treatment services that framed	Minor concerns (Minor concerns about	No or very minor concerns	No or very minor concerns	Moderate 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
• Guilcher 2016 (General qualitative inquiry, semi-structured interviews) • Pickering 2019a (General qualitative inquiry, semi-structured interviews)	them as active participants in their treatment and allowed them to gain skills for future independence. This allowed them to take ownership of their recovery journey. *'Actually owning it… you can't really blame anyone else… for what I am doing myself. I am the one putting money through these machines… So, not being in denial, that yes, I do have a problem and, you know, I am seeking the help.' (Pickering 2019a, p17)*	methodological limitations as per CASP qualitative checklist)			(Findings only derived from 2 studies but without rich data)	
Sub-theme K3.1.3 Personalised goals						
5 studies • Dunn 2012 (General qualitative inquiry [within mixed methods study], semi-structured interviews) • Guilcher 2016 (General qualitative inquiry, semi-structured interviews) • Lee 2008 (General qualitative inquiry [within mixed methods study], free-text questionnaires and focus groups) • Pickering 2019a (General qualitative inquiry, semi-structured interviews)	Treatment goals should be set by people in treatment for harmful gambling and their affected others (if they are also involved in treatment). For example, individuals might have different opinions on whether abstinence or harm-reduction is their aim. For couples involved in harmful gambling treatment, goals should focus on their own relationship and what they perceive as being the biggest issues. This may or may not relate directly to harmful gambling. *No relevant first-order quotes reported to support this theme.*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	Moderate concerns (Findings were taken from different groups of people, each with their own interpretation of personal goals)	No or very minor concerns	No or very minor 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
• Smith 2016 (General qualitative inquiry, semi-structured interviews)						
Sub-theme K3.1.4 Real-world context						
3 studies • Dunn 2012 (General qualitative inquiry [within mixed methods study], semi-structured interviews) • Guilcher 2016 (General qualitative inquiry, semi-structured interviews) • Smith 2016 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling found it helpful when their treatment was related to their daily experiences. 'Homework' from therapy helped this by allowing them time to reflect on treatment within their everyday space, particularly if they were still attending gambling venues. Treatment should also be realistic to implement for people, and not interfere with their daily lives. '*Now I can sit and see the others, what they are doing. I see who they are. Other people must have looked at me that way*.' (Dunn 2012, p266)	Minor concerns (Minor concerns about methodological limitations as per CASP qualitative checklist)	Moderate concerns (Findings related to both implementing learning and convenience of treatment itself)	No or very minor concerns	Minor concerns (Findings only derived from 3 studies but with rich data reinforced with first-order quotes)	MODERATE
Sub-theme K3.1.5 Relapse planning and prevention						
3 studies • Dunn 2012 (General qualitative inquiry [within mixed methods study], semi-structured interviews) • Pickering 2019a (General qualitative inquiry, semi-structured interviews) • Piquette 2013 (General qualitative inquiry, semi-	People experiencing harmful gambling felt as though the topic of relapse was taboo and shameful. Therapies that encouraged conversation around this topic, acceptance of it as part of the recovery journey, and planning for it were preferred. '*You'll have your weak days and strong days, but what you have to remember about your weak days is you'll come through it. And even if you*	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 only derived from 3 studies but with rich data reinforced with first-order quotes)	MODERATE

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
structured interviews and focus groups)	*do lapse, it's hard to come to terms with, but don't lose faith*.' (Pickering 2019a, p16)					
Sub-theme K3.1.6 Understanding addiction and treatment						
3 studies • Dunn 2012 (General qualitative inquiry [within mixed methods study], semi-structured interviews) • Pickering 2019a (General qualitative inquiry, semi-structured interviews) • Piquette 2013 (General qualitative inquiry, semi-structured interviews and focus groups)	Therapies proved more effective when they included information on the development of addiction, the process of gambling and how treatment was designed to combat this. '*Went through all of the various types of gamblers that there are. Um, I know for myself I could see myself in every one of the steps, into how you go from being a non- or social gambler into [being a] problem or compulsive gambler. Gosh, I can see myself. I can see this progression, learning how you become addicted to the actual gambling, because for myself, I never thought of it as an addiction. I thought, 'I am a smoker or addicted to smoking.' That I understand'*. (Piquette 2013, p63)	Minor concerns (Minor concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Minor concerns (Findings only derived from 3 studies but with rich data reinforced with first-order quotes)	HIGH

Table 16: Evidence profile for theme K3.2 Delivery

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 K3.2.1 Inadequate provision						
1 study • Shandley 2008 (General qualitative inquiry [within mixed	People experiencing harmful gambling calling into a telephone helpline had greater expectations about what services could be	Serious concerns (Serious concerns about	No or very minor concerns	Moderate concerns (Findings participants	Serious concerns	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
methods study], semi-structured interviews)	delivered and what help was available than what was actually the case. This left them feeling dissatisfied with the service overall. *'Wanting someone to make the contacts for me because feeling overburdened and am going into hospital next week.' (Shandley 2008, p323)*	methodological limitations as per CASP qualitative checklist)		included non-gamblers)	(Findings only derived from 1 study without rich data)	
Sub-theme K3.2.2 Flexibility and convenience						
3 studies • Dunn 2012 (General qualitative inquiry [within mixed methods study], semi-structured interviews) • Pickering 2019b (General qualitative inquiry, semi-structured interviews) • Smith 2016 (General qualitative inquiry, semi-structured interviews)	People experiencing harmful gambling were more likely to engage in services that suited their schedule and were flexible around other commitments. This flexibility could be offered through opening times, format of delivery or content of therapy. For virtual treatments, over-complicated sign-up procedures and restrictive programmes were seen to be detrimental to engagement. *'A lot of people may not be technically savvy enough to do that, and for me there was a lot of technicalities and legalities that I didn't necessarily understand. (Pickering 2019b, p8)*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	Minor concerns (Findings derived from mixed evidence on in-person and virtual therapies)	Moderate concerns (Findings were mainly derived from studies exploring lad-based self-exclusion criteria and 1 study was in the context of larger experimental study)	Minor concerns (Findings only derived from 3 studies but with rich data reinforced with first-order quotes)	LOW
Sub-theme K3.2.3 Format of therapy – range of formats						
1 study • Rodda 2019 (General qualitative inquiry, semi-structured interviews)	Professionals involved in the treatment of harmful gambling believed that services should offer a hybrid format to the therapies offered. Digital formats could be used to	Minor concerns (Minor concerns about methodological limitations as per	No or very minor concerns	Moderate concerns (Findings derived from studies exploring online therapy formats	Serious 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
	supplement face-to-face treatments (for example, video, telephone, or email). This would allow for the flexibility of virtual therapies and the increased engagement people described with face-to-face treatment. *'I think it just needs to be a part of what a service can offer a participant and I think if it is offered to a participant that has an existing relationship with a service then it's probably more likely to be taken up rather than if somebody stumbles over a website. (Rodda 2019, p6)*	CASP qualitative checklist)		only and within the context of a larger experimental study)		
Sub-theme K3.2.4 Format of therapy – advantages of group therapy						
5 studies • Flores-Pajot 2021 (General qualitative inquiry, semi-strucutred interviews and focus groups) • Guilcher 2016 (General qualitative inquiry, semi-structured interviews) • Heiskanen 2017 (General qualitative inquiry, semi-structured interviews) • Penfold 2021 (General qualitative inquiry, semi-structured interviews) • Piquette 2013 (General qualitative inquiry, semi-	Group therapy allowed people experiencing harmful gambling to share their story in a non-judgemental environment. It also allowed them to hear other people's experiences and gain techniques and skills to maintain their treatment goals. Practical advice was also an important factor, as people often shared how to access certain auxiliary services, such as financial support services. '*you get practical help from there [GA] as well, they can advise what to do and, you get some courage to contact different places [authorities and creditors].*' (Heiskanen 2017, p32)	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	MODERATE

Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
structured interviews and focus groups)						
Sub-theme K3.2.5 Format of therapy – role of online options						
3 studies • Marionneau 2021 (General qualitative inquiry, free-text questionnaires) • Penfold 2021 (General qualitative inquiry, semi-structured interviews) • Rodda 2019 (General qualitative inquiry, semi-structured interviews)	There are mixed opinions regarding online treatments. On one hand, it increased flexibility, types of treatment offered and novelty. On the other hand, online options increased the levels of dis-engagement within therapy. People felt as though they did not form the same level of personal attachments through this method of delivery when compared to in person treatment. *'...the only reason I've changed this time is because I've gone onto the steps meeting on Zoom. If I'm honest, and that's what the GA programme is all about, and that's the message I'm hearing on the Zoom meeting is…get on the Steps meetings. Get on the steps.' (page 5, Penfold 2021)*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	Moderate concerns (Findings were about advantages and disadvantages of theme)	Moderate concerns (Findings were derived from 2 studies exploring treatment during a specific period and event [COVID-19] and 1 study in the context of larger experimental study)	No or very minor concerns	VERY LOW

Table 17: Evidence profile for theme K3.3 Practitioners and peer supporters

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 K3.3.1 Communication and feedback						
1 study • Rodda 2019 (General qualitative inquiry, semi-structured interviews)	Professionals involved in the treatment of harmful gambling viewed communication as a 2-way process. They were discouraged when they felt people were not engaging in	Minor concerns (Minor concerns about methodological limitations as per	No or very minor concerns	Moderate concerns (Findings were derived from study exploring online	Moderate concerns (Findings only derived from 1 study 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
	treatment. Having up-to-date information on service users was seen as helpful to increase therapist engagement. Additionally, counsellors preferred to communicate and offer feedback to people in a personalised manner, even if this was virtual. They reported that it allowed them to build better relationships with service users, which increased engagement in treatment. *'From my perspective, there's not enough integration between what the participant has actually been doing within the program and what information you have, other than if they tell you so in their email exchange.' (Rodda 2019, p5)*	CASP qualitative checklist)		therapy formats only and within the context of larger experimental study)		
Sub-theme K3.3.2 Training and values of practitioners						
6 studies • Guilcher 2016 (General qualitative inquiry, semi-structured interviews) • Heiskanen 2017 (General qualitative inquiry, semi-structured interviews) • Lee 2008 (General qualitative inquiry [within mixed methods study], free-text questionnaires and focus groups) • Marionneau 2021 (General qualitative	Therapeutic relationships were paramount in how people experiencing harmful gambling engaged in treatment. Due to the stigmatising nature of harmful gambling, people felt less likely to engage if they felt disrespected or their problems were being minimised by therapists. Instead, healthcare professionals should be empathetic, compassionate, and sincere during appointments. Outside of therapist -gambler relationships, people felt as though professionals involved in the wider	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	Moderate concerns (Findings derived from a range of professionals with different roles in the harmful gambling pathway)	No or very minor concerns	No or very minor 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
inquiry, free-text questionnaires) • Pickering 2019b (General qualitative inquiry, semi-structured interviews) • Shandley 2008 (General qualitative inquiry [within mixed methods study], semi-structured interviews)	treatment pathway (from general practitioners to financial advisors) should be aware of the impact of harmful gambling and the range of other services potentially available. '*Like I said with gambling or drinking, whatever, but just speaking to a regular doctor, I thought this is not their specialty. I felt somewhat embarrassed because I looked at it like…a sign of weakness, and kind of like not mentally stable, and I was worried about coming across that way. I didn't want to feel that way. I especially more recently being in an environment of shelters, I seen people with mental health problems, I didn't want to be like them. I didn't want to be associated like as being someone like that.' (Guilcher 2016, p6)*					

Table 18: Evidence profile for theme K3.4 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 K3.4.1 Crisis intervention						
1 study • Guilcher 2016 (General qualitative inquiry, semi-structured interviews)	Treatment services for gambling-related harms should include crisis intervention services, as people often required urgent help by the time they tried to access services.	No or very minor concerns	No or very minor concerns	No or very minor concerns	Serious concerns (Findings only derived from 1 study without rich data and no first-order quotes)	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 relevant first-order quotes reported to support this theme.					
Sub-theme K3.4.2 Consistency and care continuity						
1 study • Marionneau 2021 (General qualitative inquiry, free-text questionnaires)	Continuity of treatment for gambling-related harms (either as a person experiencing harmful gambling or as an affected other) is important to ensure progress is maintained. *'It would be good to have widely available distance support right not. Now many have almost a mandatory opportunity to wean off gambling, and correctly aimed support might be crucial to also not gamble in the future.' (Marionneau 2021, p15)*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	Moderate concerns (Findings were derived studies exploring treatment during a specific period and event [(COVID-19])	Serious concerns (Findings only derived from 1 study with moderately rich data)	VERY LOW
Sub-theme K3.4.3 Improving integration						
1 study • Marionneau 2021 (General qualitative inquiry, free-text questionnaires)	Treatment services for harmful gambling should be integrated into several different systems in order to increase the opportunity for early interventions for gambling-related harms. These included regular health check-ups, social benefit system, income support, and child services. *'Integration of gambling addiction support in occupational healthcare' (Marionneau 2021, p16)*	Moderate concerns (Moderate concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	Moderate concerns Findings were derived studies exploring treatment during a specific period and event [COVID-19])	Serious concerns (Findings only derived from 1 study without rich data)	VERY LOW
Sub-theme K3.4.4 Physical attributes						
1 study	The location and presentation of harmful gambling treatment services were important in fostering trust and ensuring continued attendance. This	No or very minor concerns	No or very 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
• Guilcher 2016 (General qualitative inquiry, semi-structured interviews)	extended to the presentation of service staff, who should not appear overly clinical, for instance in their manner or their dress. *'This [service agency] is in the middle of [name of park]. It's the biggest crack haven in the entire city, okay. So, let me get this straight. We're smart, we're going to put a rehab right in the middle of crack land. Are you kidding me. What do you think the success rate is there? It's horrible. You can't even go to the store and get a pack of cigarettes without some dealer in your face. Right, this is a problem. This needs to change.' (Guilcher 2016, p8)*				(Findings only derived from 1 study without rich data)	
Sub-theme K3.4.5 Treatment of co-morbidities and social issues						
3 studies • Guilcher 2016 (General qualitative inquiry, semi-structured interviews) • Heiskanen 2017 (General qualitative inquiry, semi-structured interviews) • Pickering 2019b (General qualitative inquiry, semi-structured interviews)	Many people experiencing harmful gambling also have other co-morbidities (for example, substance use disorders) and social issues (for example, financial issues or employment concerns). These need to be addressed in combination with harmful gambling in order for treatment to be holistic and effective. *'I think the big fault with our health system is listen I know I have a drug problem, and you can go to meetings and you can go to rehabs, and they're all great, they're still not telling me why… So, at the end of the day, the*	Minor concerns (Minor concerns about methodological limitations as per CASP qualitative checklist)	No or very minor concerns	No or very minor concerns	Minor concerns (Findings only derived from 3 studies but with rich data reinforced with first-order quotes)	HIGH

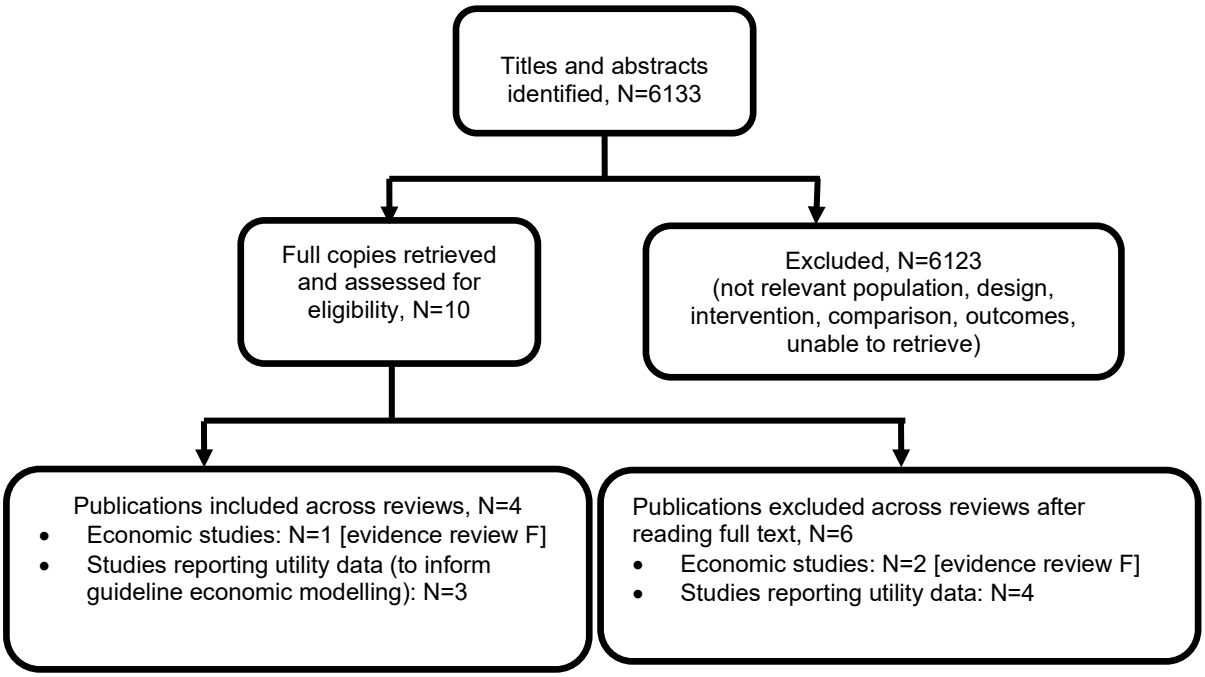
Study information	Description of theme or finding	CERQual Quality assessment				
		Methodological limitations	Coherence of findings	Relevance of evidence	Adequacy of data	Overall confidence
	crack's not the problem, the gambling's not the problem, that's the solution to us. That's our solution, right. So, we have to figure out what's causing the problem in the first place. We're not doing that…' (Guilcher 2016, p9)					

Appendix G Economic evidence study selection

Study selection for: What works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, 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 works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

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

Appendix I Economic model

Economic model for review question: What works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, 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 works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, 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 19: Excluded studies and reasons for their exclusion

Study	Code [Reason]
Achab, S., Chatton, A., Khan, R. et al. (2014) Early Detection of Pathological Gambling: Betting on GPs' Beliefs and Attitudes. BioMed Research International 2014: 360585	- Study design Quantitative data only
Corney, R. (2008) Female frequent internet gamblers: A qualitative study of their gambling, its impact and their views on treatment and policy. INTERNATIONAL JOURNAL OF PSYCHOLOGY 43(34): 431-431	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
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	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Farrelly, S., Ffrench, C., Ogeil, R.P. et al. (2007) Coping strategies and problem gambling. Behaviour Change 24(1): 14-24	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Gavriel-Fried, B. (2018) What helps people recover from a gambling disorder-Learning from those who succeed. Journal of Behavioral Addictions 7(supplement1): 71-72	- Publication type Conference abstract
Hakansson, A. and Widinghoff, C. (2020) Gambling Despite Nationwide Self-Exclusion-A Survey in Online Gamblers in Sweden. Frontiers in Psychiatry 11: 599967	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
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	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Ivanova, Ekaterina, Rafi, Jonas, Lindner, Philip et al. (2019) Experiences of responsible gambling tools among non-problem gamblers: A survey of active customers of an online gambling platform. Addictive behaviors reports 9: 100161	- Study design Quantitative data only
Johansen, Ayna B, Helland, Pal Fylling, Wennesland, Dag K et al. (2019) Exploring online problem gamblers' motivation to change. Addictive behaviors reports 10: 100187	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.

Study	Code [Reason]
Kotter, Roxana; Kraplin, Anja; Buhringer, Gerhard (2018) Casino Self- and Forced Excluders' Gambling Behavior Before and After Exclusion. Journal of gambling studies 34(2): 597-615	- Study design Quantitative data only
Ladouceur, R, Jacques, C, Giroux, I et al. (2000) Analysis of a casino's self-exclusion program. Journal of gambling studies 16(4): 453-60	- Study design Quantitative data only
McComb, Jennifer L; Lee, Bonnie K; Sprenkle, Douglas H (2009) Conceptualizing and treating problem gambling as a family issue. Journal of marital and family therapy 35(4): 415-31	- Study design Narrative review
McGowan, Virginia (2003) Counter-story, resistance and reconciliation in online narratives of women in recovery from problem gambling. International Gambling Studies 3(2): 115-131	- Other protocol criteria Paper does not provide sufficient methodological detail for critical appraisal
Morasco, B.J., Weinstock, J., Ledgerwood, D.M. et al. (2007) Psychological Factors that Promote and Inhibit Pathological Gambling. Cognitive and Behavioral Practice 14(2): 208-217	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Nelson, Sarah E, Kleschinsky, John H, LaBrie, Richard A et al. (2010) One decade of self exclusion: Missouri casino self-excluders four to ten years after enrollment. Journal of gambling studies 26(1): 129-44	- Study design Quantitative data only
NORRIE, Caroline and et, al (2022) Transferable learning about patient and public involvement and engagement in gambling support services from health and social care: findings from a narrative review and workshop with people with lived experience. Journal of Integrated Care	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
NUSKE, Elaine and HING, Nerilee (2013) A narrative analysis of help-seeking behaviour and critical change points for recovering problem gamblers: the power of storytelling. Australian Social Work 66(1): 39-55	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Oakes, J, Pols, R, Battersby, M et al. (2012) A focus group study of predictors of relapse in electronic gaming machine problem gambling, part 2: factors that 'pull' the gambler away from relapse. Journal of gambling studies 28(3): 465-79	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Oakes, Jane; Pols, Rene; Lawn, Sharon (2019) The 'Merry-Go-Round' of Habitual Relapse: A Qualitative Study of Relapse in Electronic Gaming Machine Problem Gambling. International journal of environmental research and public health 16(16)	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Pulford, Justin, Bellringer, Maria, Abbott, Max et al. (2009) Barriers to help-seeking for a gambling problem: the experiences of gamblers who have sought specialist assistance and the perceptions of those who have not. Journal of gambling studies 25(1): 33-48	- Study design Quantitative data only

Study	Code [Reason]
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 Family-Focused Options. International Journal of Mental Health and Addiction	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Takushi, Ruby Y, Neighbors, Clayton, Larimer, Mary E et al. (2004) Indicated prevention of problem gambling among college students. Journal of gambling studies 20(1): 83-93	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Thomas, Samantha L; Lewis, Sophie; Westberg, Kate (2015) 'You just change the channel if you don't like what you're going to hear': gamblers' attitudes towards, and interactions with, social marketing campaigns. Health expectations : an international journal of public participation in health care and health policy 18(1): 124-36	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Thomas, Samantha L, Randle, Melanie, Bestman, Amy et al. (2017) Public attitudes towards gambling product harm and harm reduction strategies: an online study of 16-88 year olds in Victoria, Australia. Harm reduction journal 14(1): 49	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Victorian Responsible Gambling Foundation (2012) The Victorian gambling study – qualitative component.	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.
Wieczorek, L. and Dabrowska, K. (2021) Unsatisfied treatment needs of people with comorbid alcohol/drug use and gambling disorder. Journal of Substance Use	- Phenomenon of interest No themes or data relating to what works well and/or what could be improved in gambling treatment services.

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 works well and what could be improved in gambling treatment services, including treatments for individuals, family approaches and relapse prevention, from the perspective of practitioners, people who participate or have participated in harmful gambling, and their families, friends and others close to them?

K.1.1 Research recommendation

How should gambling treatment services be adapted to meet the needs of diverse populations (for example, different ages, different races or cultural backgrounds, or people with varying neurodiversity)?

K.1.2 Why this is important

There is qualitative evidence about the preferences and views of people who experience harmful gambling about what works and what can be improved in gambling treatment services, but, apart from 2 very small studies of female gamblers, this evidence did not provide any information prospectively obtained and analysed to take into account the different needs of a diverse population. This could include people from different cultures, races or religions where gambling may be perceived differently, or people with different levels of neurodiversity.

K.1.3 Rationale for research recommendation

Table 20: Research recommendation rationale

Importance to 'patients' or the population	People from diverse groups (different cultures, races, religions, occupations and neurodiversity) are entitled to receive treatment for harmful gambling that meets their needs.
Relevance to NICE guidance	NICE guidelines do not offer advice on how treatment should be modified for different groups due to a lack of evidence.
Relevance to the NHS	NHS specialist gambling clinics are currently being set up nationwide and will need to offer treatments that are suitable for a diverse population.
National priorities	Treatment of harmful gambling is a national priority for the Office for Health Improvement and Disparities.
Current evidence base	No evidence for diverse populations was available as part of this evidence review
Equality considerations	The aim of this research is to ensure that treatment for harmful gambling is delivered in a way that is applicable to a wide variety of diverse groups.

K.1.4 Modified PICO table

Table 21: Research recommendation modified PICO table

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 the identification, assessment and management 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	What adaptations are required to gambling treatment services to ensure they are suitable for diverse population. Themes will be identified from the literature but may include: • Adaptations to increase cultural relevance • Providing services in alternative locations • Providing services in different languages or with, for example, the use of language or sign language interpreters • Amending treatments to increase accessibility for neurodiverse people • Amending treatments to increase accessibility for older people
Comparator	Not applicable for qualitative review
Outcome	Not applicable for qualitative review
Study design	Qualitative
Timeframe	Not applicable for qualitative review
Additional information	None