NICE National Institute for Health and Care Excellence

NICE guideline

Gambling-related harms: identification, assessment and management

NICE guideline

Published: 28 January 2025

www.nice.org.uk/guidance/ng248

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the Yellow Card Scheme.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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Overview

This guideline covers identifying, assessing and treating gambling-related harms. This includes people aged 18 and over who are experiencing gambling that harms, and people of any age affected by someone close to them who is experiencing gambling that harms.

Who is it for?

- Commissioners and providers of gambling treatment and gambling support services
- Healthcare professionals and social care practitioners in all settings, including the criminal justice system
- People who experience gambling-related harms or who use gambling treatment and gambling support services, their families and affected others

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Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

For information on how this guideline will be implemented, see the implementation statement.

1.1 Case identification, initial support, referral and assessment

Stigma

1.1.1 Recognise that stigma, shame and fear of disclosure can prevent people who are experiencing gambling-related harms from talking about gambling, and from seeking and accessing support and treatment. In addition, stigma may be a particular issue for certain groups such as people from marginalised, minority or under-represented groups.

For recommendations on overcoming stigma, see the section on improving access to treatment.

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For a short explanation of why the committee made this recommendation and how it might affect practice, see the rationale and impact section on improving access to treatment.

Full details of the evidence and the committee's discussion are in evidence review I: access.

Asking about gambling

These recommendations are for healthcare professionals and social care practitioners in all settings including the criminal justice system.

1.1.2 Consider asking people about gambling (even if they have no obvious risk factors for gambling-related harm) when asking them about smoking, alcohol consumption or use of other substances (for example, as part of a holistic assessment or health check, when registering for a service such as with a GP or in contacts with social services).

1.1.3 Ask people about gambling in the following situations because they may be at increased risk of gambling-related harm:

- when they present in any setting with a mental health problem or concern, in particular thoughts about self-harm or suicide, depression, anxiety, psychosis and bipolar disorder, post-traumatic stress disorder (PTSD), personality disorder, or attention deficit hyperactivity disorder (ADHD)
- when they are taking medicines that may affect impulse control, for example, dopamine agonists for Parkinson's disease, or aripiprazole for psychosis; see NICE's guideline on Parkinson's disease for advice on managing and monitoring impulse control disorders as an adverse effect of dopaminergic therapy
- at each key contact with the criminal justice system (for example, with the police, liaison and diversion services, probation services, courts and prisons)
- when they present in any setting with problems relating to alcohol or substance dependence, especially use of cocaine

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- when they are at risk of or experiencing homelessness
- when they share that they have financial concerns
- when there are concerns about safeguarding issues or violence, including domestic abuse
- when they share that there is a family history of gambling that harms or alcohol or substance dependence.

1.1.4 Consider asking people about gambling if they may be at increased risk of harm:

- because they have a neurological condition or acquired brain injury that leads to disinhibition or increased impulsivity
- because they are a young person who has recently left home for the first time
- because of their current or past occupation, for example, armed forces personnel, veterans, people working in the gambling or financial industry, and sports professionals.

1.1.5 Take into account that having multiple risk factors may have a cumulative effect and further increase the person's chances of experiencing gambling-related harms.

1.1.6 Use direct questions to ask people about gambling, such as: 'Do you gamble?' or 'Are you worried about your own or another person's gambling?'. Be aware that some people may find it difficult to talk about gambling.

1.1.7 Encourage people who have concerns about gambling to assess the level of gambling-related harms by asking them to complete the questionnaire available on the NHS website.

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For a short explanation of why the committee made these recommendations and how they might affect services, see the rationale and impact section on asking about gambling.

Full details of the evidence and the committee's discussion are in evidence review A: factors suggesting harmful gambling and evidence review B: tools for identification and assessment of harmful gambling.

Initial support for people experiencing gambling-related harms

These recommendations are for healthcare professionals and social care practitioners in all settings including the criminal justice system.

1.1.8 Advise people experiencing gambling-related harms that support and treatment are available and recovery is possible.

1.1.9 If a person is experiencing gambling-related harms, offer initial help and support. Depending on the setting, the severity of the harms and the level of concern, this could include:

- providing information on gambling-related harms (see the recommendations on information and support)
- encouraging and supporting them to seek help, for example, from their healthcare provider or social worker
- signposting them to resources and services for further help and advice (for example, the NHS website on help for problems with gambling, gambling support groups, local authority resources and the national gambling helpline), some of which can be accessed anonymously
- referring or signposting them to gambling support and gambling treatment services (see the recommendations on referral and triage).

1.1.10 Consider brief motivational interviewing to encourage people to seek further help and support if they are reluctant to access services.

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1.1.11 Recognise that gambling and gambling-related harms can be a dominant risk factor for suicidal ideation and suicide attempts, even in the absence of other risk factors.

1.1.12 If a person experiencing gambling-related harms presents considerable or immediate risk to themselves or others, refer them urgently to specialist mental health services or a crisis team, via the emergency services if necessary. See NICE's guideline on self-harm: assessment, management and preventing recurrence.

1.1.13 Ask people experiencing gambling-related harms directly about suicidal ideation and intent. If there is a risk of self-harm or suicide:

- tell them about the known link between gambling-related harms and suicide, and that the risk may be highest immediately after a gambling episode
- put in place a safety plan to help them manage the acute risk; see the section on interventions for self-harm in NICE's guideline on self-harm: assessment, management and preventing recurrence
- assess whether they have social support (for example, from their family or friends) to help protect them and are aware of other sources of help (for example, voluntary sector organisations or social care services)
- consider mobilising social support to help protect the person (for example, by contacting their family or friends, balancing the possible benefits and risks of involving family members or carers with the rights of the person)
- advise them to seek further help if the situation deteriorates.

1.1.14 Discuss with people the possibility of practical self-exclusion techniques that could be used to prevent gambling, including:

- blocking software or tools to prevent online gambling
- blocking marketing messages
- self-exclusion systems for land-based gambling such as casinos, arcades and betting shops

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- systems that block gambling payments through the person's bank account
- methods to limit access to money, for example, agreeing that a family member will take control of finances.

1.1.15 Consider providing advice on how and where to seek help and support with:

- finances, including debt management
- social issues such as housing
- employment or employer issues
- legal issues
- domestic violence or other harms to family relationships, including economic abuse and coercive behaviour.

For a short explanation of why the committee made these recommendations and how they might affect services, see the rationale and impact section on initial support for people experiencing gambling-related harms.

Full details of the evidence and the committee's discussion are in evidence review A: factors suggesting harmful gambling.

Referral and triage

These recommendations are for healthcare professionals and social care practitioners in all settings including the criminal justice system. They may also be relevant to commissioners and providers of gambling treatment and gambling support services.

1.1.16 Consider referring people experiencing gambling that harms via an NHS triage service, for triage and allocation to an appropriate level of service.

1.1.17 When discussing support or treatment with the person, tell them that self-referral, via an NHS triage service or the national gambling helpline, is an option.

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1.1.18 Recognise that gambling severity can vary over time and recent onset or short periods of less intense gambling, even after a period of abstinence, can lead to severe harms in some people, and may require referral to a gambling treatment service.

1.1.19 Consider referring affected others to gambling treatment or support services, depending on their level of need.

For a short explanation of why the committee made these recommendations and how they might affect services, see the rationale and impact section on referral and triage.

Full details of the evidence and the committee's discussion are in evidence review B: tools for identification and assessment of harmful gambling.

Assessment of gambling that harms

These recommendations are for providers of gambling treatment services.

1.1.20 Consider using an up-to-date validated tool to assess gambling that harms (examples include the Problem Gambling Severity Index and the South Oaks Gambling Screen).

1.1.21 Discuss the person's gambling with them and assess the following:

- gambling history (when the gambling started and how it has progressed, including when the frequency or intensity increased)
- type(s) and location of gambling activities
- current frequency of gambling (for example, days per week or hours per day)
- medical history, including physical and mental health, neurodevelopmental history, acquired brain injury, comorbidities, and alcohol or substance dependence
- childhood development and family history
- current mental health and the relationship with gambling-related harms (see

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recommendation 1.5.7)

- the impact of gambling on their mental health (for example, depression, anxiety and insomnia) and their physical health
- risk of suicide, including any past attempts
- financial impact of gambling (for example, money spent on gambling as a proportion of income, borrowing or stealing money for gambling)
- how gambling affects other aspects of their life (for example, social functioning, interpersonal relationships, employment, education and whether it has led to any involvement in crime)
- psychological functions of gambling for them, or the motivation for gambling
- factors that may contribute to continued gambling (for example, triggers and cravings, and how thoughts and emotions may have been influenced)
- role of advertising and marketing in contributing to gambling
- alignment to ICD-11 or DSM-5 criteria for gambling disorder
- reasons for seeking support, motivation to change and expectations and goals of treatment
- safeguarding issues or concerns
- immediate needs (for example, help with housing, food and debts).

1.1.22 Assess whether current pharmacological therapy may be contributing to gambling that harms (for example, aripiprazole and medicines for Parkinson's disease). Think about reducing or optimising these medicines in consultation with the relevant specialist services.

1.1.23 Develop a case formulation, care plan and safety plan (if needed) with the person based on the results of the assessment, including any immediate actions that can be taken (see recommendation 1.1.14).

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For a short explanation of why the committee made these recommendations and how they might affect services, see the rationale and impact section on assessment of gambling that harms.

Full details of the evidence and the committee's discussion are in evidence review B: tools for identification and assessment of harmful gambling.

1.2 Information and support

These recommendations are for providers of gambling treatment and gambling support services.

For more guidance on communication and giving information, including providing accessible information, see NICE's guidelines on patient experience in adult NHS services and service user experience in adult mental health. For advice on discussing risks and benefits, see NICE's guideline on shared decision making.

1.2.1 Provide unbiased information to people who are experiencing gambling-related harms (including affected others) to support their treatment and recovery. This could include information on:

- why people gamble and what induces them to continue gambling or return to gambling, despite the harm; include information on the addictive nature of gambling, effects on the reward system in the brain and how the gambling industry and advertising may incentivise, encourage and promote gambling behaviour
- the different types of gambling activities, how different products are targeted to different groups of people (for example, in-game sports betting is promoted mainly to young men and some online games are promoted mainly to women) and how the addictive characteristics and harm of different gambling products and environments may vary
- that it is common to feel shame or fear and to experience stigma when disclosing gambling harms
- the harms that can be caused by gambling, for example, distress; impact on

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self-esteem, self-control, decision making and mental health; the potential for increased risk of suicide, debt and possible involvement in crime

- how to recognise the potential harms associated with gambling, including the link with mental health conditions, and alcohol or substance dependence
- what services are available for gambling-related harms (including crisis services for people at risk of suicide; voluntary sector organisations or social care services; and national, regional or local treatment services) and how to access them (see the recommendations on referral and triage)
- how to access other sources of support for gambling-related harms (for example, informal support from family and friends, peer support groups and online forums)
- how to access practical support (for example, debt services, financial help and advice on how to avoid gambling sites, inducements and marketing).

1.2.2 Discuss with people experiencing gambling-related harms:

- their reasons for seeking support and treatment and how these can help to motivate them to change
- that recovery is achievable (for example, sharing positive testimonies, stories and films and providing access to people who have recovered from gambling-related harms).

1.2.3 Provide unbiased information to affected others, including:

- how they can support the person who is experiencing gambling that harms
- how they can be supported by gambling treatment services, healthcare providers, voluntary sector organisations or social care services, either with the person experiencing gambling that harms or by themselves
- how they can access help for themselves, including support for their own mental health and practical issues such as financial support.

1.2.4 Provide information and support in ways that the person prefers, for example, at face-to-face consultations or online, such as through websites, apps or social

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media.

1.2.5 Service providers should ensure that information:

- is well promoted and signposted in local and national health and social care services, as well as in the wider community, including in the criminal justice system
- can be accessed anonymously.

For a short explanation of why the committee made these recommendations and how they might affect services, see the rationale and impact section on information and support.

Full details of the evidence and the committee's discussion are in evidence review C: information and support.

1.3 Models of care and service delivery

These recommendations are for commissioners and providers of gambling treatment and gambling support services.

Gambling treatment services

Gambling treatment services will be commissioned by the NHS but may be provided by a range of providers, including the NHS or voluntary sector organisations. At the time of publication (January 2025), only the specialist gambling clinics are commissioned by the NHS. However, there is a planned reconfiguration of gambling treatment services. There will therefore be a period over which this change will be fully implemented (see the implementation statement).

1.3.1 Gambling treatment services should include:

- specialist gambling clinics, which will usually provide assessment, information, treatment and support, including case management, for people with a greater severity of gambling-related harms or a greater severity of co-

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occurring needs (such as mental health conditions, suicidality, previous trauma, neurodiversity, learning disabilities, and alcohol or substance dependence)

- community-based gambling treatment services, which will usually provide treatment and support for people experiencing gambling-related harms, including affected others, but with lower levels of gambling-related harms or complexity than specialist gambling clinics.

Gambling support services

Gambling support services may be commissioned by the NHS or may operate independently and be provided by a range of providers, including the NHS or voluntary sector organisations.

1.3.2 Gambling support services should provide information and support to people experiencing gambling-related harms, including affected others. This support may include brief interventions, peer support, advice and signposting and referring to other services, including gambling treatment services.

All services

1.3.3 Gambling treatment and support services should be provided to meet the needs of people with different levels of gambling-related harm.

1.3.4 People should be offered the appropriate level of care to meet their needs, based on the severity of their gambling (including the Problem Gambling Severity Index score if available), presence of comorbidities, other co-occurring needs, and according to their preferences.

1.3.5 Gambling treatment and support services should be commissioned and provided without influence or involvement from the gambling industry, ensuring there are no conflicts of interest between the commissioners and providers of services and the gambling industry.

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1.3.6 Commissioners and service providers should ensure that all services:

- allow for the prompt and ongoing assessment of the risk and severity of gambling-related harms, including the risk of suicide and self-harm
- take into account the needs of the individual to ensure that people are offered the relevant support and treatment, referring people to other services such as specialist gambling clinics if necessary
- deliver timely support so that treatment can start as soon as possible after assessment
- provide easy access to treatment, including for people who may otherwise find it difficult to access services (for example, people experiencing homelessness, people in the criminal justice system and in military service); see the recommendations on improving access to treatment
- are multidisciplinary and provide coordinated support for people experiencing gambling-related harms across mental and physical health services and local authorities, including social care and the criminal justice system, with agreed protocols for sharing information between providers
- work with services for people with learning disabilities, mental health conditions (such as PTSD or severe ADHD), alcohol or substance dependence, or acquired cognitive impairments (see recommendation 1.5.8)
- provide support and treatment for as long as needed, including follow-up and aftercare support
- support the integrated delivery of services across providers, to ensure that people do not fall into gaps in service provision.

1.3.7 Commissioners and providers should ensure that the workforce delivering support and treatment services for people experiencing gambling-related harms is trained and competent to do so (for example, cognitive behavioural therapy [CBT] should be delivered by psychologists or accredited CBT therapists; see recommendation 1.5.9).

1.3.8 Service providers should routinely collect and publish nationally agreed standardised sets of data on people entering services for gambling-related

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harms, including waiting times, demographics, baseline data on type of gambling and severity of gambling-related harms, and treatment outcomes.

For a short explanation of why the committee made these recommendations and how they might affect services, see the rationale and impact section on models of care and service delivery.

Full details of the evidence and the committee's discussion are in evidence review D: models of care and service delivery.

1.4 Improving access to treatment

These recommendations are for commissioners and providers of gambling treatment and gambling support services.

Overcoming stigma

1.4.1 To lessen the impact of stigma and to support access to treatment:

- use a person-centred, empathic, non-judgemental approach **and**
- discuss with people any fears or concerns that are preventing them from seeking help, and having or continuing with treatment.

1.4.2 To help people feel more comfortable and reduce stigma when accessing treatment, consider modifying treatments or their delivery for different groups, including making reasonable adjustments. Depending on local needs, this may include providing:

- sex or gender-specific services such as women-only groups
- vocation-specific services such as veterans' groups
- groups for affected others
- culturally sensitive services that are tailored to the needs of local communities and take into account factors such as ethnic background and

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religion

- treatments for gambling-related harms in separate locations from services for alcohol or substance dependence.

Supporting access for people with mental health problems

1.4.3 Recognise that people with mental health problems (for example, PTSD, depression or anxiety) may find it more difficult to access support and treatment for gambling-related harms.

1.4.4 Ensure that treatment for gambling-related harms is coordinated with treatment for any coexisting alcohol or substance dependence or mental health problems (see recommendation 1.5.8).

Supporting and encouraging access and engagement

1.4.5 Ensure that referral and treatment pathways are simple and easy to access. To enable this, the pathways should:

- be accessible through self-referral or referral by practitioners in a variety of settings (see the recommendations on referral and triage)
- take into account the needs of particular groups, for example, by providing access for people in the criminal justice system
- be designed to minimise drop-out and maximise engagement, for example, by avoiding a requirement to complete multiple steps to gain access to treatment.

1.4.6 Explain to people accessing treatment that:

- gambling treatment and support services are usually free, although some charges may apply (for example, for prescriptions)
- all conversations are private and confidential, although it may be necessary

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to share confidential information without their consent in certain circumstances (for example, if they or others may be in danger).

1.4.7 Encourage access to and engagement with treatment by starting evidence-based interventions as soon as possible after identifying gambling-related harms.

1.4.8 Encourage engagement with interventions by providing treatment in a location and using a delivery method that reflects the person's needs and preferences (for example, individual sessions if group therapy is not available or suitable, in person or via phone or video conferencing).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on improving access to treatment.

Full details of the evidence and the committee's discussion are in evidence review I: access.

1.5 Treatment of gambling-related harms

These recommendations are for commissioners and providers of gambling treatment and gambling support services.

General principles of treatment

For more guidance on tailoring healthcare services for individuals, see NICE's guidelines on patient experience in adult NHS services and service user experience in adult mental health. For advice on making decisions about treatment and care, see NICE's guideline on shared decision making.

1.5.1 Recognise that the holistic care of people experiencing gambling-related harms should include multidisciplinary teams where necessary, for example, healthcare professionals, social care practitioners, and people working in the criminal justice system and voluntary sector organisations.

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1.5.2 Involve a partner, family member or other person close to the person experiencing gambling that harms in their treatment and in communication with the care team, if that is what they both agree to. Discuss that it may be useful to meet individually and jointly.

1.5.3 Discuss and agree the aim of treatment for gambling that harms (typically abstinence) with the person.

1.5.4 Discuss with the person, and those close to them if present, if they have any other goals that are important to them, for example:

- reducing financial difficulties
- improving relationships
- improving their mental health, such as reducing anxiety and distress.

1.5.5 Offer gambling-specific interventions for the treatment of gambling that harms.

1.5.6 Ensure that a variety of methods (including in-person or remote, for example, via phone or videoconferencing) are available for delivering interventions. Discuss the different methods with the person, including that:

- remote delivery (via phone or videoconferencing) may be more convenient and less time-consuming than in-person treatment
- in-person treatment is more likely to lead to the development of a supportive therapeutic relationship than remote treatment, and this may help ongoing engagement.

1.5.7 Recognise that some mental health conditions, alcohol or substance dependence or acquired cognitive impairments may be:

- a consequence of gambling that harms and may resolve or improve with successful treatment for gambling **or**
- underlying conditions that occur before or alongside gambling that harms and need concurrent treatment **or**
- so severe (for example, severe PTSD, or alcohol or substance dependence)

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that they need treatment first, to improve engagement with treatment for gambling that harms.

1.5.8 Ensure that there are established links with services to treat comorbidities (for example, alcohol or substance dependence; or cognitive, mental and physical health problems including Parkinson's disease) or in-house expertise, to provide a timely, comprehensive, coordinated service for people with comorbidities and avoid the need for multiple appointments with different services.

1.5.9 Interventions should be delivered by trained, competent practitioners who practice using an agreed competency framework. This includes those who provide peer support or facilitate group therapies.

1.5.10 Practitioners should deliver interventions in a way that:

- is understanding, empathic, supportive and helpful
- encourages ownership and engagement by the person experiencing gambling-related harms
- avoids minimising concerns
- avoids stigmatising language
- develops and builds a therapeutic relationship with the person
- encourages a 2-way dialogue and ongoing communication
- provides continuity of care wherever possible.

Peer support

1.5.11 Offer peer support as an integral part of the support and treatment for gambling-related harms for people who wish to engage with it. Explain that peer support can provide:

- an opportunity to discuss aspects of recovery (social and personal) with others who have been through similar experiences

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- an opportunity to hear what has worked for other people
- an opportunity to discuss topics that might feel stigmatising (for example, relapse)
- encouragement to continue with treatment.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on treatment of gambling-related harms: general principles and peer support.

Full details of the evidence and the committee's discussion are in evidence review K: improving gambling treatment services.

Psychological interventions for gambling that harms

These recommendations are for commissioners and providers of gambling treatment services.

1.5.12 Consider motivational interviewing to strengthen people's confidence and commitment to change, or to encourage people who are unsure or have reservations about starting treatment.

1.5.13 Offer group CBT to reduce gambling severity and frequency. Start this intervention as soon as possible after diagnosis.

1.5.14 Offer individual CBT if the person does not wish to join a group, if group therapy is not possible (for example, there are no other people available to form a suitable group), or it is assessed as not suitable for the person.

1.5.15 CBT should:

- be delivered as a group intervention ideally by 2 practitioners (see recommendation 1.3.7), at least 1 of whom has gambling-specific CBT training and competence, or as an individual intervention by 1 practitioner with gambling-specific CBT training and competence

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- be delivered in line with evidence-based treatment protocols
- be provided as a course, usually with 8 to 10 sessions for group therapy or 6 to 8 sessions for individual therapy (in some cases, more sessions may be needed or fewer sessions may be sufficient)
- include a relapse prevention component (covering, for example, how to deal with triggers and how to respond to a relapse).

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on psychological interventions for gambling that harms.

Full details of the evidence and the committee's discussion are in evidence review F: psychological and psychosocial treatment of harmful gambling.

Pharmacological treatment for gambling that harms

These recommendations are for commissioners and providers of gambling treatment services.

1.5.16 Consider naltrexone to reduce gambling severity if:

- psychological therapy has not achieved the desired outcomes after an appropriate course has been completed **or**
- the person has repeated relapses despite having received an appropriate course of psychological therapy.

  In January 2025, this was an off-label use of naltrexone. See NICE's information on prescribing medicines.

1.5.17 Naltrexone should be started by, or under the supervision of, an appropriately qualified and experienced specialist. See the National prescribing guideline for naltrexone in gambling disorder.

1.5.18 Consider continuing psychological therapy in combination with naltrexone.

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1.5.19 When starting naltrexone:

- check that kidney and liver function are within normal ranges
- check that people are not taking opioids before starting naltrexone (and advise people to avoid taking opioids while taking naltrexone)
- consider an initial dose of 25 mg once a day for 3 days, then increase the dose to 50 mg once a day for 4 to 6 months
- agree a follow-up plan with the person to regularly monitor for effectiveness, safety and side effects (for example, regular liver function tests, and the onset of chest pain or palpitations); see the National prescribing guideline for naltrexone in gambling disorder.

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on pharmacological treatment of gambling that harms.

Full details of the evidence and the committee's discussion are in evidence review E: pharmacological treatment of harmful gambling.

1.6 Relapse and ongoing support

These recommendations are for commissioners and providers of gambling treatment and gambling support services.

1.6.1 Recognise that relapse in people whose gambling has decreased after treatment can be distressing for the person and may lead to suicide or self-harm.

1.6.2 Discuss the risk of relapse with people experiencing gambling that harms. Include that:

- relapse is not shameful and it may be part of a recovery journey or learning event
- relapse does not indicate individual failure, and having a plan in place to

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recover quickly increases confidence and reduces shame

- relapse can occur because of individual or environmental factors
- understanding the causes and triggers which may lead to relapse, including exposure to advertising and marketing, may be helpful
- skills and techniques can be taught during treatment to reduce the chance of relapse (for example, using blocking tools, stimulus control and strategies for coping with high-risk situations).

1.6.3 Continue to provide support, follow-up, and rapid re-entry to therapy after a course of psychological or pharmacological treatment according to the person's needs and preferences.

1.6.4 Consider additional treatment or support for people:

- where the agreed outcomes have not been achieved through the original intervention
- who may be at higher risk of relapse
- who have lapsed or relapsed.

1.6.5 Discuss with the person what additional treatment or support they may need. This could include:

- additional sessions of an intervention (for example, CBT)
- other support such as peer support or support groups
- support with ongoing harms (for example, relating to employment, finance, health, housing, relationships or legal issues), which may be provided by voluntary sector organisations.

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For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on relapse and ongoing support.

Full details of the evidence and the committee's discussion are in evidence review H: relapse prevention.

1.7 Interventions and support for families and affected others

These recommendations are for commissioners and providers of gambling treatment and gambling support services.

1.7.1 Recognise that:

- the recommendations in this guideline on case identification, initial support and referral, information and support, improving access to treatment, overcoming stigma and general principles of treatment also apply to family members and affected others
- gambling-related harms, including stigma, may also have a severe impact on family members and affected others.

1.7.2 Offer support to affected others, including:

- the opportunity to receive help and advice both by themselves and with the person experiencing gambling that harms (if that is what they both agree to)
- techniques to manage their own distress and prioritise their needs
- support to help them engage in non-judgemental communication with the person experiencing gambling that harms.

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For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on interventions for families and affected others.

Full details of the evidence and the committee's discussion are in evidence review G: interventions for families and affected others.

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Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions, see the NICE glossary and the Think Local, Act Personal Care and Support Jargon Buster.

Affected others

People who do not gamble themselves but who experience gambling-related harms because of the gambling of a family member, friend or other person close to them.

Case formulation

A hypothesis about the psychological mechanisms that cause and maintain an individual's symptoms and problems. It is a framework used by practitioners to help identify and understand a person's problems in order to develop a treatment plan.

Gambling-related harms

The adverse impacts of gambling on the health and wellbeing of individuals, families, communities and society. These harms affect people's resources, relationships and health. They can include loss of employment, debt, crime, breakdown of relationships and deterioration of physical and mental health, domestic violence and suicide.

Harms are not experienced only by people who gamble. They can also affect their families, friends and others close to them (also called affected others).

Gambling that harms

Gambling of any type or frequency that causes harm, problems or distress for the person experiencing it, or for their family, friends or those close to them.

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Unbiased information

Evidence-based information from a reliable source that has been produced without input or influence from organisations with a conflict of interest, such as the gambling industry, and which clearly states who it was produced by and the source of funding.

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Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Asking about gambling

What is the accuracy of individual brief screening tools in identifying gambling-related harms?

For a short explanation of why the committee made this recommendation for research, see the rationale section on asking about gambling.

Full details of the evidence and the committee's discussion are in evidence review B: tools for identification and assessment of harmful gambling.

2 Tools to assess gambling-related harms

What is the accuracy of tools to assess gambling-related harms?

For a short explanation of why the committee made this recommendation for research, see the rationale section on assessment of gambling that harms.

Full details of the evidence and the committee's discussion are in evidence review B: tools for identification and assessment of harmful gambling.

3 Models of care and service delivery

What is the effectiveness and cost-effectiveness of care pathways and models of care for people who experience gambling-related harms (including those with comorbid conditions such as depression, anxiety and substance-use disorders, those at high-risk and those

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under-represented in services)?

For a short explanation of why the committee made this recommendation for research, see the rationale section on models of care and service delivery.

Full details of the evidence and the committee's discussion are in evidence review D: models of care and service delivery.

4 Combination of pharmacological and psychological interventions

What is the effectiveness and cost effectiveness of pharmacological treatment with and without psychological therapy for the treatment of gambling that harms?

For a short explanation of why the committee made this recommendation for research, see the rationale section on pharmacological treatment of gambling that harms.

Full details of the evidence and the committee's discussion are in evidence review E: pharmacological treatment of harmful gambling.

5 Long-term effectiveness of treatments for gambling-related harms

What is the long-term effectiveness and cost-effectiveness, including prevention of suicide and self-harm, of psychological treatments for gambling that harms?

For a short explanation of why the committee made this recommendation for research, see the rationale section on psychological interventions for gambling that harms.

Full details of the evidence and the committee's discussion are in evidence review F: psychological and psychosocial treatment of harmful gambling.

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6 Preventing relapse

What is the effectiveness and cost effectiveness of interventions and approaches (for example, building recovery capital, mutual aid, peer support and mentoring programmes) for preventing relapse in people who have previously experienced gambling that harms?

For a short explanation of why the committee made this recommendation for research, see the rationale section on relapse and ongoing support.

Full details of the evidence and the committee's discussion are in evidence review H: relapse prevention.

Other recommendations for research

7 Interventions to improve access

What is the effectiveness and cost-effectiveness of interventions or approaches designed to improve access to gambling treatment services for people from under-represented groups who are experiencing gambling-related harms?

For a short explanation of why the committee made this recommendation for research, see the rationale section on improving access to treatment.

Full details of the evidence and the committee's discussion are in evidence review J: interventions to improve access.

8 Treatment of gambling-related harms for diverse groups

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)?

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For a short explanation of why the committee made this recommendation for research, see the rationale section on treatment of gambling-related harms: general principles and peer support.

Full details of the evidence and the committee's discussion are in evidence review K: improving gambling treatment services.

9 Psychological or psychosocial interventions

What is the effectiveness and cost effectiveness of psychological or psychosocial interventions to reduce gambling symptoms and increase recovery capital?

10 Combination psychological or psychosocial interventions

What sequential or combination psychological or psychosocial interventions are most effective and cost effective for the treatment of gambling that harms?

11 Psychological or psychosocial interventions with comorbidities

What is the effectiveness and cost effectiveness of psychological or psychosocial interventions for gambling that harms with comorbid conditions (for example, depression, anxiety or alcohol or substance dependence)?

For a short explanation of why the committee made these recommendations for research, see the rationale section on psychological interventions for gambling that harms.

Full details of the evidence and the committee's discussion are in evidence review F: psychological and psychosocial treatment of harmful gambling.

12 Combination pharmacological treatment

What is the effectiveness and cost effectiveness of combination pharmacological treatment for gambling that harms?

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13 Pharmacological treatment for different groups of people

What is the effectiveness and cost effectiveness of pharmacological treatment for gambling that harms in people with comorbidities (for example, depression, anxiety or alcohol or substance dependence)?

For a short explanation of why the committee made these recommendations for research, see the rationale section on pharmacological treatment of gambling that harms.

Full details of the evidence and the committee's discussion are in evidence review E: pharmacological treatment of harmful gambling.

14 Reducing gambling-related harms for families and affected others

What is the effectiveness and cost-effectiveness of interventions and approaches (including structured approaches validated for gambling and psychoeducation) for reducing gambling-related harms for affected others?

For a short explanation of why the committee made this recommendation for research, see the rationale section on interventions for families and affected others.

Full details of the evidence and the committee's discussion are in evidence review G: interventions for families and affected others.

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Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice.

Asking about gambling

Why the committee made the recommendations

Recommendations 1.1.2 to 1.1.7

There was no evidence identified on the accuracy of simple (1 to 5 item) tools to identify people experiencing gambling-related harms in non-specialist settings such as primary care. Therefore, the committee made a recommendation for research on asking about gambling.

The committee discussed the barriers to people seeking help, including the stigma that can be associated with experiencing gambling-related harms, the lack of awareness that help is available and how to access it, and people recognising that they have a problem. The committee agreed that it is important to proactively ask about gambling to identify concerns and support people to access help. They discussed that most people are familiar with being asked questions about their smoking status, alcohol consumption and use of other substances when undergoing any health check or holistic assessment. Based on their knowledge and experience, the committee suggested that simple questions about gambling could be added to these routine assessments, which could include GP registrations and health checks in any setting.

There was evidence from several non-gambling specialist settings (for example, prisons, alcohol and substance dependence treatment settings and GP surgeries) that engaging in crime, having substance (particularly cocaine) or alcohol dependence, having mental health problems or concerns, experiencing violence or domestic abuse, having a family history of gambling, and experiencing homelessness may indicate an increased likelihood of gambling that harms. The committee were also aware that people on certain medications may be at increased risk of gambling that harms. The committee agreed that any of these factors should prompt practitioners to ask the person about their own or another person's gambling.

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There was some evidence that veterans may be more likely to experience gambling-related harms. Based on their knowledge and experience, the committee were aware that people with some neurological conditions and other occupational groups may also be at increased risk. The committee identified, based on their own experience, that young people leaving home for the first time may be particularly at risk, and so they added this to the recommendations.

The committee noted that a self-assessment tool was already available on the NHS website (based on the Problem Gambling Severity Index [PGSI]) and that people could therefore be encouraged to assess their own level of harm using this tool.

How the recommendations might affect services

These recommendations will increase the number of people being asked about gambling, being identified as experiencing gambling-related harms and directed to sources of support and treatment. The number of people who may need treatment will therefore rise. However, effective early identification and treatment may reduce the number of people experiencing longer term or more serious harm from gambling, which may lead to savings for the NHS, and the wider public sector, including the criminal justice system.

Return to recommendations

Initial support for people experiencing gambling-related harms

Why the committee made the recommendations

Recommendations 1.1.8 to 1.1.15

The committee discussed what practitioners should do if people have worries about their own or someone else's gambling. Based on their knowledge and experience, they made recommendations to provide signposting to further sources of help, including referring to gambling treatment or support services and on offering initial brief motivational interviewing that encourages people to seek help.

The committee agreed that people experiencing gambling-related harms may be at increased risk of self-harm or suicide. Therefore, it was important to assess their risk and

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ensure that they have access to support according to their needs.

There was evidence from the review on what works well in gambling treatment, that people appreciated advice on self-exclusion techniques and support for and signposting to other forms of help, such as finance and social support.

How the recommendations might affect services

The additional time taken for providing initial support will increase resource use for the NHS. However, effective early identification and support may reduce the number of people experiencing longer term or more serious harm from gambling, which may lead to savings for the NHS, and the wider public sector, including the criminal justice system.

Return to recommendations

Referral and triage

Why the committee made the recommendations

Recommendations 1.1.16 to 1.1.19

Based on stakeholder feedback that the guideline needed to include advice to ensure that people were referred to an appropriate treatment or support service, the committee agreed, based on their knowledge and experience, that there would need to be a system of triage. The exact nature of this system of triage will likely be decided as part of the planned reconfiguration of gambling treatment services. The new statutory levy will provide a significant increase in investment for support and treatment services for gambling-related harm. This is likely to result in an increase in the amount of NHS-provided and NHS-commissioned services. The committee also added recommendations, based on their knowledge and experience, to alert professionals and practitioners to the fact that gambling severity can vary over time, and that affected others may benefit from referral too.

How the recommendations might affect services

These recommendations will increase the number of people being directed to sources of support and treatment. The additional time taken for referral and treatment will increase

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resource use for the NHS, but it will be part of a planned reconfiguration of funding and commissioning of gambling treatment services. However, effective early identification and treatment may reduce the number of people experiencing longer term or more serious harm from gambling, which may lead to savings for the NHS, and the wider public sector, including the criminal justice system.

Return to recommendations

Assessment of gambling that harms

Why the committee made the recommendations

Recommendations 1.1.20 to 1.1.23

There was very limited evidence about the accuracy of tools to identify and assess gambling-related harms in people presenting to a gambling treatment service.

There was some evidence that a score of 4 or more on the South Oaks Gambling Screen had sensitivity and specificity both above 90% to identify 'problem gamblers'. However, the committee had concerns about the quality and applicability of the evidence because it came from small studies, some of which did not reflect the age range of most people seeking treatment for gambling in the UK. There was no evidence for the accuracy of the PGSI in people presenting to a gambling treatment service. However, the committee were aware that this is the most commonly used tool in UK practice and the one with which most practitioners providing gambling treatments would be familiar.

The committee agreed that a validated tool to assess severity could be useful, but the lack of evidence meant they could not recommend the use of a specific tool. The committee made a recommendation for research on tools to assess gambling-related harms.

Based on their knowledge and experience, the committee agreed some of the key factors needed to assess the type and severity of a person's gambling in a treatment service, to allow the development of a care plan for that person.

The committee also made a recommendation, based on stakeholder feedback, about types of pharmacological therapy that could be contributing to gambling. Reviewing or optimising this therapy may reduce compulsive behaviour caused by these medicines.

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How the recommendations might affect services

These recommendations will increase the number of people being directed to sources of support and treatment. The additional time taken for providing referral and treatment will increase resource use for the NHS, but it will be part of a planned reconfiguration of funding and commissioning of gambling treatment services. However, effective early identification and treatment may reduce the number of people experiencing longer term or more serious harm from gambling, which may lead to savings for the NHS, and the wider public sector, including the criminal justice system.

Return to recommendations

Information and support

Recommendations 1.2.1 to 1.2.5

Why the committee made the recommendations

There was qualitative evidence from people experiencing gambling that harms and from affected others about the information and support they valued. The committee used this evidence, in addition to their knowledge and experience, to make recommendations for both groups.

The committee had concerns about the influence of the gambling industry on information provided to people experiencing gambling-related harms. They discussed that information should be unbiased, and agreed a definition of unbiased information in the context of the guideline.

There was evidence from the qualitative reviews on access and what works best, that people who experienced gambling-related harms were not always aware of the addictive nature of gambling and what induced them to gamble. Nor did they understand the different types of gambling and the harm they caused. They may also be unaware of treatment services available to them or how to access them. There was evidence that people experiencing gambling-related harms would like to receive information about sources of support (such as informal support and practical issues). This information would help them understand that the harms they are experiencing due to gambling are not their fault, and that help and support is available to reduce these harms.

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People experiencing gambling-related harms welcomed the opportunity to discuss the reasons why they wanted to change their gambling behaviour. They valued information about the potential for recovery and recognised that positive real-life stories of recovery could give them hope, and so encourage them to participate in treatment.

The evidence showed that affected others valued information on how they could help to support the person who was experiencing gambling that harms. However, there was also evidence that they wanted support for themselves, both for practical and emotional issues, and they wanted to know how they could access this help. Evidence also showed that they valued education and general information on gambling that harms to help them understand why the person close to them was gambling.

People experiencing gambling-related harms expressed a preference for accessing information in a variety of ways, including online – such as through apps and social media – as well as in face-to-face consultations. They also valued access to information through other routes in the community. The evidence highlighted the need for information about the risks and harms of gambling and the support available to be more visible and accessible. The committee agreed that it needs to be more widely promoted to raise awareness of the support available. They discussed where people might particularly benefit from being able to access this information, based on their experience, such as through the NHS website and NHS social media, in all health and social care settings, in the criminal justice system, and through other institutions, such as voluntary sector organisations. People also wanted to be able to access this information anonymously, so the committee agreed that service providers should prioritise this to ensure that people felt confident they could safely access information with their identity protected.

How the recommendations might affect services

The recommendations will encourage the NHS to develop systems to deliver information and support to people affected by gambling-related harms. To ensure that unbiased information is used, the NHS may need to develop sources of information, and this will have a resource impact.

Return to recommendations

Models of care and service delivery

Recommendations 1.3.1 to 1.3.8

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Why the committee made the recommendations

No evidence was identified for this review, so the committee made a recommendation for research on models of care and service delivery. They used their knowledge and experience of current gambling treatment services and other similar treatment pathways (for example, for alcohol and substance dependence, and NHS Talking Therapies) to produce recommendations on how gambling treatment and support services could be organised, commissioned and delivered in the future. The components of the service were also informed by the evidence from other quantitative reviews, as well as the preferences expressed by people experiencing gambling that harms and by affected others, which were reported in the qualitative evidence reviews.

Based on stakeholder feedback, the committee agreed that advice was needed to explain the future likely commissioning arrangements. This included the need to ensure that people were offered the level of support or treatment appropriate to their needs. Details were also needed on the role of specialist gambling clinics and community-based treatment services, and the role of gambling support services. The committee discussed that it was likely, with the planned reconfiguration of services, that the NHS would take over as the commissioner of treatment services, although these could be provided by the NHS or by other organisations (including the voluntary sector). The committee agreed that NHS commissioned services would be likely to be subject to the same clinical governance arrangements as other NHS services. Gambling support services are currently provided mainly by the voluntary sector and it was agreed that this was likely to continue.

The committee agreed that the commissioning and provision of all treatment and support services should be free of influence or conflicts of interest with the gambling industry and that there should be no link between the availability of funding for research, education and treatment and what those services provide. The committee agreed that the planned introduction of a statutory levy on the gambling industry would support this.

Based on their knowledge and experience, the committee made recommendations on what should be considered when commissioning and delivering gambling treatment and support services. They are designed to maximise entry to the service, ensure that people receive an appropriate level of treatment based on the severity of their gambling, increase engagement and optimise outcomes. As some people experiencing gambling-related harms will also have comorbidities and other needs, the committee agreed it was important that services for these comorbidities, including the support provided by local authorities and social care, were coordinated.

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The committee agreed that having a range of competent practitioners to deliver these interventions would ensure optimal outcomes for people experiencing gambling-related harms. In addition, collecting standardised data would allow gambling treatment services to be properly evaluated.

How the recommendations might affect services

The recommendations will need revised commissioning arrangements for a range of gambling treatment services. This is likely to have substantial resource implications to reconfigure existing services and transfer staff or services currently provided by other providers into NHS-commissioned services. However, given the high excess costs to the NHS, wider public sector and society associated with gambling that harms (see the context for further details), the costs of NHS-commissioned services may be partly offset by cost savings if people experiencing gambling-related harms are treated and supported effectively.

Return to recommendations

Improving access to treatment

Recommendation 1.1.1 and recommendations 1.4.1 to 1.4.8

Why the committee made the recommendations

Qualitative evidence showed that the following issues may discourage people from accessing gambling treatment services: lack of awareness of help available, difficulty with complex systems to access services, fear and stigma, concerns about lack of confidentiality and concerns about having to pay for treatment. So the committee made recommendations for positive actions that could help overcome these barriers.

The committee noted that stigma was a particular issue for people needing treatment. It may be a particular problem for people who gamble (compared with those who have alcohol or substance dependence) because gambling is normalised in society, and often perceived as an acceptable and harmless leisure pursuit. However, professionals and practitioners may not be aware of this, so they added a recommendation to the beginning of the guideline to highlight this issue. There was some evidence that stigma may be worse for some groups of people. These include women, migrants or people who are

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unfamiliar with NHS systems, and people from cultural backgrounds where gambling is prohibited. Stakeholders also suggested several other groups. The committee agreed that the recommendations should highlight that there were certain categories of people who may face additional stigma but that it was not possible to list all the individual groups.

The evidence also showed that special consideration may be needed when providing treatment services to certain groups to overcome stigma and support access.

There was evidence from women experiencing gambling-related harms, that they were often in a minority in treatment groups with men, and that they would prefer women-only groups. In addition, the committee were aware, based on their knowledge and experience, that people may be more likely to engage with treatment services that were focused on their needs and therefore more relevant to them.

The evidence also suggested that co-locating gambling services with alcohol or substance dependence services can increase stigma and reduce access. The committee agreed that having gambling treatment services available in separate locations might therefore encourage access.

There was also evidence that mental health problems may prevent people from accessing treatment services. The committee agreed that awareness of barriers such as stigma and mental health problems should be highlighted, alongside ways to improve access for people affected by these issues.

Qualitative evidence suggested that access to treatment for gambling-related harms could be improved by making information more widely available (see the recommendations on information and support), increasing signposting to treatment services, and having quicker and simpler pathways to treatment. The committee discussed how systems and pathways to access care could be simplified.

There was no evidence for any interventions to increase access to gambling treatment services and so the committee did not make any recommendations on specific interventions. Instead, they made a recommendation for research on interventions to improve access for under-represented groups.

How the recommendations might affect practice

The recommendations should increase access to and uptake of gambling treatment

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services, which will increase resource use.

Return to recommendation 1.1.1

Return to recommendations 1.4.1 to 1.4.8

Treatment of gambling-related harms: general principles and peer support

Recommendations 1.5.1 to 1.5.11

Why the committee made the recommendations

There was qualitative evidence about the views of people experiencing gambling that harms and affected others, and some views from practitioners on what works well and what can be improved in their treatment. The committee used this evidence to make recommendations on the general principles for treatment, and some recommendations on access, peer support, interventions for affected others and relapse.

Based on their knowledge and experience, the committee agreed that treatment would be better in people experiencing gambling-related harms if their needs were met by a range of staff, which may include people from healthcare, social care and voluntary sector organisations. These different groups could deal with different aspects of the help and support they needed.

Evidence showed that the involvement of affected others and setting personalised treatment goals can be helpful. In addition, people appreciated having a choice over the method (for example, remote or in-person) used to deliver treatments. There was also evidence that people experiencing gambling that harms wanted treatment that was designed for gambling and not just for dependence in general, as general treatment may not be relevant to them. For example, it may not address the particular stimulus control needed for gambling. Similarly, there was evidence that some people experiencing gambling that harms did not want to have to attend treatment centres with people who were having treatment for alcohol or substance dependence as this increased the stigma they felt. However, people wanted treatment services to coordinate with other services so that if they did have comorbidities, these could be addressed alongside their gambling. The committee agreed, based on their knowledge and experience, that the treatment of

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gambling that harms and comorbidities would need to be considered on an individual basis, as the optimal order of treatment may differ for different people.

There was evidence that people wanted to have treatment by trained competent practitioners, and this included those facilitating groups. The committee were aware that there are currently already competency criteria for some professional groups such as GPs, and ongoing work to develop competency criteria for other professional groups working in gambling treatment services.

There was a range of evidence on people's preferences for the delivery of treatment. The committee agreed that these factors, which included the attitude and skills of practitioners, were likely to increase engagement.

There was evidence that peer support was greatly valued and appreciated as an additional source of help and advice.

As there was very little evidence on the needs or preferences of people from diverse groups, the committee made a recommendation for research on treatment of gambling-related harms for diverse groups.

How the recommendations might affect practice

The recommendations will reinforce current good practice and improve the standard and uniformity of gambling treatment services.

Return to recommendations

Psychological interventions for gambling that harms

Recommendations 1.5.12 to 1.5.15

Why the committee made the recommendations

There was some evidence that motivational interviewing reduced gambling frequency; however, there was uncertainty around its effectiveness in reducing gambling symptom severity as a standalone intervention. Nevertheless, it was a cost-effective treatment

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under both an NHS and personal social services and a public sector perspective. An initial session of motivational interviewing was often part of the offered intervention in the included CBT trials. In the committee's experience, motivational interviewing is a useful technique to improve commitment to change and encourage participation for people who are uncertain about having treatment. However, it is unlikely to lead to the behavioural change needed to treat gambling that harms as a standalone intervention.

There was evidence that cognitive behavioural therapy (CBT) was effective and cost-effective for treating gambling that harms. The committee also looked at the differences between group CBT and individual CBT. In the network meta-analysis conducted to inform the guideline, group CBT showed a greater effect versus no treatment compared with the effect of individual CBT versus no treatment, in reducing gambling severity. Individual CBT showed a greater effect versus no treatment in reducing gambling frequency. According to the results of the guideline's economic analysis, group CBT was cost effective under both an NHS and personal social services and a public sector perspective. Individual CBT was also cost effective under a public sector perspective, which was given a higher weight when making recommendations. Group CBT was more cost effective than individual CBT.

The committee recognised there may be situations when a suitable group is not available, group CBT is not suitable for the person, cannot be provided, or there may be some people who prefer individual therapy. Therefore, they recommended that individual therapy be offered in these situations. The committee used information from the evidence on CBT, along with their knowledge and experience, to define how it should be delivered, for example, how many sessions and how many practitioners.

There was some evidence that behavioural therapy was effective and cost effective (under a public sector perspective) but the evidence base was more limited and there was uncertainty around the effectiveness evidence. The committee agreed that including a cognitive component was important because cognitive errors may increase the chances of experiencing gambling that harms, and therefore they decided not to recommend behavioural therapy.

There was limited evidence that individual counselling was cost effective under a public sector perspective but its relative effects versus no treatment in reducing gambling severity were lower than those seen for CBT. In addition, there was high uncertainty around the clinical-effectiveness evidence. The committee therefore agreed not to recommend counselling.

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There was limited evidence about the long-term effectiveness of psychological and psychosocial treatments for gambling that harms, including their effectiveness at reducing suicide or self-harm or on recovery capital, and for some treatments known to be effective in other dependence, for example, the 12-step programme and on combination treatments. There was also uncertainty over the effectiveness of treatments for gambling that harms with comorbid conditions or when used in combination. The committee therefore made recommendations for research on the long-term effectiveness of treatments, psychological or psychosocial interventions to reduce symptoms and increase recovery capital, combination treatment, and treatment for people with comorbid conditions.

How the recommendations might affect practice

The recommendations will increase the number of people receiving motivational interviewing and CBT for the treatment of gambling that harms, which will increase resource use.

Return to recommendations

Pharmacological treatment of gambling that harms

Recommendations 1.5.16 to 1.5.19

Why the committee made the recommendations

There was some limited evidence for the effectiveness of the opioid-receptor antagonists naltrexone and nalmefene in reducing the severity of gambling. There was also some evidence for the effectiveness of naltrexone in reducing depression and anxiety and improving functional impairment.

The committee agreed, based on the evidence and their knowledge and experience, that naltrexone should be available as a treatment option, even though it is not approved in the UK for this indication. The doses used in the clinical studies were similar to those used in the UK for the approved indication (prevention of relapse in people who were previously dependent on opioids or alcohol). The committee also had clinical experience of naltrexone used at these doses.

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The committee discussed the possible use of nalmefene. However, the doses used in the studies had been much higher than those approved for use in the UK (for alcohol dependence) and the committee did not have clinical experience of its use and so they decided not to recommend it in national guidance.

The committee agreed that the evidence was not convincing enough to consider naltrexone for first-line use in people experiencing gambling that harms and that psychological therapies would be the usual first-line treatment. However, they agreed that naltrexone should be an option for people whose gambling had not sufficiently improved or who had had multiple relapses with psychological therapy. Based on their knowledge and experience, the committee agreed that naltrexone should not replace psychological therapy but that psychological therapy should usually be continued when people are started on naltrexone, although this would be an individualised decision. Also, as this is an unlicensed use of naltrexone, a specialist would need to be involved in starting and monitoring treatment, and the committee added details on the monitoring and safety concerns relating to the use of naltrexone. The committee were aware of a national prescribing guideline for naltrexone in gambling disorder, which provided more detailed advice and so included a link to this document.

Because of the lack of evidence for the place of pharmacological treatments in the care pathway or who would benefit most from them, the committee made recommendations for research about their use alone, as combination treatment with psychological therapy, use as combination treatment and use in different subgroups of people.

How the recommendations might affect practice

The recommendations may increase the use of naltrexone to treat gambling that harms, which will increase resource use.

Return to recommendations

Relapse and ongoing support

Recommendations 1.6.1 to 1.6.5

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Why the committee made the recommendations

There was evidence from the qualitative review on improving gambling treatment services that people valued addressing the risk of relapse as part of treatment. It can be a cause of shame and stigma, and discussing it and planning to reduce it can be helpful. The committee were also aware, based on their knowledge and experience, that relapse, although often part of a recovery pathway, may lead to distress and self-harm or suicide.

There was a very small amount of evidence that individual and group relapse prevention interventions based around stimulus control reduced the number of relapses at certain time points, as well as decreasing gambling severity and anxiety at 12 months. As the evidence was minimal, the committee agreed that they could not recommend this specific intervention for relapse prevention. However, based on their knowledge and experience, they agreed that some groups of people would need additional treatment or support to prevent or treat relapses, and suggested the types of interventions that could be considered.

As there was so little evidence, the committee made a recommendation for research on interventions and approaches for preventing relapse.

How the recommendations might affect practice

The recommendations may increase the number of people who have a discussion about relapse and who are considered for additional treatment. However, this may prevent people from relapsing, so it is likely to be cost saving in the long term.

Return to recommendations

Interventions for families and affected others

Recommendations 1.7.1 and 1.7.2

Why the committee made the recommendations

Based on their knowledge and experience, the committee highlighted that affected others were likely to experience gambling-related harms and that the guideline recommendations in several areas applied to them, as well as those experiencing gambling that harms.

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There was no evidence from the review of interventions for families and affected others demonstrating the benefit of any particular intervention for families or affected others to reduce gambling-related harms, so the committee made a recommendation for research on reducing gambling-related harms for families and affected others.

There was some evidence (from the qualitative review about what works best or what can be improved in gambling treatment services) that affected others appreciated the opportunity to receive help and advice by themselves or with the person experiencing gambling that harms. They also valued help to communicate with and support the person experiencing gambling that harms and to prioritise their own needs.

How the recommendations might affect practice

The recommendations will reinforce current good practice and improve the standard and uniformity of gambling treatment and support services for families and affected others.

Return to recommendations

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Context

Liberalisation of gambling laws in 2005, the advent of online gambling and the ease of access to addictive gambling products, as well as ubiquitous advertising and marketing, has created an environment in which gambling that harms is an increasing problem.

The Gambling Survey for Great Britain (2023) reported that 2.5% of the population aged 18 years and over living in Great Britain participate in 'problem gambling' (defined as a Problem Gambling Severity Index [PGSI] score of 8 or more), with an additional 12% of the survey population participating in gambling with an elevated risk of harm (PGSI score 1 to 7). Consequences from an individuals' own gambling is also reported for participants who had gambled in the past 12 months. Overall, 2.8% of participants who had gambled in the past 12 months reported experiencing at least 1 severe consequence. Rates were higher among male participants and were also higher among younger adults (those aged 18 to 34) than older adults (those aged 55 and over). Relationship breakdown because of gambling was the most reported severe consequence: 1.6% of participants who had gambled in the past 12 months experienced this. This was followed by losing something of significant value, experience of violence or abuse and committing a crime. Male participants were more likely than female participants to report losing something of financial value and to experience violence or abuse. All participants reported their experience of suicidal ideation or attempts, and whether this was related to their gambling. Overall, 11.4% of all participants reported that they had either thought about taking their own life or attempted to do so in the past 12 months.

In addition, it is estimated that 7% of the population of Great Britain (3.8 million adults, children and young people) are 'affected others' and have personally experienced negative effects from another person's gambling. However, there are a variety of different methods used by other organisations to obtain prevalence data and so these figures are only estimates. People who participate in gambling that harms may present with both physical and mental health conditions (in particular, depression, anxiety and suicidal ideation). The Office for Health Improvement & Disparities (OHID) has estimated there are between 117 and 496 suicides associated with problem gambling or gambling disorder each year in England.

Gambling can lead to social problems for the person and their family, including violence, family breakdown, neglect of children and homelessness. It can also have financial consequences, both for individuals and their families, and for society in general. It may

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lead people into crime such as theft. There may be substantial costs to health services (predominantly mental health), welfare and unemployment services, housing services and the criminal justice system. The excess costs to the NHS, wider public sector and society have been estimated to be between £1.05 to £1.77 billion annually in 2021 to 2022 prices, according to an OHID report.

Only a small proportion of people receive treatment and currently most treatment is delivered by services outside the NHS. However, the NHS gambling service is expanding, and there are now 15 specialist gambling treatment clinics in place. As set out in the government response to the consultation on the structure, distribution and governance of the statutory levy on gambling operators, the new statutory levy will provide a significant increase in investment for support and treatment services for gambling-related harm. This is likely to result in an increase in the amount of NHS-provided and NHS-commissioned services. However, there is still a lack of coordinated systems for early identification and intervention. Also, health and social care services do not routinely identify or refer people at risk of, or experiencing, gambling that harms for treatment, with most referrals into services being self-referrals.

There are currently no national guidelines on diagnosing or treating gambling that harms in the UK. Treatment pathways are unclear and unknown by many, with limited poor-quality data to accurately assess outcomes. Current gaps in care include poor provision of treatments aimed at specific groups of people (for example, different age groups, different ethnic groups and people with comorbidities) and a lack of follow-up and ongoing care. Most treatments are offered on a short-term basis and relapse is common. There is also a lack of identification and support for affected others, such as family members and friends.

This guideline provides advice on the identification and assessment of people 18 years and over who gamble and affected others of all ages. It provides evidence-based advice on the support and information that should be offered to these people, recommendations to increase access to treatment services and guidance on the most effective and cost-effective treatments. The guideline takes an 'all harms' approach, focusing on the needs of all those experiencing gambling-related harms, including affected others. However, there was a lack of evidence for interventions or support specifically for affected others and so more research is needed. It also provides guidance to commissioners on the future shape and standards of gambling treatment services.

The guideline does not cover the primary prevention of gambling, legislative interventions to reduce the supply of gambling (for example, limitations on advertising, sponsorship,

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inducements, licensing of betting), or interventions to reduce the uptake of gambling (for example, public health campaigns about potential harms of gambling, school or college-based educational outreach and employer-based initiatives).

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Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the NICE topic page on addiction.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

ISBN: 978-1-4731-6794-0

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