Identification, assessment, and management of gambling-related harms: summary of NICE guideline

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What you need to know

• Consider asking questions such as “Do you gamble?” or “Are you worried about your own or another person’s gambling?” when asking about smoking, alcohol consumption, or use of other substances. It may also be useful to ask people who disclose gambling about the frequency and duration of episodes
• Refer people experiencing gambling-related harms for support or treatment, or advise them that they can self-refer
• Current evidence suggests that group cognitive behavioural therapy may be the most clinically and cost effective psychological treatment for reducing gambling severity

About 15% of adults living in Great Britain are estimated to participate in “problem gambling” or in gambling with an elevated risk of harm, as reported by the 2023 Gambling Survey for Great Britain.[1] Adverse impacts of gambling, known as gambling-related harms, include loss of employment, debt, crime, breakdown of relationships, domestic violence, and suicide. They affect people who gamble, their families and others close to them, and society.[2]

Liberalisation of UK gambling laws in 2005 (when gambling was changed from a permitted activity to a stimulated market), the increased availability and ease of access to addictive gambling products, and ubiquitous advertising and marketing are contributing to an increase in gambling, particularly in relation to the most addictive products, such as online casino products, in-play micro betting on sports, and land based gambling machines.[3] From 2021 to 2022, costs to the NHS, wider public sector, and society were estimated to be between £1.05bn and £1.77bn.[4]

This article summarises new recommendations from the recently published National Institute for Health and Care Excellence (NICE) guideline on identifying, assessing, and managing gambling-related harms in the UK.[5] These recommendations are intended to support healthcare professionals and social care practitioners across non-specialist settings, including primary care and emergency department settings.

Recommendations

NICE recommendations are based on systematic reviews of best available evidence and explicit consideration of cost effectiveness. When minimal evidence is available, recommendations are based on the guideline committee's experience and opinion of what constitutes good practice. To ensure representation of the setting in which the recommendations are to be applied, the guideline committee included two general practitioners. Evidence levels for the recommendations are given in italic in square brackets.

GRADE Working Group grades of evidence

• High certainty—we are very confident that the true effect lies close to that of the estimate of the effect.

• Moderate certainty—we are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.

• Low certainty—our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect.

• Very low certainty—we have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect.

Gambling products can be harmful, and the addictive potential of different forms of gambling vary. In health, social care or criminal justice settings, such as GP registration or

social services contacts, practitioners should consider asking everyone about gambling. This is in the context of holistic assessments and in the same way people are asked about smoking and alcohol consumption, reflecting a population-based approach to gambling-related harm. The guideline also highlights situations in which people may have been more exposed to harmful gambling products or more likely to have experienced gambling-related harms.

Currently only a small proportion of people experiencing gambling-related harms receive support and treatment. Professionals and the public may not know that certain symptoms are linked to gambling. People may not know that support and treatment are available, or may be reluctant to seek help because of stigmatisation, shame, and fear of disclosure. The guideline committee did not find any published evidence on short screening tools (five questions or fewer) that could be used to identify gambling-related harms proactively in a wide range of non-specialist settings, including primary care, social care, or in the criminal justice system:

- 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).
- 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.

  [Recommendations based on the experience and opinion of the guideline committee]

Risk factors and indicators

Evidence from 33 cross sectional studies was used to agree a list of risk factors or 'red flags' that may indicate an increased likelihood of exposure to gambling-related harms. A low cut-off of 2% was used, as the committee agreed that the risk factors were not diagnostic but could be used to guide which people should be asked about gambling-related harms. As well as the risk factors identified in the evidence review, the committee used their expertise to include certain demographics, neurological conditions, or occupations known to be associated with gambling-related harms. The committee agreed that the risk factors were not diagnostic but could be used as indicators to support identification and investigation.

- 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 the NICE

guideline on Parkinson's disease[6] 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
- 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 they have a family history of gambling that harms or alcohol or substance dependence.

• 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.

[Recommendations based on very low to moderate certainty evidence and the experience and opinion of the guideline committee]

Initial support

The guideline outlines a range of support that can be offered to people experiencing gambling-related harms.

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

• 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
- 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.

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

• 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.

• 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 the NICE guideline on self-harm: assessment, management and preventing recurrence.[7]

- 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 NICE guideline on self-harm: assessment, management and preventing recurrence[7]
  - 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.
- 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
  - 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.
- 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.

[Recommendations based on the experience and opinion of the guideline committee]

Information and support

A systematic qualitative review was undertaken to identify the information and support needs of people experiencing gambling-related harms, including affected others. This identified several themes relating to information and how it should be provided by gambling treatment and gambling support services. Although the confidence rating of this evidence was assessed as being low, it aligned with the committee's experiences.

- 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 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
- 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.

[Recommendations based on low certainty evidence and the experience and opinion of the guideline committee]

Referral and triage

Initial support and advice can be provided across multiple health and social care settings, but people with gambling-related harms (including affected others) may need to be referred to gambling treatment or support services such as a specialist NHS gambling treatment clinic or services via the voluntary sector, or advised that self-referral is also an option.

- Consider referring people with gambling that harms, via an NHS triage service, for triage and allocation to an appropriate level of service.
- 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.
- 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.
- Consider referring affected others to gambling treatment or support services, depending on their level of need.

[Recommendations based on the experience and opinion of the guideline committee]

Psychological and pharmacological treatments

The effectiveness of psychological treatments for people experiencing gambling-related harms was determined by carrying out a systematic review and network meta-analysis of 48 studies assessing psychological treatments, and developing an accompanying health

economic model. This found that group cognitive behavioural therapy (CBT), tested on 121 participants across six trial arms in the network, was associated with improvements in gambling symptom severity when compared with no treatment (which was the reference treatment) (standardised mean difference (SMD) -1.08, 95% confidence interval (CI) -1.82 to -0.35).

Individual CBT, tested on 592 participants across 17 trial arms in the network, was also associated with an improvement in gambling symptom severity when compared with no treatment (SMD -0.54, 95% CI -1.11 to 0.04). Meanwhile, motivational interviewing, tested on 303 participants across five trial arms in the network, showed some improvement in gambling symptom severity when compared with no treatment, which was lower than that of other treatments and was characterised by uncertainty (SMD -0.29, 95% CI -0.90 to 0.32). Group CBT was shown to be the most cost-effective treatment option among those assessed in the guideline economic analysis, followed by motivational interviewing. All three treatments were cost effective under a public sector perspective, which considered costs to the NHS and personal social services, criminal justice system costs, homelessness support and welfare/unemployment benefits associated with gambling-related harms.

The efficacy of pharmacological treatments was determined using a 2022 Cochrane review of 17 studies assessing pharmacological treatments, with most of the evidence being of very low certainty.[8] Naltrexone was the only option recommended by the committee, to be started by or under the direct supervision of specialists.

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

  [Recommendation based on the experience and opinion of the guideline committee]
- 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.
- Offer group CBT to reduce gambling severity and frequency. Start this intervention as soon as possible after diagnosis.
- Offer individual CBT if the person does not wish to join a group, if group therapy is not possible (for example, no other people are available to form a suitable group), or it is assessed as not suitable for the person.
- CBT should:
  - Be delivered as a group intervention ideally by two practitioners at least one of whom has gambling specific CBT training and competence, or as an individual intervention by one practitioner with gambling specific CBT training and competence
  - Be delivered in line with evidence based treatment protocols

- Be provided as a course, usually with eight to 10 sessions for group therapy or six to eight 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).

[Recommendations based on a network meta-analysis, the conclusions of which were robust to potential changes in the evidence according to the threshold analysis,[9] *economic modelling results, and the experience and opinion of the guideline committee]*

• Commissioners and providers should ensure that the workforce delivering support and treatment services to people experiencing gambling-related harms is trained and competent to do so (for example, CBT should be delivered by psychologists or accredited CBT therapists).

[Recommendation based on the experience and opinion of the guideline committee].

Implementation

Implementation requires additional resources, changes to the configuration of gambling support and treatment services nationally, and the development of new systems for referral and triage. Currently, gambling treatment services are mainly provided by the voluntary sector and commissioned by the charity GambleAware using money from voluntary donations from the gambling industry. The UK government has announced that the introduction of a statutory levy on the gambling industry is replacing this current system from April 2026, with commissioning being taken over by the NHS, although it is likely that services will be provided by both NHS and voluntary sector providers. Therefore, there will be a period before these changes can be fully implemented.

Increased identification of people experiencing gambling-related harms is likely to increase the number of people seeking and needing support and treatment, including CBT within gambling treatment services. To support this the NHS gambling service is expanding and there are now 15 specialist gambling treatment clinics in place and further resourcing for treatment services is planned to be provided via the forthcoming levy. Earlier identification may help reduce the number of people experiencing severe harms, including self-harm and suicidal ideation.

NICE has produced a resource impact tool and implementation support which can be accessed at https://www.nice.org.uk/guidance/ng248/resources.

Future research

Evidence is lacking for many of the topics considered during guideline development and so a range of research recommendations were made, of which the following three were prioritised:

- What is the accuracy of individual brief screening tools in identifying gambling-related harms?
- What is the accuracy of tools to assess gambling-related harms?
- 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 under-represented in services)?

Guidelines into practice

- How do you assess whether gambling may be a contributory factor when people present with depression, anxiety, or suicidal ideation?
- What local gambling support and treatment services are available? How do you refer to them?

Further information on the guidance

This guidance was developed by NICE's guideline development team A and an expert committee in accordance with NICE guideline methodology (www.nice.org.uk/media/default/about/what-we-do/our-programmes/developing-nice-guidelines-the-manual.pdf). A guideline committee was established by NICE, which incorporated healthcare and allied professionals (two psychiatrists, two psychologists, two GPs, two representatives from voluntary sector organisations that provide gambling treatment or support services, one mental health nurse, one representative from the criminal justice system, one academic, one commissioner, one mental health pharmacist) and three lay members.

The guideline is available at https://www.nice.org.uk/guidance/ng248

The guideline committee identified relevant review questions and collected and appraised clinical and cost effectiveness evidence. Quality ratings of the evidence were based on GRADE methodology (www.gradeworkinggroup.org). These relate to the quality of the available evidence for assessed outcomes or themes rather than the quality of the study. The guideline committee agreed recommendations for clinical practice based on the available evidence or, when evidence was not found, based on their experience and opinion using informal consensus methods. Original economic modelling was undertaken in priority areas.

The scope and the draft of the guideline went through a rigorous reviewing process, in which stakeholder organisations were invited to comment; the guideline committee took all comments into consideration when producing the final version of the guideline.

NICE will conduct regular reviews after publication of the guidance, to determine whether the evidence base has progressed significantly enough to alter the current guideline recommendations and require an update.

How patients were involved in the creation of this article

LR was a lay member on the committee and an affected other. Committee members involved in this guideline update included other lay members who had lived experience and who contributed to the formulation of the recommendations summarised here.

The members of the guideline committee were (shown alphabetically): Susan Acton, Owen Baily, Jenny Blythe, Henrietta Bowden-Jones, Gemma Buckland, Robert Dawson, Dragos Dragomir, Matt Gaskell, Andre Geel, Ellie Gordon, Anna Hargrave, Peter Hoskin (chair), Mohammed Rahman, Liz Ritchie, Emma Ryan, Barbara Sahakian, Soyar Sherkat.

The members of the NICE technical team were (shown alphabetically): Stephanie Arnold, Melissa Bolessa, Hilary Eadon, Jennifer Francis, Anja Fricke, Ifigeneia Mavranezouli, Odette Megnin-Viggars, Alice Navein, Steve Pilling, Tim Reeves, Joshua South, Georgina Winney.

Funding sources for included evidence: The guideline committee had concerns about using potentially biased evidence that had been funded by the gambling industry in the development of the guideline. Reviewed evidence was therefore analysed separately using three strata for “any industry funding”, “no industry funding”, and “unclear funding source”. The committee considered the evidence for each stratum when making recommendations.

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The guideline authors’ full statements can be viewed at: https://www.nice.org.uk/guidance/ng248/documents/register-of-interests

Contributorship and guarantor: All authors confirm that they meet all four authorship criteria in the ICMJE uniform requirements. JF, AF, and AN reviewed the evidence and assessed the data within the guidance. IM reviewed the economic evidence and conducted the economic modelling. LR and MG interpreted the evidence and generated the recommendations with other committee members. All authors contributed to the initial draft of this article, helped revise the manuscript, and approved the final version for publication and agree to be accountable for the accuracy and integrity of the work.

MG is the guarantor for this article.

The guideline referenced in this article was produced by guideline development team A at the National Institute for Health and Care Excellence (NICE). The views expressed in this article are those of the authors and not necessarily those of NICE.

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