NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Harmful gambling: identification, assessment and management

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This guideline covers the identification, assessment and treatment of people who may be harmed by gambling. This includes:

- people over 18 years who are experiencing harmful gambling
- people of any age who are experiencing gambling-related harms because of the gambling of someone close to them.

It includes advice on improving access to treatment and help for families and affected others.

Who is it for?

- Commissioners and providers of gambling treatment services
- Healthcare professionals in community, primary, secondary and tertiary care
- People who experience gambling-related harms or who use gambling treatment services, their families and affected others

What does it include?

- the recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice
- the guideline context.

Information about how the guideline was developed is on the guideline's webpage. This includes the evidence reviews, the scope, details of the committee and any declarations of interest.

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1 # 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.

2 ## 1.1 Case identification, assessment and initial support

3 ### Asking about gambling

4 These recommendations are for health and social care practitioners, and for
5 practitioners working in the criminal justice system. They may also be relevant to
6 people working in the voluntary, community and social enterprise sectors.

7 1.1.1 Consider asking people about gambling when asking them about
8 smoking, alcohol consumption or use of other substances (for example,
9 as part of a holistic assessment or health check, when registering for a
10 service such as with a GP or on first contact with social services).

11 1.1.2 Ask people about gambling in the following situations, because they may
12 be at increased risk of harm:

13 - when they present in any setting with a mental health problem or
14 concern, in particular depression, anxiety, psychosis, post-traumatic
15 stress disorder (PTSD), personality disorder, attention deficit
16 hyperactivity disorder (ADHD), or thoughts about self-harm or suicide
17 - at each new contact with the criminal justice system (for example, with
18 the police, liaison and diversion services, probation services, courts
19 and prisons)
20 - when they present in any setting with an addiction (for example, alcohol
21 or drug misuse, in particular 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 there is a family history of gambling or other addictions.

1.1.3 Consider asking people about gambling if they may be at increased risk because of:

- a medication, for example, people taking dopamine agonists for Parkinson's disease, or aripiprazole for psychosis
- a neurological condition or acquired brain injury
- their current or past occupation, for example, armed forces personnel, veterans, people working in the gambling or financial industry and sports professionals.

1.1.4 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.

1.1.5 Use direct questions to ask people about gambling, such as: 'Do you gamble?' and 'Are you worried about your own or another person's gambling?'

1.1.6 Encourage people to assess the severity of their gambling by completing the questionnaire available on the NHS website. This is based on the problem gambling severity index (PGSI). Advise them that a score of 8 or above indicates that they may need to seek support and treatment from an NHS-commissioned specialist gambling treatment service.

Initial support for people experiencing harm from their own or another's gambling

1.1.7 If a person is experiencing harm from their own or another person's gambling, offer help and support. Depending on the setting, the severity of the harms and the level of concern, this could include:

- brief motivational interviewing to encourage them to seek further help and support
- 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, telephone helplines)
- encouraging and supporting them to seek help, for example from their healthcare provider or social worker
- referring or signposting them to NHS-commissioned specialist gambling treatment services (for example, if they have a PGSI score of 8 or more, they have a lower PGSI score but complex harms or comorbidities, or they appear to be experiencing significant harms).

1.1.8 Discuss with people whether they can use practical self-exclusion techniques to limit their gambling, including:

- blocking software or tools for online gambling
- exclusion systems for land-based gambling such as casinos, arcades and betting shops
- systems that block gambling payments through the person's bank account
- methods to limit their access to money.

1.1.9 Provide advice on how and where to seek help and support with:

- finances
- social issues such as housing
- employment or employer issues.

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

- assess whether the person has adequate social support (for example, from their family) and is aware of other sources of help (for example, voluntary sector organisations or social care services)
- arrange help appropriate to the level of need and cause of harm
- advise the person to seek further help if the situation deteriorates.

1.1.11 If a person experiencing gambling-related harms presents considerable or immediate risk to themselves or others, refer them urgently to specialist mental health services. See the NICE guideline on self-harm: assessment, management and preventing recurrence.

Assessment of gambling-related harms in specialist settings

These recommendations are for providers of gambling treatment services.

1.1.12 Consider using a tool to assess gambling-related harms. Use an up-to-date validated tool such as the South Oaks Gambling Screen (SOGS) or the PGSI.

1.1.13 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)
- current frequency of gambling (for example, days per week or hours per day)
- 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, financial, social functioning, interpersonal relationships, employment, education and whether it has led to any involvement in crime)
- impact of gambling on their mental health (for example, depression, anxiety, insomnia)
- type of gambling activities

- factors that may contribute to their continued gambling (for example, triggers and cravings, how thoughts and emotions may have been distorted, role of advertising and marketing)
- psychological functions of gambling for them, or the motivation for gambling
- alignment to DSM criteria for gambling disorder
- reasons for seeking support, motivation to change and expectations and goals of treatment
- risk of suicide
- safeguarding issues or concerns
- medical history, including physical and mental health, comorbidities, and alcohol and substance use
- their immediate needs (for example, help with housing, food, debts).

1.1.14 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 1.1.8).

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

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.

1.2 Information and support

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

For more guidance on communication and information giving, including providing accessible information, see the NICE guidelines on patient experience in adult NHS services and service user experience in adult mental health.

1.2.1 Provide unbiased information to people who are experiencing gambling-related harms (including those who are affected by the gambling of family members, friends or others close to them) 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 and how the gambling industry may impact gambling behaviour
- the different types of gambling, 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
- the harms caused by gambling, including distress, impact on self-esteem, agency, decision-making and mental health, the potential for increased risk of suicide and possible involvement in crime such as theft
- how to recognise the link between gambling and harm
- what services are available for gambling-related harms (including crisis services for people at risk of suicide; social care and voluntary sector support 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).

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, by sharing positive testimonies, stories and films and providing access to people who have recovered from harmful gambling).

1.2.3 Provide unbiased information to people who are affected by the harmful gambling of family members, friends or others close to them, including:

- how they can support the person who is experiencing harmful gambling
- how they can be supported by gambling treatment services, health and social care providers, and the voluntary sector, either with the person experiencing harmful gambling 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 apps or social media.

1.2.5 Service providers should ensure that information about gambling-related harms:

- is well promoted and signposted in local and national health and social care services and 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 practice, 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, evidence review I: access and evidence review K: improving gambling treatment services

1.3 Models of care and service delivery

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

1.3.1 Gambling treatment 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.

1.3.2 Commissioners and service providers should ensure that services:

- allow for the prompt and ongoing assessment of the severity and risk of gambling-related harms, including the risk of suicide and self-harm
- have multiple entry points and ways to access the service, including self-referral
- have clear criteria for entry to all levels of the service (for example, by referring people with a PGSI score of 8 or more, or people with a lower PGSI score if they have complex harms or comorbidities, to NHS-commissioned specialist gambling treatment services)
- deliver timely support so that treatment can start as soon as possible after diagnosis
- provide easy access to treatment, including for people who may otherwise find it difficult to access services (for example, 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 health services and local authorities, including social care, with agreed protocols for sharing information between providers
- coordinate with services for people with learning disabilities, mental health conditions (such as PTSD or severe ADHD), alcohol or substance misuse, or acquired cognitive impairments (see recommendation 1.5.7).

1.3.3 Consider using a range of providers to deliver services for people experiencing harmful gambling and those affected by gambling-related harms (such as family members, friends or others close to them). This could include:

- individual practitioners in primary care and social care asking people about gambling-related harms, providing initial support, signposting and referring
- gambling support services such as the voluntary sector, providing advice, brief interventions and peer support
- specialist gambling treatment services, for people experiencing greater harm from gambling (for example, a PGSI score of 8 or more, or a lower PGSI score but complex harms or comorbidities).

Support the integrated delivery of services across providers, to ensure that people do not fall into gaps in service provision.

1.3.4 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 (see recommendation 1.5.9).

1.3.5 Service providers should routinely collect data on people entering services for harmful gambling, including demographics, baseline data on type 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 services.

Overcoming stigma

1.4.1 Recognise that there is stigma relating to harmful gambling, including from healthcare and other practitioners.

1.4.2 Recognise that stigma, shame and fear of disclosure can prevent people affected by gambling-related harms from seeking and accessing support and treatment, and that stigma may be a particular issue for certain groups such as:

- women
- migrants and other groups unfamiliar with NHS systems
- people whose gambling-related harms include involvement in crime
- people from some cultural backgrounds.

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

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

1.4.4 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:

- gender-specific services such as women-only groups
- vocation-specific services such as veterans' groups
- culturally sensitive services that are tailored to the needs of local communities and take into account factors such as ethnic background and religion
- treatments for gambling-related harms in separate locations from other addiction services.

Supporting access for people with mental health problems

1.4.5 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.

1.4.6 Ensure that treatment for gambling-related harms is coordinated with treatment for any co-existing addictions or mental health problems (see recommendation 1.5.8).

Supporting and encouraging access and engagement

1.4.7 Service providers should ensure that referral and treatment pathways are simple and easy to access. To enable this, the pathways should:

- be accessible through different routes, including self-referral, or referral by practitioners in a variety of settings
- take into account the needs of particular groups, for example by providing access for people in the criminal justice system
- designed to minimise drop-out and maximise engagement, for example, by avoiding multiple assessments or steps.

1.4.8 Explain to people accessing treatment that:

- gambling treatment services provided by the NHS are free at the point of access (although some charges may be payable, for example for prescriptions)
- all conversations are private and confidential.

1.4.9 Encourage access to and engagement with treatment by:

- starting evidence-based interventions as soon as possible after identifying gambling-related harms
- avoiding over-complicated sign-up procedures and restrictions for online services.

1.4.10 Encourage engagement with treatment 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 acceptable, in person or online).

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 and evidence review J: interventions to improve access.

1.5 Treatment of harmful gambling and gambling-related harms

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

General principles of treatment

1.5.1 Recognise that the holistic care of people experiencing gambling-related harms, including those affected by the gambling of others, should include multidisciplinary teams where necessary, for example healthcare staff, social care staff and voluntary sector organisations.

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

1.5.3 Discuss and agree the aim of treatment for harmful gambling (typically abstinence) with the person experiencing gambling-related harms.

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
- reducing anxiety and distress.

1.5.5 Provide gambling-specific treatments that have evidence of efficacy and cost effectiveness for treating harmful gambling. This applies to all settings, including in the criminal justice system.

1.5.6 Ensure that a variety of methods (including online and in-person) are available for delivering treatments. Discuss the different methods with the person, including that:

- online treatment 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 online treatment, and this may help ongoing engagement with treatment.

1.5.7 Recognise that some mental health conditions and other comorbidities may be:

- a consequence of gambling-related harms and may resolve or improve with successful treatment for harmful gambling, **or**
- underlying conditions which occur before or alongside gambling-related harms and require concurrent treatment, **or**
- so severe (for example severe PTSD, or alcohol or drug dependence) that they require treatment first, to improve engagement with treatment for harmful gambling.

1.5.8 Ensure that there are established links with services to treat comorbidities (for example, alcohol or drug abuse, or cognitive, mental and physical health problems) 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 Treatments for harmful gambling should be delivered by trained, competent practitioners who meet agreed competency framework criteria, including those who provide peer support or facilitate group therapies.

1 1.5.10 Practitioners providing treatments for harmful gambling should deliver
2 these in a way that:

3 - is understanding, empathetic, supportive, and helpful
4 - encourages ownership and engagement by the person experiencing
5 gambling-related harms
6 - avoids minimising concerns and stigma
7 - develops and builds a therapeutic relationship with the person
8 - encourages a 2-way dialogue and ongoing communication
9 - provides continuity of care wherever possible.

10 **Peer support**

11 1.5.11 Offer peer support as an integral part of the support and treatment for
12 gambling-related harms for people who wish to engage with it. Explain
13 that peer support can provide:

14 - an opportunity to discuss aspects of recovery (social and personal) with
15 others who have been through the same experiences
16 - an opportunity to discuss topics that might feel stigmatising (for
17 example, relapse)
18 - 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 harmful gambling and 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.

19 **Psychological treatment for harmful gambling**

20 1.5.12 Consider motivational interviewing to encourage people who are unsure
21 or have reservations about starting treatment, or to strengthen people's
22 commitment to change.

1.5.13 Offer group cognitive behavioural therapy (CBT) to reduce gambling severity and frequency. Start treatment as soon as possible after diagnosis.

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

1.5.15 CBT should:

- be delivered as a group intervention by 2 practitioners, 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
- be delivered in line with current treatment manuals
- be provided as a course, usually with 8 to 10 sessions for group therapy or 6 to 8 sessions for individual therapy
- include a relapse prevention component (covering, for example, how to deal with triggers).

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 harmful gambling – psychological interventions.

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 harmful gambling

1.5.16 Consider naltrexone to treat harmful gambling if:

- psychological treatments have not achieved the desired outcomes after an appropriate course of treatment has been completed, **or**
- the person has repeated relapses with psychological treatment.

In August 2023, 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 or experienced specialist. After the initial prescription, subsequent prescriptions may be issued in primary care using a shared care agreement. For more information about shared care, see NHS England's guidance on responsibility for prescribing between primary and secondary/tertiary care.

1.5.18 Consider continuing psychological treatment in combination with naltrexone.

1.5.19 When starting naltrexone:

- check kidney and liver function
- advise people to avoid 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, the onset of chest pain or palpitations)

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 harmful gambling - pharmacological interventions.

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 services.

1.6.1 Recognise that relapse in people whose gambling-related harms have decreased after treatment can be distressing for the person and may increase the risk of suicide or self-harm.

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

- relapse is not shameful, may be part of a recovery journey and does not indicate individual failure
- relapse can occur due to 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, stimulus control and strategies for coping with high-risk situations).

1.6.3 Continue to provide support, follow-up, and rapid re-access 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 treatment (for example, CBT)
- other support such as peer support or support groups
- support with legacy harms (for example, relating to employment, finance, health, housing, relationships, or legal issues) which may be provided by the voluntary sector or other organisations.

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 for families and affected others

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

1.7.1 Recognise that:

- the recommendations in this guideline on information and support, improving access to treatment, overcoming stigma and general principles of treatment also apply to family members, friends or others close to people who are experiencing harmful gambling
- gambling-related harms, including stigma, may impact as much on family members, friends and others close to them, as they do on the person experiencing harmful gambling.

1.7.2 Offer support to people affected by the harmful gambling of someone close to them, such as a partner, family member or friend, including:

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

For a short explanation of why the committee made this recommendation and how it 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.

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.

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.

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.

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 and impact section on case identification, assessment and initial support.
>
> 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 and impact section on case identification, assessment and initial support.

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)?

For a short explanation of why the committee made this recommendation for research, 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.

4 Combination interventions

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

For a short explanation of why the committee made this recommendation for research, see the rationale and impact section on treatment of harmful gambling – pharmacological interventions.

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-related harms?

For a short explanation of why the committee made this recommendation for research, see the rationale and impact section on treatment of harmful gambling – psychological interventions.

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

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-related harms?

For a short explanation of why the committee made this recommendation for research, 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.

Other recommendations for research

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 and impact 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.

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 genders, different races or cultural backgrounds, or people with varying neurodiversity)?

For a short explanation of why the committee made this recommendation for research, see the rationale and impact section on treatment of harmful gambling and 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 or psychosocial interventions

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

Combination psychological or psychosocial interventions

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

Psychological or psychosocial interventions with comorbidities

What is the effectiveness and cost-effectiveness of psychological or psychosocial interventions for gambling-related harms with comorbid conditions (for example, depression, anxiety or other addictions)?

For a short explanation of why the committee made these recommendations for research, see the rationale and impact section on treatment of harmful gambling– psychological interventions.

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

Combination pharmacological treatment

What is the effectiveness and cost-effectiveness of combination pharmacological therapy for the treatment of gambling-related harms?

Pharmacological treatment for different groups of people

What is the effectiveness and cost-effectiveness of pharmacological treatment for gambling-related harms in people with comorbidities (for example depression, anxiety or other addictions)?

For a short explanation of why the committee made these recommendations for research, see the rationale and impact section on treatment of harmful gambling – pharmacological interventions.

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

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 harmful gambling and psychoeducation) for reducing gambling-related harms for families, friends and others close to people who gamble?

For a short explanation of why the committee made this recommendation for research, 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.

Rationale and impact

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

Case identification, assessment and initial support

Recommendations 1.1.1 to 1.1.14

Why the committee made the recommendations

Asking about gambling

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 research recommendation on asking about gambling.

The committee discussed the barriers to people seeking help, including the stigma associated with harmful gambling, 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, drug and alcohol treatment settings and GPs) that engagement in crime, drug (particularly cocaine) and alcohol addictions, mental health problems or concerns, violence or domestic abuse, family history of gambling, and homelessness may indicate an increased likelihood of harmful gambling. The committee agreed that any of these factors should prompt practitioners to ask the person about their own or another person's harmful gambling.

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 of other occupational groups who may also be at increased risk. The committee also noted that people on certain medications or with other neurological conditions may be at increased risk of gambling-related harms.

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.

Initial support for people experiencing harm from their own or another's gambling

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 on offering initial brief motivational interviewing that encouraged people to seek help, signposting and further sources of help, including referring to specialist gambling treatment services for those experiencing greater gambling-related harms. 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.

The committee agreed that people experiencing harm from their own or another person's gambling may be at increased risk of self-harm or suicide. Therefore, it was important to assess their risk and ensure that they have access to support according to their needs.

Assessment of gambling-related harms in specialist settings

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

There was some evidence that a score of 4 or more on the South Oaks Gambling Screen had sensitivity and specificity 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 harmful 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 research recommendation on tools to assess gambling-related harms.

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

How the recommendations might affect services

These recommendations will increase the number of people identified as experiencing gambling-related harms, and of those who are directed to sources of support and treatment. The number of people who may need treatment will therefore rise. This will increase resource use for the NHS, but it will be part of a planned expansion of gambling treatment services. However, effective identification and treatment may reduce the number of people experiencing longer term or more serious harm from gambling, which may lead to savings to the NHS.

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 harmful gambling 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 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 people 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.

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 harmful gambling. 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 behaviour to help them understand why the person close to them was experiencing harmful 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, such as their workplace. However, the evidence highlighted the need for information about harmful gambling and the support available to be more visible and accessible. The committee agreed that it needs to be more widely promoted by providers of gambling treatment services through a variety of health and social care services and in the community to raise awareness of the support available. The committee 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 external

institutions. 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 harmful gambling. 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 1.3.5

Why the committee made the recommendations

No evidence was identified for this review, so the committee made a research recommendation on models of care and service delivery. However, the committee agreed that as the remit of the guideline was to provide guidance to the NHS on the best way to identify, assess and manage harmful gambling, they could use their knowledge and experience of current gambling treatment services, other similar treatment pathways (for example, for alcohol and substance use, and Improving Access to Psychological Therapies) to produce recommendations on how gambling treatment services could be organised, commissioned and delivered. The components of the service were also informed by the evidence from other quantitative reviews, as well as the preferences expressed by people experiencing harmful gambling and affected others, which were reported in the qualitative evidence reviews.

The committee agreed that NHS-commissioned services should be free of influence or conflicts of interest with the gambling industry, otherwise this may lead to less effective treatments being offered which fail to halt harmful gambling or lead to early relapse.

Based on their knowledge and experience, the committee made recommendations on factors that may be important in a gambling treatment service to maximise entry to the service, ensure people receive an appropriate level of treatment based on the severity of their harmful gambling, increase engagement and optimise outcomes. As some people with 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.

The committee agreed that a range of competent practitioners should be supported to deliver these interventions. This would ensure optimal outcomes for people experiencing gambling-related harms. The committee agreed that it was necessary to advise that data, including outcomes, should be collected by any gambling treatment services to allow for services to be properly evaluated.

The committee used work conducted by the Office for Health Improvement and Disparities (OHID) to define the stratification of gambling harms. They agreed the suggested Problem Gambling Severity Index (PGSI) cut-off of a score of 8 or more as a suggested entry point for specialist gambling treatment services, although a lower score may be applicable for people with complex harms or comorbidities.

How the recommendations might affect services

The recommendations will require revised commissioning arrangements for a range of gambling treatment services and the development of new services. This is likely to have substantial resource implications, such as for setting up new services, employing new staff, or transferring services currently provided by other providers into NHS-commissioned services. However, the committee noted that there are high costs to the NHS and society associated with harmful gambling, and that the costs of new treatment services may be offset by cost savings if people experiencing harmful gambling are treated effectively in the new services.

Return to recommendations

Improving access to treatment

Recommendations 1.4.1 to 1.4.10

Why the committee made the recommendations

There was qualitative evidence 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 which could help overcome these barriers.

There was some evidence that stigma may be worse for some groups of people, including women, migrants or people who are unfamiliar with NHS systems, and people from cultural backgrounds where gambling is prohibited. The evidence also showed that special consideration may be needed when providing treatment services to certain groups.

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 other groups may be more likely to engage with treatment services that were focused on and therefore more relevant to their needs.

The evidence also suggested that co-locating gambling services with other addiction 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 harm could be improved by making information more widely available (and this had already been recommended in the section on information and support), increasing signposting to treatment services, and having quicker and simpler pathways to treatment. The committee discussed a range of locations that should have information available about gambling treatment services and 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 research recommendation 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 services, which will increase resource use.

Return to recommendations

Treatment of harmful gambling and 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 harmful gambling and affected others, and some views from practitioners on what works well and what can be improved in the treatment of harmful gambling. 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 people experiencing gambling-related harms would be better treated if their needs were met by a range of staff, which may include healthcare, social care and the voluntary sector. These different groups could deal with different aspects of the help and support they needed.

There was evidence that involvement of affected others and setting personalised treatment goals can be helpful. Evidence also showed that people appreciated having a choice over the method used to deliver treatments. There was also evidence that people experiencing gambling-related harms wanted treatment that was designed for gambling addiction and not just for addictions in general, as general treatment may not be relevant to them. For example, it may not address the

particular stimulus control needed for harmful gambling. Similarly, there was evidence that some people experiencing gambling-related harms did not want to have to attend treatment centres with people who were being treated for drug or alcohol addictions as they felt this increased the stigma associated with their addiction. However, people wanted treatment services to coordinate with other services so that if they did have comorbidities these could be addressed in a coordinated manner alongside their gambling addiction. The committee agreed, based on their knowledge and experience, that the treatment of gambling-related 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 be treated by trained competent practitioners, and this included those facilitating groups. The committee were aware that there is currently ongoing work to develop competency criteria for those 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 research recommendation.

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

Treatment of harmful gambling – psychological interventions

Recommendations 1.5.12 to 1.5.15

Why the committee made the recommendations

There was some evidence that motivational interviewing reduced gambling frequency and it was a cost-effective treatment under both an NHS/personal social services and a public sector perspective. The committee agreed that it is a useful technique to improve commitment to change and encourage participation for people who are uncertain about having treatment.

There was evidence that cognitive behavioural therapy (CBT) was effective and cost effective for treating harmful gambling. Group CBT was more effective than individual CBT at reducing gambling severity, and individual CBT was more effective at reducing gambling frequency. Group CBT was cost effective under both an NHS/personal social services and a public sector perspective, whereas individual CBT was cost effective only under a public sector perspective. Group CBT was more cost effective than individual CBT. However, the committee recognised there may be situations when group CBT cannot be provided, or there may be some people who prefer individual therapy. Therefore, they recommended that individual therapy could 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 and the committee agreed that the inclusion of a cognitive component was important to address the cognitive aspects of gambling behaviour.

There was limited evidence that individual counselling was cost-effective under a public sector perspective but its effects in reducing gambling severity were lower than that seen for CBT, and there was high uncertainty around the clinical effectiveness evidence. The committee therefore agreed not to recommend counselling.

There was limited evidence about the long-term effectiveness of psychological and psychosocial treatments for harmful gambling, including their effectiveness at reducing suicide or self-harm or on recovery capital, and for some treatments known

to be effective in other addictions, for example, the 12-step programme and on combination treatments. There was also uncertainty over the effectiveness of treatments for harmful gambling with comorbid conditions or when used in combination. The committee therefore made research recommendations 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 harmful gambling, which will increase resource use.

Return to recommendations

Treatment of harmful gambling – pharmacological interventions

Recommendation 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 formerly dependent on opioids or alcohol). The committee also had clinical experience of naltrexone used at these doses.

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. Therefore, they chose not to recommend it.

The committee agreed that the evidence was not convincing enough to consider naltrexone for first-line use in people experiencing gambling-related 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 treatment. Based on their knowledge and experience, the committee agreed that naltrexone should not replace psychological therapy but that psychological therapy should continue when people are started on naltrexone. 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.

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 research recommendations 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 harmful gambling, which will increase resource use.

Return to recommendations

Relapse and ongoing support

Recommendations 1.6.1 to 1.6.5

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 increase the risk of self-harm and 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 research recommendation 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 a number of areas applied to them, as well as those experiencing harmful gambling.

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 research recommendation.

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 harmful gambling. They also valued help to communicate with and support the person experiencing harmful gambling 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 services for families and affected others.

Return to recommendations

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 harmful gambling is an increasing problem.

The Public Health England gambling-related harms evidence review reported that 0.5% of the population aged 16 years or over in England (approximately 300,000 people) participate in 'problem gambling' (defined as a PGSI score of 8 or more), with an additional 3.8% of the population (2.1 million people) participating in gambling with a risk of harm (PGSI score 1 to 7). 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 behaviour.

People who participate in harmful gambling may present with both physical and mental health conditions (in particular, depression, anxiety and suicidal ideation). The Office for Health Improvement & Disparities has estimated (based on international evidence due to a lack of official UK data) that between 117 and 496 people die by suicide each year as a result of problem gambling.

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 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.

Only a small proportion of people involved in harmful gambling currently receive treatment and, until recently, most treatment was delivered by services outside the NHS. However, the NHS gambling service is expanding, and there are plans to have 15 clinics in place by 2024. There are also plans to move to a statutory levy on the gambling industry to fund research, prevention and treatment of gambling-related harm. This may 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, community, primary and secondary healthcare services do not routinely identify or refer people at risk of, or participating in, harmful gambling for treatment.

There are currently no national guidelines on diagnosing or treating harmful gambling in the UK. 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 other people affected by a person's harmful gambling, such as family members, friends and others close to them.

This guideline provides advice on the identification and assessment of people over 18 years who may be harmed by their own gambling and people of all ages who may be harmed by the gambling of someone close to them. 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, which means that it considers gambling-related harms and needs of affected others, as well as those experiencing harmful gambling. However, there was a lack of evidence for interventions or support specifically for this group 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 harmful gambling, legislative interventions to reduce the supply of gambling (for example, limitations on advertising, sponsorship, 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, employer-based initiatives).

Finding more information and committee details

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

For details of the guideline committee see the committee member list.

[After consultation the editor will expand this section to include additional links]

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