



Pragmatic, Brief, Free, and Validated: Screening, Assessment, and Outcome Measures for Gambling Treatment

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Private and public gambling treatment services are available worldwide, yet there is limited guidance on selecting screening, assessment, and treatment outcome measures for practical use. The most effective treatments are cognitive behavioral therapies (CBT) and motivational interviewing (MI), often adapted to incorporate cultural and holistic approaches. Although multiple systematic reviews have proposed sets of measures, few are designed specifically for service delivery in community settings. This paper outlines pragmatic selection criteria for measures in these settings, recommending that they be validated, brief, free to use, and suitable for self-administration by gambling clients or their family members and friends (affected others). After reviewing existing guidelines and recommendations, the article provides an overview of measures appropriate for routine use and discusses delivery considerations such as timing, administration mode, and client engagement. It emphasizes the importance of aligning measurement tools with treatment goals and adapting them for culturally diverse contexts. While outcome measurement for gambling clients is relatively well developed, process and outcome measures for affected others remain limited.

PRIVATE and public gambling treatment services operate globally, with countries that regulate gambling providing support to hundreds of thousands of people experiencing gambling harm, including family members and friends (affected others). Treatment-seekers almost always have symptoms that can be classified as Gambling Disorder (GD) or problem gambling (Bijker et al., 2022; Dowling, Merkouris, et al., 2021) and tend to reflect the demographic patterns of gambling engagement in their jurisdiction. For example, in regions where online gambling is the dominant form, help-seeking typically relates to online gambling (Marionneau et al., 2024). In contrast, where online gambling is not regulated and land-based gambling generates the most revenue, help-seeking is more commonly related to gaming machines (Barratt et al., 2014).

People presenting to treatment frequently have co-occurring mental health conditions such as depression, anxiety, and substance use disorders (Armoon, Griffiths, Fleury, et al., 2023; Dowling et al., 2015) as well as gambling-related issues linked to video gaming, including loot box engagement (Spicer et al., 2022). These challenges are often accompanied by suicidal ideation or impulsivity (Armoon, Griffiths, Mohammadi, et al., 2023), and in some cases mandated treatment due to legal or financial consequences (Grant & Chamberlain, 2023). Presenting concerns often extend beyond comorbidities to include difficulties with daily functioning, such as family violence, housing instability, unemployment, and social disconnection (Dowling et al., 2014; Hahmann et al., 2021). These are further compounded by inequities and vulnerabilities including migration stress, shift work, colonization, and the normalization of gambling (Raybould et al., 2021; Roberts et al., 2020). Most clients report high levels of readiness and willingness to change but low confidence in managing high-risk situations, including urges to gamble (Dowling, Merkouris, et al., 2021; Kowatch & Hodgins, 2015; Rodda et al., 2015). Although GD was once seen as

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progressive, chronic, and unrelenting, research demonstrates that trajectories are variable (Williams & Williams, 2025), with some people remitting after a single episode and some fluctuating in and out of harm, with only a small proportion experiencing a chronic course. Relapse is common, however, affecting one-third to one-half of people within 2 to 3 years. Only around one in five people with GD seek professional, nonprofessional, or self-help treatment (Bijker et al., 2022), which is typically in response to crisis-level harms, including relationship breakdown and an inability to meet financial obligations due to uncontrolled gambling (Loy et al., 2019).

Cognitive behavioral therapies (CBT) and motivational interviewing (MI) have the strongest evidence base for treating gambling disorder (GD) (Di Nicola et al., 2020; Pfund, Forman, et al., 2023; Pfund, Ginley, et al., 2023), although most studies have focused on samples that are predominantly White, employed, and with at least some higher education (Pfund & Ginley, 2019). Numerous trials have demonstrated the effectiveness of CBT and MI, with some comparing treatment modalities and concluding that outcomes are generally positive across formats, depending on treatment intensity and client engagement (Pfund, Ginley, et al., 2023). CBT approaches target the thoughts, emotions, and behaviors that sustain gambling despite increasing financial, psychological, and social harm. They typically address gambling urges, distorted cognitions, and functional impairments linked to gambling harm (Pfund & Ginley, 2019; Pfund, Ginley, et al., 2023). Clinicians report that relapse prevention, goal setting, motivational enhancement, information provision, cognitive restructuring, financial regulation, information gathering, planning social support, and decision balance are effective strategies (Keshani et al., 2025). Treatment planning usually involves identifying client goals and setting session numbers, most commonly 5–8 sessions (Rodda et al., 2018) but may extend up to 20 sessions or more (Pfund et al., 2021). Although some clinicians use other therapeutic orientations, such as psychoeducation, mindfulness-based therapies, solution-focused therapies, acceptance and commitment therapy, narrative therapy, interpersonal psychotherapy, dialectical behavior therapy, and family interventions, evidence supporting these approaches is still emerging (Guyett et al., 2025).

Aligning Client Outcome Evaluations With Their Intended Purposes

Clarifying which outcomes are expected to change with treatment is essential for evaluating treatment effectiveness. The Banff consensus, developed almost

20 years ago, remains one of the most widely cited frameworks for outcome measurement in gambling studies, including trials and treatment evaluations (Walker et al., 2006). It recommends assessing net gambling expenditure, gambling frequency (e.g., days per month), time spent thinking about or engaging in gambling, gambling severity, and the consequences of gambling on health, relationships, finances, legal issues, and overall quality of life. The Banff group also highlighted the importance of measuring the processes or mechanisms of change specific to the treatment approach. For CBT, this includes constructs such as the degree of distorted or erroneous gambling-related cognitions (Walker et al., 2006). While comprehensive, the Banff recommendations were not developed with a focus on pragmatic delivery and do not account for constraints like limited session time or the need for brief, self-report tools in routine care.

More recently, Marionneau et al. (2025) described a collaboration aiming to standardize helpline data collection across four Nordic countries (Denmark, Finland, Norway, and Sweden), with a view to encouraging international standardization. An initial mapping exercise of current data collection practices revealed considerable variability in the data each helpline collected. Based on this activity, they identified key helpline data collection variables for both callers who gamble and affected others, including background variables (e.g., age, gender, problem gambling duration), gambling behaviors (problem gambling activities), and harms. They identified several key advantages to standardizing data collection, such as providing more structure to helpline conversations, improving intervention targeting and reach, strengthening research and data infrastructures, and promoting international collaboration.

Assessing treatment outcomes involves collecting information about a client's psychological, emotional, and social functioning (Pickering et al., 2018). In the clinical management of GD, screening, assessment, diagnosis, and monitoring treatment outcomes are interconnected and sequential, but distinct, processes that are important for providing high-quality psychological care (Aslan et al., 2025; Australian Psychological Society, 2025). In gambling services, these processes are often blurred, with instruments being used interchangeably and sometimes inappropriately, which can complicate clinical care (Aslan et al., 2025; Australian Psychological Society, 2025). This highlights the need for a structured approach for selecting instruments for their intended purposes. Moving towards measurement-based care and the routine and systematic use of validated measures to monitor client progress throughout treatment addresses this

issue (Scott & Lewis, 2015). This approach supports collaborative decision-making, helps clinicians adjust treatment plans based on objective feedback, and fosters greater engagement from clients. By embedding measurement-based care, gambling services can strengthen their clinical effectiveness and provide data to support continuous improvement and funding decisions.

In specialist gambling services, screening tools may be used at intake to identify the presence of risk factors or symptoms that may require more comprehensive assessment or referral to other services. These tools can flag urgent concerns such as suicidal ideation or family violence, as well as other co-occurring issues like hazardous alcohol or other drug use, mental health symptoms such as depression and anxiety, or gaming disorder symptoms. Unlike clinical trials, which often exclude clients based on these co-occurring conditions (Pfund, Forman, et al., 2023), community treatment services can use screening to guide the most appropriate response rather than to determine eligibility for treatment.

In contrast, assessment in these services is more in-depth and multifaceted and may involve interviews, behavioral observations, and psychometric testing (Australian Psychological Society, 2025; National Institute for Health and Care Excellence, 2025). Assessment plays a key role in clarifying the presenting problems and their potential causes, whether biological, psychological, or social, as well as identifying client strengths and supports. Assessment can also include the administration of diagnostic tools, which provide in-depth evaluation to establish whether a diagnosis of GD is warranted, if necessary.

Finally, outcome monitoring in gambling treatment services should focus on the intended outcomes of the treatment, which reflect the aims of the intervention, which could include gambling-specific symptoms and behaviors or broader indicators such as depression, anxiety, or quality of life (Black et al., 2024; Pickering et al., 2021; Pickering et al., 2018). In recognition that recovery defined only as the absence or remission of symptoms and a return to a former state of functioning is insufficient, the gambling literature has emphasized a broad and holistic understanding of recovery as a dynamic and individualized process aimed at achieving optimal health, functioning, and well-being (Pickering et al., 2018). As noted earlier in the context of the Banff consensus, outcome measures should also reflect the therapeutic targets of the intervention, including the processes or mechanisms of change (Walker et al., 2006). For example, CBT aims to reduce gambling-related cognitions or urges, while

motivational interviewing focuses on constructs such as readiness to change or self-efficacy. These constructs should be measured over time to determine whether treatment is working as intended. These process-of-change measures can also inform the development of treatment plans that are tailored to the client's needs. While the Banff consensus suggests these follow-up assessments should be conducted at posttreatment, 3–6 months posttreatment, 1-year posttreatment, and 2-years posttreatment (Walker et al., 2006), medium- to longer-term follow-ups may not be feasible for routine service delivery. Ideally, at a minimum, these assessments should include posttreatment and short-term follow-up (3 and 6 months following the completion of treatment).

Affected Others Outcome Evaluation

All of the considerations above apply equally to affected others who are harmed by someone else's gambling. Prevalence estimates suggest that between 5% and 21% of the general population are affected others, most often partners, children, and close family members (Dowling, Hawker, et al., 2025a). In treatment-seeking populations, the harms reported are wide-ranging, including financial hardship, relationship difficulties, emotional distress, depression and anxiety, and physical health problems, with partners and children reporting the highest levels (Dowling, Hawker, et al., 2025a). Affected others also report higher levels of their own gambling compared to people without gambling harm in their family, including at-risk and problem gambling (Dowling, Hawker, et al., 2025a). When they seek help, it is often in response to distress, disruption to daily life, concerns for dependents, or health issues (Dowling, Hawker, et al., 2025b). Evidence for treatments shows promise, from brief helpline assistance through to structured family-focused interventions such as the 5-Step Method and coping skills training (Dowling, Hawker, et al., 2025b). Importantly, treatment goals can differ with gambler-focused approaches that support affected others in encouraging the gambler to recognize problems, seek help, and reduce their gambling, while family-focused approaches, such as those aligned with the Stress–Strain–Coping–Support (SSCS) model, prioritize the recovery and well-being of affected others themselves, with or without gambler involvement (Dowling, Hawker, et al., 2025b). Together, these findings highlight the importance of including affected others in outcome evaluation and ensuring approaches reflect their specific experiences and treatment goals.

Aims of the Current Study

Multiple reviews have reported on tools to measure treatment outcomes and have identified the most frequently used instruments in gambling research for people with gambling problems (Dowling et al., 2019; Pfund, Ginley, et al., 2023; Pickering et al., 2018) and affected others (Dowling, Hawker, et al., 2025b). However, these studies primarily focus on gambling measures only or measures for clinical trials, where longer and more time-consuming measures may be acceptable because participants are typically remunerated and enrolled in structured research protocols. In routine care, these conditions do not apply, and lengthy measures may place unnecessary burden on clients and clinicians and become a barrier to receiving care. Furthermore, there have been multiple calls for the need to identify pragmatic measurement tools for diagnosis, screening, and outcome measurement (Bowden-Jones et al., 2022), albeit for the purposes of research as distinct from delivery of routine treatment services. This paper therefore considers tools that are brief, free to use, and psychometrically validated and able to reliably detect meaningful change over time. When nonvalidated tools are used, measurement becomes unreliable and akin to stepping on a faulty scale that gives a different number each time and fails to reflect true change. Given the significant harms that can result from gambling to people with gambling problems and their affected others, it is important to know whether treatment is working so that additional support can be offered when needed, or treatment plans can be adjusted if outcomes have already improved. This is particularly relevant for CBT and MI, which are structured around clearly defined treatment targets and mechanisms of change.

The aim of this paper is to provide guidance to gambling service providers on measurement for screening and outcome assessment in gambling treatment for people with gambling problems and their affected others. This guidance is based on a review of available measurement literature and the application of pragmatic selection criteria to identify measures that may be feasible and appropriate for use in services. The resulting review is intended as a practical resource for treatment providers as well as researchers seeking brief, validated outcome measures for use in community-based contexts.

Evidence Sources for the Review

A literature search was conducted in October 2024 and updated in May 2025 using key terms such as gambling, measurement, systematic review, meta-analysis, and consensus guidelines. Given the focus on psycho-

logical interventions, particularly CBT and MI, outcome measures specific to pharmacotherapy were excluded. Searches were conducted in PsycINFO, Medline, and Google Scholar, alongside forward citation searches of key papers such as the Banff Consensus. This process identified 18 articles focused on gambling screening and outcome measurement (Black et al., 2024; Bonfils et al., 2019; Caler et al., 2016; Dowling et al., 2019; Forward et al., 2022; Marionneau et al., 2025; Otto et al., 2020; Pickering et al., 2018; Problem Gambling Research and Treatment Centre, 2011; Walker et al., 2006; Yarbakhsh et al., 2023) and outcome measures specific to CBT or the components of treatment and recovery (Mansueto et al., 2024; Nower & Blaszczyński, 2008; Pfund, Forman, et al., 2023; Pfund, Ginley, et al., 2023; Pickering et al., 2021; Rodda et al., 2018). Seven reviews focusing on screening and assessment for affected others were also identified (Dowling, Hawker, et al., 2025a, 2025b; Edgren et al., 2022; Merkouris et al., 2023; Merkouris et al., 2022; Riley et al., 2021; Vassallo et al., 2023). Three clinical guidelines (Australian Psychological Society, 2025; National Institute for Health and Care Excellence, 2025; Problem Gambling Research and Treatment Centre, 2011) were also identified, all of which but one focused on both gambling and affected other clients.

Measure Selection Criteria

Seven criteria were established to guide the selection of measures for use in routine service delivery in gambling harm treatment. These criteria emphasized strong psychometric properties, including reliability, validity, classification accuracy, and sensitivity to change. They also took into account practical considerations such as self-report administration, brevity, and free availability (Aslan et al., 2025; Dowling et al., 2019). The selection criteria were also developed with the context of gambling services in mind, where CBT and MI are commonly used, and where a recovery-oriented, client-centered focus is prioritized. Cultural suitability, involving an examination of the psychometric properties in the country, jurisdiction, or cultural sample in which they are measured, is also an important consideration for gambling services when they are selecting appropriate measures (Aslan et al., 2025).

As outlined in Table 1, psychometric quality was assessed across four key areas. Reliability refers to the consistency of results across time, items, or raters, including internal consistency, test-retest reliability, and interrater reliability. Validity considers whether the tool accurately measured the intended construct and included evidence of content, construct, and criterion validity. Preference was given to tools with

Table 1
Selection Criteria for Measures Gambling Treatment and Routine Service Delivery

Selection Basis	Description	Selection Decision
Measures are reliable	Produce consistent results across time, items, and raters.	Included tools with strong internal consistency, test-retest, and/or inter-rater reliability.
Measures are valid	Accurately assess the intended construct such as urges, cognitions or quality of life.	Preference given to tools with evidence of content, construct, and criterion validity, especially those currently used in gambling or mental health contexts.
Measures have good classification accuracy	Ability to identify those with (sensitivity) and without (specificity) the condition.	Preference given to high sensitivity tools to reduce missed cases of harm.
Measures are sensitive to change	Detect meaningful changes over time, particularly in response to short-term CBT or MI interventions.	Prioritised measures with short recall periods (e.g., past 7 or 14 days) and demonstrated sensitivity to change.
Measures are self-report	Suitable for client-completed administration in CBT settings.	Included self-report tools that are easy to administer, with clear wording and evidence of acceptability.
Measures are brief	Short tools reduce burden in time-limited services.	Screening: ≤ 5 items. Outcomes: ≤ 15 items for assessment and outcome measures.
Measures are freely available	Instruments must be publicly accessible and free to use in routine care settings.	Excluded measures requiring licensing fees or paid access unless already funded for service use.

multiple forms of validation, particularly those that had been evaluated in gambling or mental health settings. Where no measure demonstrated satisfactory reliability or validity for a specific construct, alternative suggestions are made, and this limitation is noted. Classification accuracy was evaluated based on sensitivity and specificity, with a preference for high sensitivity to minimize the risk of missing clients experiencing gambling symptoms. Sensitivity to change and the ability to detect meaningful improvement was prioritized given the short-term nature of most CBT and MI interventions in gambling studies (Pfund et al., 2021). For outcome measurement, instruments with brief recall periods (e.g., past 7 or 14 days) were preferred to capture change over the course of treatment.

The pragmatic criteria required that only self-report tools were generally included, reflecting their practicality and widespread use in CBT and MI-based services (Dowling et al., 2019; Rodda et al., 2018). Clinician-administered or tools that required training in administration and scoring protocols were excluded unless feasible for routine service delivery. The criteria required that measures were freely available, as licensing costs can limit use in publicly funded or private treatment services. Brevity was also prioritized to reduce burden in time-limited settings. Screening tools were therefore limited to five items or fewer, and assessment and outcome tools to 15 items or fewer. These criteria are consistent with a previous review of brief screening instruments for problem gambling

(Dowling et al., 2019) to ensure that the selected measures are both scientifically robust and practical for integration into routine gambling treatment services.

Measurement Selection Overview

A total of 80 measures were extracted from the reviewed studies and evaluated against the measurement criteria. Measures were excluded if they showed poor psychometric properties or exceeded recommended lengths (more than 5 items for intake or screening, or more than 15 items for treatment outcomes). The remaining measures were organized into four categories: screening measures (to identify the presence symptoms that may require further evaluation or referral), assessment measures (to describe the sample at intake or first session), treatment outcome measures (to assess the intended outcomes of treatment, including gambling behavior, psychological outcomes, and recovery outcomes), and processes-of-change measures (to measure the treatment's mechanisms of change and to aid in treatment planning). These categories were based on a framework informed by existing assessment guidelines (Aslan et al., 2025; Australian Psychological Society, 2025). There is also a need to consider planned or unplanned treatment closure, including reasons for pulling out of treatment, assessments measuring client satisfaction, and session outcomes. While these guidelines are not always specific to routine service delivery, they offer a useful structure for identifying clinically relevant tools. The next

Table 2
Domain, Constructs, and Illustrative Measures for Gambling Clients

Domain	Construct	Illustrative Measures
Screening measures	Suicidal ideation	• Beck Depression Inventory-II (Item 9) • Patient Health Questionnaire (PHQ-9) (Item 9) • Ask Suicide-Screening Questions • Patient Safety Screener (PSS)
	Family violence	• Hurt, Insult, Threaten, and Scream (HITS) • Woman Abuse Screening Tool- Short Form (WAST-SF) • Partner Violence Screen (PVS) • Abuse Assessment Screen (AAS)
	Hazardous alcohol use	• Alcohol Use Disorders Identification Test (Short Forms) (AUDIT-C, AUDIT-3) • CAGE • T-ACE/TWEAK • Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TPS-Part 1) – Alcohol item
	Other drug use	• Severity of Dependence Scale (SDS) • Single-Question Screening Test for Drug Use in Primary Care • Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TPS-Part 1) – Alcohol item
	Depression symptoms	• Patient Health Questionnaire-2 (PHSQ-2) • Kessler scales (K6 or K10) (depression items)
	Anxiety symptoms	• Generalised Anxiety Disorder-2 (GAD-2) • Spielberger State-Trait Anxiety Inventory (5-item Short Form) (STAI-Short Form) • Kessler scales (K6 or K10) (anxiety items)
	Excessive gaming	• Three-Item Gaming disorder Test Online Centred (TIGTOC)
Assessment measures (descriptive at intake only)	Problem gambling type	• Bespoke items
	Gambling mode	• Bespoke items
	Problem gambling severity	• Problem Gambling Severity Index (PGSI) • Gambling Disorder Identification Test (G-DIT) • Problem and Pathological Gambling Measure (PPGM/PPGM-Revised) • Sydney Laval Universities Gambling Screen (SLUGS) • Early Intervention Gambling Health Test (EIGHT)
	Gambling harm	• Gambling Harms Scale-10 (GHS-10) (formerly Short Gambling Harms Scale: SGHS) • 7-Item Domain-General Gambling Harm Scale (DGHS-7) • Gambling Disorders Identification Test (Negative Consequences subscale) • Victorian Gambling Screen (Harm to Self subscale) • Problem Pathological Gambling Measure (PPGM) (Harm subscale) • CPGI-Population Harm
Treatment outcome measures (gambling outcomes)	Gambling symptoms	• Gambling Symptom Assessment Scale (G-SAS) • Problem Gambling Yale-Brown Obsessive Compulsive Scale (PG-YBOCS) (Self-Report version) • Gambling Follow-up Scale-Short Form (GFS-SF)
	Gambling frequency and expenditure	• Timeline Followback • Bespoke global assessment items
	Treatment goal and achievement	• Recovery Index for Gambling Disorder (RIGD) (Gambling Reduction Subscale)

Table 2 (continued)

Domain	Construct	Illustrative Measures
Treatment outcome measures (non-gambling outcomes)	Depression symptoms	• Goal Attainment Scaling (GAS) • Patient Health Questionnaire (PHQ-2 or PHQ-9) • Depression Anxiety Stress Scale (DASS) (Depression subscale) • Hospital Anxiety and Depression Scale (HADS_ (Depression subscale) • Beck Depression Inventory-Short Form (BDI-SF) • Kessler scales (K6 or K10) (Depression items)
	Anxiety symptoms	• Generalised Anxiety Disorder (GAD-2 or GAD-7) • Depression Anxiety Stress Scale (DASS) (Anxiety subscale) • Hospital Anxiety and Depression Scale (HADS) (Anxiety subscale) • Hamilton Anxiety Rating Scale • Spielberger State-Trait Anxiety Inventory-Short Form (STAI-SF) • Kessler scales (K6 or K10) (Anxiety items)
	Functional impairment	• Recovery Index for Gambling Disorder (RIGD) (Life Functioning subscale) • WHO Disability Assessment Schedule (WHO-DAS) • Work and Social Adjustment Scale (WSAS)
	Well-being/quality of life	• Personal Well-being Index (PWI) • WHO-5 Well-being Index • EUROHIS-QOL-8
Processes of change measures	Gambling cognitions	• Gamblers Beliefs Questionnaire (GBQ) (Luck/Perseverance subscale, Illusion of Control subscale) • Gambling Cognitions Inventory (Luck and Chance subscale) • Gambling-Related Cognitions Scale (GRCS) – 5 subscales including Interpretive control/bias subscale • Gambling-Related Cognitions Scale (RCS) - Illusion of Control subscale (4 items) and predictive control (6 items) • Johnson-Abbott Scale (Gambling Fallacy subscale)
	Gambling urges	• Gambling Symptom Assessment Scale (G-SAS) (Urge subscale) • Gambling Urge Scale (GUS) • Gambling Craving Scale (GCS) • Recovery Index for Gambling Disorder (RIGD) (Urge Coping subscale) • Penn Gambling Craving Scale (PGCS) • Craving Experience Questionnaire (CDQ) (Frequency subscale, Strength subscale)
	Readiness to change	• Readiness ruler (readiness) • Volitional Scale • Gambling Readiness to Change Questionnaire (GRTC) • University of Rhode Island Change Assessment Scale (URICA-12)
	Self-efficacy	• Brief Situational Confidence Questionnaire-Gambling (BSCQ-G) • Readiness ruler (confidence)
Client satisfaction measures	Client satisfaction	• Client Satisfaction Questionnaire (CSQ-4 or CSQ-8) • Service Evaluation Questionnaire (SEQ)
	Client session satisfaction/outcomes	• Session Rating Scale (SRS) • Session Impacts Scale (SRS) • Clinical Global Impressions Scale (Severity, Improvement) (clinician-reported)

Table 3
Domain, Constructs, and Illustrative Measures for Affected Others

Domain	Construct	Illustrative brief measures
Screening measures	Suicidal ideation	• Beck Depression Inventory-II (Item 9) • Patient Health Questionnaire (PHQ-9) (Item 9) • Ask Suicide-Screening Questions • Patient Safety Screener (PSS)
	Family violence	• Hurt, Insult, Threaten, and Scream (HITS) • Woman Abuse Screening Tool- Short Form (WAST-SF) • Partner Violence Screen (PVS) • Abuse Assessment Screen (AAS)
	Hazardous alcohol use	• Alcohol Use Disorders Identification Test (Short Forms) (AUDIT-C, AUDIT-3) • CAGE • T-ACE/TWEAK • Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TPS-Part 1) – Alcohol item
	Other drug use	• Severity of Dependence Scale (SDS) • Single-Question Screening Test for Drug Use in Primary Care • Tobacco, Alcohol, Prescription Medication, and other Substance use Tool (TPS-Part 1) – Alcohol item
	Depression symptoms	• Patient Health Questionnaire-2 (PHSQ-2) • Kessler scales (K6 or K10) (depression items)
	Anxiety symptoms	• Generalised Anxiety Disorder-2 (GAD-2) • Spielberger State-Trait Anxiety Inventory (5-item Short Form) (STAI-Short Form) • Kessler scales (K6 or K10) (anxiety items)
	Own gambling problems	• One-Item Screen • Brief Problem Gambling Screen (BPGS) (2-5 item versions) • Lie/Bet Questionnaire • Consumption Screen for Problem Gambling (CSPG) • NODS-CLiP/NODS-CLiP2 • Problem Gambling Severity Index-Short Form (PGSI-SF) • Rapid Screener for Problem Gambling (self-assessment version) (RSPG-SA) • NODS-PERC
		• Single items
Assessment measures (Descriptive at intake only)	Affected other status	• Adapted Lie/Bet Questionnaire • Concerned Others Gambling Screen • CSO DSM-IV Screening Questionnaire
	Gambling harms	• Problem Gambling Significant Other Impact Scale (PG-SOIS) • Problem Gambling Family Impact Measure (PG-FIM) • Inventory of Consequences Scale (ICS) (CSO Emotional Consequences subscale, CSO Behavioral Consequences subscale) • Gambling Harm Scale-10-Affected Others (GHS-10-AO) • Short Gambling Harms Screen-Concerned Significant Others Scale (SGHS-CSO) • Short Questionnaire for Family Members Affected by Addiction (SQFM-AA) (Psychological Symptoms subscale, Physical Symptoms subscale)
Treatment outcome measures (affected other focused)	Depression symptoms	• Patient Health Questionnaire (PHQ-2 or PHQ-9) • Depression Anxiety Stress Scale (DASS) (Depression subscale) • Hospital Anxiety and Depression Scale (HADS_ (Depression subscale)

Table 3 (continued)

Domain	Construct	Illustrative brief measures
Treatment outcome measures (gambler focused)	Anxiety symptoms	• Beck Depression Inventory-Short Form (BDI-SF) • Kessler scales (K6 or K10) (Depression items) • Generalised Anxiety Disorder (GAD-2 or GAD-7) • Depression Anxiety Stress Scale (DASS) (Anxiety subscale) • Hospital Anxiety and Depression Scale (HADS) (Anxiety subscale) • Hamilton Anxiety Rating Scale • Spielberger State-Trait Anxiety Inventory-Short Form (STAI-SF)
	Stress symptoms	• Kessler scales (K6 or K10) (Anxiety items) • Perceived Stress Scale-4 (PSS-4)
	Functional impairment	• WHO Disability Assessment Schedule (WHO-DAS) • Work and Social Adjustment Scale (WSAS)
	Well-being/quality of life	• Personal Well-being Index (PWI) • WHO-5 Well-being Index • EUROHIS-QOL-8
Processes of change measures	Gambling support self-efficacy	• Caregiving Self-Efficacy Scale-8 (CSES-8)
Processes of change measures	Coping	• Brief COPE (e.g., Active Coping subscale, Planning Coping subscale, Self-Blame subscale, Behavioral Disengagement subscales) • Short Questionnaire for Family Members Affected by Addiction (SQFM-AA) (Tolerant-Inactive Coping subscale, Withdrawal Coping subscale, Engaged-Emotional Coping subscale, Engaged-Assertive Coping subscale)
	Social support	• Brief-COPE (Emotional Support subscale, Instrumental Support subscale) • Brief Social Support Scale (BSS6) • Perceived Social Support Questionnaire (PSSQ) • Short Questionnaire for Family Members Affected by Addiction (SQFM-AA) (Helpful Informal Support subscale, Unhelpful Informal Support subscale, Helpful Formal Support subscale)
Client satisfaction measures	Client satisfaction	• Client Satisfaction Questionnaire (CSQ-4 or CSQ-8) • Service Evaluation Questionnaire (SEQ)
	Client session satisfaction/outcomes	• Session Rating Scale (SRS) • Session Impacts Scale (SRS) • Clinical Global Impressions Scale (Severity, Improvement) (clinician reported)

section outlines these measures separately for gambling clients (Table 2) and affected other clients (Table 3).

Assessment of Gambling Clients Screening Measures

Screening for common comorbidities and risk factors associated with GD was limited to tools with five or fewer items. These screening instruments focus on

issues that may affect treatment engagement or indicate a need for additional support, such as suicidal ideation, family violence (victimization and perpetration), hazardous alcohol or drug use, depression, anxiety, and gaming. It is worth noting that there are few brief screening tools for some of these issues, including suicidal ideation, family violence perpetration, and excessive gaming. For example, conducting an accurate suicide risk assessment using brief screening measures remains a challenge as there are various factors

that influence suicidality levels; as such, risk formulation should be a process that involves both standardized measures and detailed clinical interviews repeated over time (Lotito & Cook, 2015). Similarly, few brief screening instruments are available for family violence perpetration, although some gambling studies have adapted short victimization screens to screen for perpetration (Dowling et al., 2018; Dowling et al., 2014; Dowling, Oldenhof, et al., 2021). Finally, the Three-Item Gaming disorder Test Online Centred (TIGTOC) is the only brief standardized screening tool for gaming available. It demonstrates good reliability and validity, as well as good classification accuracy relative to mental health specialist diagnoses of gaming disorder criteria (Jo et al., 2018). These tools are nondiagnostic but are used to inform clinical judgment or guide referrals.

Assessment Measures

Measures to describe gambling clients usually focus on key characteristics relevant at treatment entry. These characteristics can include demographics (typically including gender, age, ethnicity or culture, household income, and postcode, with other fields included depending on local priorities), the gambling activities on which clients experience harm, the mode of gambling, problem gambling severity, and gambling-related harm. While not core to assessment, it may also be helpful to assess aspects of help-seeking, including previous service use and experiences.

Bespoke items tend to be used to assess the gambling activities on which clients experience harm or the mode of gambling as there are no specific standardized measures available. Some measures like the South Oaks Gambling Screen (SOGS; Lesieur & Blume, 1987) and the longer form of the PGSI (CPGI; Ferris & Wynne, 2001) include items about gambling activities. For example, the SOGS asks about the frequency of engagement with 10 forms of gambling (not at all, less than once a week, once a week or more), while the CPGI measures gambling involvement (type, frequency, duration and expenditure) over the past 12 months asking how often the person spent money/played/bet on different forms of gambling selected from a list. It has been noted that the list should reflect the jurisdiction in which the tools are being administered and to cover all gambling activities that are available (Ferris & Wynne, 2001). Furthermore, terminology can be adjusted to suit the local context, such as pokies, slots, or fruit machines. Given the rise in online gambling, including sports and numbers games (Tran et al., 2024), it is important to determine the mode of gambling. This information is collected to describe the broader population accessing

services. While more detailed insights into gambling behavior are captured through outcome measures later in treatment, these intake questions are designed to support service-level reporting and planning.

Problem gambling and gambling harm are conceptually related, but distinct, constructs (Delfabbro & King, 2020). Problem gambling involves behavioral dependence such as tolerance, loss of control, continued use despite negative consequences, withdrawal symptoms, and mood modification alongside harmful consequences (American Psychiatric Association, 2013). In contrast, gambling harm refers to any initial or exacerbated adverse consequence resulting from engagement with gambling that leads to a decline in health or well-being at the individual, family, community, or population level (Abbott et al., 2018; Langham et al., 2015). Many problem gambling assessment instruments, such as the Problem Gambling Severity Index (PGSI; Ferris & Wynne, 2001), were designed for population prevalence studies and are not well suited to monitoring change in clinical settings. These measures use past-year timeframes and tend to classify most people who seek treatment as experiencing gambling problems (Merkouris et al., 2020), which limits discrimination among treatment seekers and reduces sensitivity to clinical change. Most reports indicate that clinical services see a majority of people who score 8 or more on the PGSI (Merkouris et al., 2020; Molander & Wennberg, 2023; Rodda & Lubman, 2014; Ronzitti et al., 2017; Rush et al., 2002; Sharman et al., 2019). However, where a formal classification or diagnosis is required for referral, insurance, eligibility for funded care, or other administrative purposes, measures such as the PGSI can be used, ideally followed by a diagnostic clinical interview to ascertain diagnostic status (Aslan et al., 2025).

Gambling harm focuses on the impacts of gambling behavior regardless of whether dependence symptoms are present. Gambling harm is not suitable as a treatment outcome (Aslan et al., 2025; Australian Psychological Society, 2025) because harms tend to lag behind changes in gambling behavior and can persist long after gambling behavior has reduced or ceased (Rockloff et al., 2022). Moreover, gambling harm is usually measured with a past-year or lifetime timeframe. However, it may be a useful descriptive construct at intake, helping services understand the types and extent of impact experienced by clients at the point of treatment entry. While increasingly used in research and practice, tools measuring gambling harm remain in the early stages of validation for routine clinical settings. The 10-item Gambling Harms Scale (Browne et al., 2018), which measures gambling harm over the previous year, is the most widely validated

measure, but the 7-item Global Harms Scale (Syvertsen et al., 2023) is recommended when comprehensive coverage across harm domains is needed.

Treatment Outcome Measures

Measurement of treatment outcomes is most effective when it reflects the aims and intentions of the intervention delivered. Outcome measurement for gambling clients can include gambling-specific outcomes (e.g., gambling frequency, expenditure, or symptom severity), nongambling outcomes (e.g., depression or anxiety), and broader recovery outcomes (e.g., well-being or goal achievement). These outcomes are commonly assessed at multiple timepoints, such as posttreatment and follow-up, to support evaluation of progress over time.

Gambling Outcomes

There are very few measures specifically designed to assess change in gambling symptoms during treatment. One exception is the Gambling Symptom Assessment Scale (G-SAS; Kim et al., 2009), which focuses on gambling symptoms over the past 7 days. The G-SAS has demonstrated good reliability and validity for tracking symptom change throughout treatment, with cut-off scores indicating extreme, severe, moderate, mild, and minimal gambling symptoms.

Despite being widely used in both research and clinical settings, there are no standardized measures of gambling behavior that assess frequency, expenditure, or time spent. The TimeLine Followback (TLFB) method is widely regarded as a gold standard for detailed behavioral assessment (Weinstock et al., 2004). It uses a calendar-based system with visual prompts to support recall of past behavior and is valued for its accuracy. However, the TLFB also requires specific training and can be time intensive to administer. Recent evidence suggests that, for expenditure at least, brief single-item global questions may perform just as well as the more detailed TLFB method (Paul et al., 2024). In practice, many services develop their own global assessment items to measure these indices of gambling behavior. Given the increasing rate of online access across all forms of gambling (Gainsbury et al., 2015), an example of this approach is the use of brief items to assess gambling frequency and expenditure by modality. For example, clients may be asked to report the number of days and total amount spent on in-venue gambling (such as pokies, casino games, lotteries, or bingo) and on online gambling (such as racing, sports betting, or other app- or web-based platforms) over the past month. When interpreting expenditure responses, services may choose to compare this data against low-risk gambling limits, which have been

developed in several jurisdictions including Australia, Canada, and the UK (Dowling et al., 2022; Dowling, Youssef, et al., 2021; Hodgins et al., 2023; Young et al., 2024). These limits reflect increased risk of harm when individuals gamble more frequently, spend more, or use a higher proportion of income than recommended. International evidence suggests risk increases when gambling exceeds 1–3% of income, occurs more than five to eight times per month, or involves spending more than US\$45–90 per month (Hodgins et al., 2023).

A harm reduction approach is common in many treatment services, allowing for both abstinence and nonabstinence goals. Research indicates that approximately one-quarter to one-third of clients select nonabstinence goals, such as reducing or avoiding specific gambling types while continuing other forms of gambling at manageable levels or reducing the frequency, expenditure, or duration of gambling (Rodda et al., 2018). Research shows that nonabstinence goals are viable in the treatment of GD (Dowling et al., 2009) but there are few measures of treatment goal achievement. One recent development is the Gambling Reduction subscale of the Recovery Index for Gambling Disorder (RIGD; Pickering et al., 2021), which supports the setting and evaluation of personalized goals. It includes assessment of goal type (e.g., reduce, avoid, continue), self-efficacy to meet the goal, and whether the goal was achieved. This subscale has demonstrated good reliability and validity. Because goals may change over time (Ladouceur, 2005), measurement of treatment goals and gambling behavior relative to these goals should occur at multiple points throughout treatment and follow-up.

Nongambling Outcomes

Nongambling outcomes reflect changes in areas beyond gambling behavior, including mental health, daily functioning, and overall well-being or quality of life. These domains are particularly relevant in treatment settings in which treatment goals extend beyond gambling symptom reduction to broader indicators of recovery.

Depression and anxiety are among the most common mental health concerns reported by people seeking support for gambling-related problems (Armoon, Griffiths, Fleury, et al., 2023; Dowling et al., 2015), highlighting the importance of screening for these conditions at intake for possible referral to mental health services. They are also very commonly reported in GD treatment outcome trials (Pickering et al., 2018), suggesting they are often targeted by GD treatments. If improvements in these symptoms are intended treatment outcomes, various brief, validated screening tools

are available for their assessment. Common examples include the Patient Health Questionnaire-2 (Kroenke et al., 2003), which assesses the frequency of depressed mood and anhedonia (core symptoms of depressive disorders) and the Generalised Anxiety Disorder-2 (Sapra et al., 2020), which focuses on nervousness and difficulty controlling worry. Both tools are widely used due to their brevity, and each has demonstrated good reliability, validity, classification accuracy relative to gold-standard diagnosis, and sensitivity to change. Composite measures such as the Kessler-6 (K6; Kessler et al., 2002) are also used in some settings to screen for general psychological distress across anxiety and depressive symptoms.

Functional impairment, which refers to the extent to which gambling disrupts an individual's ability to perform everyday tasks and fulfill roles in work, home life, and social relationships, is increasingly recognized as an important outcome in gambling treatment (Pickering et al., 2021). Although related to harm, functional impairment specifically focuses on the impact of gambling on day-to-day functioning, rather than the consequences of gambling behavior itself. While several measures are available, many are lengthy, oriented toward physical health, or restricted by licensing requirements. In practice, a brief tool like the Work and Social Adjustment Scale (Mundt et al., 2002) can be used to assess functioning across areas such as employment, domestic responsibilities, leisure activities, and relationships. This tool has demonstrated good reliability, validity, classification accuracy, and sensitivity to change over time.

The concept of recovery has broadened in recent years to encompass more than just abstinence or the reduction of symptoms (Mansueto et al., 2024; Nower & Blaszczynski, 2008; Pickering et al., 2021). Recovery is now widely understood as a dynamic and individualized process that includes improvements in overall health, functioning, and well-being (Mansueto et al., 2024; Nower & Blaszczynski, 2008; Pickering et al., 2021). This broader perspective emphasizes that quality of life is a meaningful and legitimate treatment outcome. There is a large range of brief tools to measure quality of life and well-being. The EUROHIS-QOL-8 is one example, offering the briefest version of the WHO's internationally recognized quality-of-life instruments, appropriate for use across cultures (Schmidt et al., 2006). It provides a concise assessment of overall quality of life across diverse populations and has demonstrated good cross-cultural performance, reliability, validity, and sensitivity to change.

Processes of Change Measures

Treatment outcome measurement is strengthened when it also captures the processes or mechanisms targeted by intervention (Walker et al., 2006). These constructs can support treatment planning and help explain how therapeutic approaches lead to desired outcomes. In gambling treatment, these mechanisms are often considered secondary outcome measures because they reflect the underlying psychological processes targeted by therapy (Australian Psychological Society, 2025; Pickering et al., 2018; Walker et al., 2006). For example, CBT aims to change unhelpful thinking patterns and reduce gambling urge intensity, while MI focuses on enhancing readiness to change and self-efficacy (confidence) to manage high-risk situations. Measuring these processes can help services understand whether the treatment is working as intended, even before changes in gambling behavior are observed.

CBT interventions target distorted gambling-related thoughts through cognitive restructuring techniques (Pfund, Ginley, et al., 2023). While gambling cognitions are sometimes measured as treatment outcomes, many existing tools are lengthy and not feasible for use in routine care, highlighting the need for measures that are able to be embedded in routine service delivery. Clinicians also use and endorse the effectiveness of urge management in the context of relapse prevention in CBT (Keshani et al., 2025; Rodda et al., 2018). The most used measure of gambling urges is the Gambling Urge Scale (Smith et al., 2013), but it only measures the presence of gambling urges in the moment. The Penn Gambling Craving Scale (Tavares et al., 2005), which was adapted from that for alcohol use, is a good alternative as it measures urge frequency, intensity, duration, and self-efficacy to manage urges over the previous week.

In MI, readiness to change refers to how prepared a person feels to make changes to their gambling behavior, while importance reflects how meaningful the change is to them, and confidence/self-efficacy refers to their perceived ability to make the change (Heather et al., 2008). These concepts are often assessed using readiness rulers that are brief numerical or visual tools commonly used in MI and other behavior change interventions. Sometimes described as assessing how "ready, willing, and able" a person is to change, these tools offer a simple and intuitive way to engage clients in conversations about motivation and progress (Rodda et al., 2015). Slightly longer measures are also available, such as the University of Rhode

Island Change Assessment to measure readiness to change (Petry, 2005) or the Brief Situational Confidence Questionnaire–Gambling to measure self-efficacy in various high-risk situations (Coloma-Carmona et al., 2025). These measures can help identify ambivalence, tailor strategies to the client's stage of change, and be revisited throughout treatment to track change over time.

In addition to these commonly targeted mechanisms, there are a range of other constructs that may support treatment planning or function as processes of change. These include coping strategies, social support, self-esteem, emotion regulation, distress tolerance, anger, mindfulness, acceptance, problem-solving, and exposure to stressful life events. Brief, validated tools that assess these areas may be useful in specific cases, particularly where treatment is tailored to address co-occurring issues or barriers to change.

Issues Relating to Service Closure

Evidence suggests that a considerable proportion of clients pull out of gambling treatment early (Hawker, Dias, et al., 2025; Hawker, Dowling, et al., 2025; Pfund et al., 2021). It is therefore helpful to document how and why treatment ends. Services may choose to record whether the client is expected to return for further sessions and, if not, the reason for treatment closure. Recording this information can support accurate reporting, improve understanding of client pathways, and help differentiate between planned completions, disengagement, and other administrative outcomes. Assessing client satisfaction at posttreatment and follow-up also provides important insight into the perceived quality and effectiveness of care from the client's perspective. Satisfaction data can inform service improvement, support person-centred care, and help ensure that treatment aligns with client expectations. In routine practice, brief satisfaction measures are commonly used due to their ease of administration and interpretation. These measures demonstrate good reliability, validity, and sensitivity to change. Given some clients who pull out of treatment are unable to be contacted (Hawker, Dowling, et al., 2025), session satisfaction measures, such as the Session Rating Scale (Duncan et al., 2003) or the Session Impacts Scale (Elliott & Wexler, 1994), supplemented with clinician session ratings of severity and/or improvement using the Clinical Global Impressions Scale (Busner & Targum, 2007), can offer ultra-brief insights into the satisfaction and outcomes of each client at their last service contact.

Assessment of Affected Others

There are few brief fit-for-purpose validated instruments to assess affected others (Australian Psychological Society, 2025; Dowling, Hawker, et al., 2025b). It has therefore been suggested that the available tools can therefore be supplemented or replaced with generic measures (Australian Psychological Society, 2025).

Screening Measures

Like gambling clients, affected other clients may experience difficulties that interfere with engagement or signal a need for further evaluation or support. Screening for issues such as suicidal ideation, family violence, hazardous alcohol use, other drug use, and mental health symptoms (depression and anxiety) can be helpful in identifying these concerns. Given that affected others have higher rates of gambling participation, problems, and harm than nonaffected others (Dowling, Hawker, et al., 2025a; Dowling, Spence, et al., 2025; Spence et al., 2024), brief screening instruments, such as the 4-item NODS-PERC (Volberg et al., 2011), 3-item Problem Gambling Severity Index-Short Form (PGSI-SF; Williams & Volberg, 2012), 3-item NODS-CLIP (Toce-Gerstein et al., 2009), 2-item Lie/Bet Questionnaire (Johnson et al., 1997), and 1-item Screen (Thomas et al., 2010), can help determine whether additional intervention is warranted.

Assessment Measures

Services working with affected others can collect key intake information to better understand who is accessing support and the impacts they are experiencing. Like approaches used for gambling clients, this information is gathered at the beginning of treatment and may include demographic characteristics, the nature of the relationship to the person who gambles, and the degree of harm experienced as a result of that person's gambling.

Initial questions may ask whether the client has been personally affected by someone else's gambling within the past 12 months, followed by an item asking their relationship to the person who has affected them (or affected them the most), such as spouse/partner, parent/stepparent, child/stepchild, other person (in your household), other family member (not in your household), ex-partner, work colleague, friend, neighbour, and other person (Australian Psychological Society, 2025; Dowling, Hawker, et al., 2025b). This

allows for the identification of “affected family members,” “affected non-family members,” and “affected close friends.” Although there are several measures of gambling harms for affected others, most have not been subject to adequate evaluation. The exception is the Gambling Harm Scale–10 for Affected Others (GHS-10-AO; Browne et al., 2023), a brief tool developed to measure harm in affected others across multiple domains relevant to affected others, including emotional and psychological distress, relationship conflict, disruptions to routine or responsibilities, and financial strain. Although recently introduced, this scale demonstrates promising psychometric performance and aligns with broader harm frameworks used in gambling research and treatment.

Treatment Outcome Measures

Psychological interventions for affected others generally focus on either supporting the individual in coping with the consequences of someone else’s gambling (affected other-focused treatment) or helping them assist the person who gambles in seeking help or reducing their gambling (gambler-focused treatment) (Australian Psychological Society, 2025; Dowling, Hawker, et al., 2025b). In routine settings, there is limited evidence to guide outcome measurement for either approach.

Affected Other-Focused Outcomes

The 33-item Short Questionnaire for Family Members Affected by Addiction (SQFM-AA; Orford et al., 2017) offers the briefest measure to assess affected other outcomes, with broad coverage of key elements in the Stress-Strain-Coping-Support (SSCS) model (Orford et al., 2017). This framework highlights the cumulative strain experienced by family members or close others as a result of ongoing gambling-related stressors. Services may choose selected subscales of this measure, but an advantage of this measure is that a Total Family Burden (TFB) can be calculated. Because treatment outcome tools specifically developed for affected others are limited, however, many services rely on general mental health and well-being indicators. These include symptoms of depression, anxiety, functional impairment, and overall quality of life, which can be measured with the same instruments described for gambling clients. Stress is also particularly relevant construct in this context, as it is central to the SSCS model.

Gambler-Focused Outcomes

Some CBT approaches developed for the treatment of affected others, such as Community Reinforcement and Family Training (Archer et al., 2020), integrate

goals related to both the affected individual and the person who gambles. These might include improvements in the affected person’s well-being (affected other-focused outcomes) but also includes efforts to reduce gambling or increase help-seeking in the gambling client (gambler-focused outcomes). However, because the behavior of another person is outside the affected person’s direct control, focusing on gambling outcomes may be inappropriate. Instead, services may consider assessing the affected person’s confidence in supporting a family member or friend who gambles. While gambling-specific self-efficacy tools for affected others are also not yet well developed, general measures of caregiver confidence or perceived ability to cope with challenges can offer useful insights and inform treatment planning.

Processes of Change Measures. The SSCS model suggests that the degree to which the behaviors of people who gamble result in psychological and physical health problems in their family members is determined by both the ways the family members cope with the stress, as well as the professional and informal social support they receive (Orford et al., 2017). For affected other-focused treatments, processes of change may therefore include how individuals cope with stress or access emotional and practical support from others. Although there are many available measures of coping and social support, only a few are suitable for brief use in clinical settings. Services may consider using short sets of items to track changes in coping strategies or brief assessments of perceived social support. These can be revisited over time to understand whether interventions are influencing these underlying processes.

Issues Related to Service Closure

As with clients who gamble, follow-up assessment with affected others can help track progress, revisit treatment goals, and gather feedback on their experience of care. This includes using brief satisfaction or session satisfaction measures, combined with clinician session ratings of severity and/or improvement. These tools are often preferred for routine use, as the insights they provide help guide service development and ensure responsiveness to client needs. In terms of documenting treatment closure, services may use the same categories applied for gambling clients to indicate whether the client is expected to return and, if not, to record the reason the episode of care has ended. This supports accurate reporting, improves interpretation of service outcomes, and helps distinguish between planned completions and early disengagement.

Implementation of Gambling Screening and Assessment

Communicating About Gambling in a Clinical Context

Language can shape engagement with gambling-support services. Diagnostic terms such as “problem gambling” or “gambling disorder” are useful when clinical precision is critical, yet there is increasing recognition that they may also stigmatise and discourage help-seeking. Many stakeholders prefer the broader, public-health term “gambling harm,” which shifts attention from individual pathology to the social, cultural, policy, economic, environmental, and industry factors that affect individuals, families, and communities. Using this term, however, presents challenges in many clinical contexts (Delfabbro & King, 2020) as it can introduce measurement inconsistencies, reduce diagnostic precision, undermine clinical validity, remove some of the benefits of diagnostic labels, and divert focus from factors that can explain individual vulnerability and guide tailored interventions (Australian Psychological Society, 2025). A pragmatic approach for services and clinicians is therefore to reserve diagnostic terms for contexts demanding specificity, such as diagnosis, assessment interpretation, and treatment formulation or planning, but adopt broader, less stigmatizing language in client interactions, including when administering assessment measures or providing assessment feedback to clients (Australian Psychological Society, 2025). In routine practice, clinicians can reduce stigma by introducing assessment tools as ways to understand how gambling affects a person’s life and using person-first language (e.g., “person experiencing gambling harm”) instead of identity-first labels (e.g., “problem gamblers”) (Victorian Responsible Gambling Foundation, 2024). It is also important to note that people with lived experience of gambling harm have varied reactions to different terms (Victorian Responsible Gambling Foundation, 2024), highlighting the need for clinicians to also consider each client’s preferred language to support engagement and person-centred practice (Australian Psychological Society, 2025).

Administration and Delivery of Tools

All recommended tools in this guidance can be self-administered without requiring an interview or in-person assessment. The only exception is the use of clinician-reported session outcomes for services that require an indication of client functioning at last service contact in the context of clients pulling out of treatment early. While not all have been formally tested for online delivery, there is potential to explore remote

administration. For example, clients could complete brief measures between initial contact and their first session, providing helpful data for early case formulation. However, this approach is not suitable for all clients. Barriers such as uncertainty about seeking help, lower levels of literacy, or discomfort with disclosing information online may make digital completion inappropriate. In such cases, it is important to introduce tools in a way that reinforces their relevance. For example, frame the tool as part of “getting to know what matters” rather than data collection. Where possible, it is also helpful to share results with clients, either as personalized feedback or as an explanation of what the scores indicate, thereby supporting collaborative care and positioning clients as active participants in their treatment journey.

Timeliness of administration is also important. Clients often present in crisis, and in such circumstances, screening may be postponed until later sessions or missed entirely, reducing its value for treatment planning and evaluation. Introducing measures early, ideally at the point of entry or in the first session, provides a baseline against which meaningful changes can be observed, such as reduced gambling or improved self-efficacy. In terms of follow-up, international guidelines suggest repeated assessments across several time points after treatment (Walker et al., 2006). While extended follow-up over 1 to 2 years is not always achievable in routine practice, services can strengthen their evaluation efforts by at least incorporating assessments immediately after treatment and again within the first 6 months. This balance offers a practical approach that acknowledges service constraints while still supporting meaningful outcome monitoring.

A further question is whether services can choose which measures to use. While pragmatic considerations are acknowledged, it is generally recommended that services measure the outcomes they are aiming to influence. For gambling services, this means that change in gambling behavior should be evident, whether immediately or over the longer term, regardless of the types of interventions or supports offered. The recommended core items therefore reflect the minimal outcomes expected for anyone seeking help. Where it is not feasible to administer the full set of measures, such as in helpline settings, services may prioritize core gambling outcomes, including expenditure, frequency, or severity.

Cultural Adaptation and Modification of Tools

Many of the measures included in the current study have been translated into different languages and vali-

dated with non-English speaking populations. For example, the G-SAS has been validated for delivery in Chinese (Liu et al., 2025), Japanese (Yokomitsu & Kamimura, 2019), and Spanish (Diaz-Sanahuja et al., 2023). Services can search for specified tools to determine if they have been translated into languages common in their service or whether jurisdiction specific validation has occurred. Services may also wish to adapt tools to better reflect the cultural needs of their clients or the local context. This can include offering translated versions, adapting language for accessibility, or substituting tools entirely where specific cultural considerations are involved. These changes may be appropriate, particularly where tools have not been validated in the local population or where certain phrasing may not resonate with clients. However, any modification of tools should be approached with care. Measures are typically validated in their original form, and even small changes can affect their reliability and validity. If adapting a tool, services should consider conducting basic testing such as cognitive interviews or focus groups to ensure items are understood as intended. Ideally, this process would be guided by a researcher or evaluator to ensure rigour. Because the guidance in this document is intended for broad use across settings, tools were not selected on the basis of cultural validation. However, services are encouraged to consider whether a measure has been validated for use in their specific setting, population, or language.

Use of Supplementary Measures

There are many valid ways to implement CBT and its variants, and similarly, many paths through which individuals experience recovery from gambling harm. Given this diversity, the core outcomes and screening items identified in this guidance are not intended to be exhaustive. Rather, they reflect the common elements most consistently targeted in practice and supported by available evidence. These core items serve as a foundation for routine measurement but do not preclude the use of additional tools tailored to specific needs.

In addition to the core measures, services may wish to include supplementary tools to explore areas such as trauma and PTSD, ADHD, parenting, relationship functioning, or financial stress. These can add clinical value, particularly when they align with the client's presenting concerns. However, tools administered to all clients (Marionneau et al., 2025) signal that the domains being measured are universally relevant and routinely addressed in treatment. For example, if all clients are asked to complete a measure on relationship quality, this implies that relationship issues form a standard part of the intervention. In most services,

such domains will only apply to a subset of clients. Administering specialized tools more broadly than needed can lead to confusion, reduced engagement, or unnecessary assessment burden. A more effective approach is to use these tools selectively, based on clinical judgment, treatment planning, or specific referral pathways. This allows for a more individualized and responsive assessment process, while maintaining clarity about which outcomes are shared across the client population.

Public Health and Community-Based Use of Screening Tools

Many gambling services also engage in community outreach, public health initiatives, and partnerships with allied sectors such as alcohol and other drug treatment and mental health services. It is recommended that screening for gambling harm be implemented in settings where individuals at risk are likely to present (Australian Psychological Society, 2025; Cowlishaw et al., 2025; Dowling et al., 2014; Manning et al., 2017; National Institute for Health and Care Excellence, 2025). These include financial counselling services, mental health and addiction services, general practice settings, and occupations associated with higher rates of gambling harm, such as those working in the gambling industry or the military. Allied services may also use brief problem gambling screens, such as the NODS-CLiP (Dowling et al., 2019). While these tools show promise for identifying at-risk or problem gambling in community settings, further research is needed to ensure they are sufficiently sensitive for detecting more severe GD, particularly in nonspecialist contexts.

Strengthening Outcome Measurement in Gambling Services

Improving outcome measurement in gambling treatment requires tools that are both practical for service delivery and meaningful to clients. CBT remains the most commonly used approach, though its delivery varies widely (Rodda et al., 2018). The core outcomes identified here reflect shared goals across services, including symptom reduction, improved functioning, and recovery. These measures also capture mechanisms of change central to CBT and MI, such as readiness to change, coping, and cognitive distortions. Measures for other therapeutic approaches that are also used (Maynard et al., 2018) could be added where appropriate. Similarly, objective process measures are emerging, such as the ratio of sustain talk to change talk, and these could be a focus for future studies.

There is a clear need for stronger evidence on who is accessing gambling services, particularly to deter-

mine whether their needs differ from those typically represented in clinical trials. This requires attention to cultural diversity, lived experience, and the specific contexts in which services are delivered. Outcome measures must be brief, easy to administer, and appropriate for services where clients may not be paid or motivated by research incentives. When applied effectively, such tools can strengthen the scientist-practitioner model, support collaborative treatment planning, and enhance engagement by encouraging clients to reflect on their own progress and priorities. Despite the maturity of the field, it is concerning that evidence continues to lag behind practice, with many widely validated screening tools still lacking adequate validation in gambling-specific populations. Future development should focus on building a stronger evidence base for tools that work across diverse treatment models and client populations. This includes validating tools for broader cultural and linguistic contexts and ensuring that they align with what matters to clients, not just what is easy to measure. Engaging clinicians, clients, and people with lived experience will be key to ensuring outcome measurement supports the therapeutic process.

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